DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	09G232		05/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES, INC	5706 14TH STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from May 1, 2013 through May 3, 2013. A sample of three clients was selected from a population of five females with various intellectual disabilities. This survey was initiated utilizing the fundamental survey process; however, during the survey it was revealed that the facility failed to obtain 24-hour skilled nursing services timely in order to address Client #3's change in health status (unresponsiveness). Based on the aforementioned information, it was determined that conditions existed that posed an immediate and serious threat to Client #3's health and safety. On May 3, 2013, at 5:15 p.m., the administrator was notified that an immediate jeopardy (IJ) existed. The facility presented a plan to address the IJ on May 3, 2013, at 8:15 p.m. The plan was reviewed and the IJ lifted at 8:35 p.m. The plan included the following: - As of May 3, 2013, the facility will staff Client #3 with licensed practical nurse (LPN) or registered nurse (RN) staffing 24 hours a day, 7 days a week until skilled nursing is approved through the Department on Disability Services (DDS). The LPN and facility will be competent to address the episodes if the client becomes unresponsive through specific comprehensive training on her Health Management Care Plan, Health Passport, recent hospitalizations and Emergency Protocol Procedures. - Long term procedures include identifying and hiring additional LPN's specifically for the increased acuity levels. However, until that time,	W 000	Received 6/3/13 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: VaShaun Gaill | TITLE: Program Director | (X6) DATE: 6-3-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 000	Continued From page 1 the facility will continue to use current LPN personnel to ensure Client #3's health and safety through 24-hour skilled nursing. - All nurses, current and future, will be trained on Client #3's Health Management Care Plan, Health Passport, recent hospitalizations and Emergency Protocol Procedures. Per shift training will start May 3, 2013, and will be continuous until all LPN's covering the shifts have completed the necessary training. - All direct support professionals (DSP's) will be in-serviced on Client #3's Health Management Care Plan, Health Passport, recent hospitalizations and Emergency Protocol Procedures. Training will begin May 3, 2013, with continuous training per shift until all DSP's working at this facility have completed the necessary training. Competency based testing will be given on May 9, 2013, to ensure the training was effective and comprehensive. In addition, henceforth the RN will give monthly refresher training, and comprehensive testing will be put in place as a Quality Assurance tool to ensure DSP's are knowledgeable of Client #3's health concerns and emergency procedures. - As per our intermediate care facility provider agreement, the primary care physician (PCP) is available 24/7 for full contact in cases of emergency or concern. In addition, the PCP has been notified on May 3, 2013, of the implementation of the 24hr. skilled nursing for Client #3. [Note: Although the plan was approved by the State agency and the immediacy was removed,	W 000		

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W 000	Continued From page 2 the facility was monitored on the following day (May 4, 2013), at 11:24 p.m., to ensure compliance with the plan of correction submitted. There was a nurse on site and the visit did not reveal any concerns. The facility however, remained out of compliance with the condition of participation in Health Care Services.] The findings of the survey were based on observations in the home and one day program, interviews with two court-appointed medical guardians, direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	W 000		
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that justified the withdrawals/expenditures from each client's personal account, for one of three clients in the sample. (Client #1) The finding includes: On May 2, 2013, at 1:48 p.m., review of Client #1's Psychological Evaluation, dated March 5,	W 140	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; As a corrective action Marjul Homes has replaced the money that was unaccounted for in receipts. The unaccounted for amount of funds for Individual #1 was 1000.00 after finding receipts for the amounts which were 182.69 and 317.99 the Surveyor at the time found a total of 500.68 in receipts. The total withdrawal amount was 1500.00 once you minus the 500.68 from 1500.00 the total amount unaccounted for is a total of 999.32. Therefore Marjul Homes deposited on 5/3/13 a total of 1000.00 in #1 Capital One Community Bank Account. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken: Due to the findings of the survey, MarJul Homes will complete a monthly financial audit to ensure that all other withdrawals have the	

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W 140	Continued From page 3 2013, revealed that she was functioning at the profound level and lacked the capacity to make decisions independently, including financial decisions. The client's Individual Support Plan, dated March 3, 2013, assigned the management of her funds to the facility and the client's service coordinator. On May 3, 2013, beginning at 3:25 p.m., review of Client #1's financial records revealed that $1,500 dollars was withdrawn from her account on August 30, 2012. There were two receipts dated August 30, 2012 for purchases of $182.69 and $317.99. There was no record of what happened to the balance ($1499.99). On May 3, 2013, at 4:45 p.m., the facility's program director (Staff #4) was asked about Client #1's bank withdrawal from August 30, 2012. After reviewing Client #1's financial records, at 4:54 p.m., she confirmed there were no additional receipts indicating other purchases, and no evidence that the balance had been deposited back into the client's account. Further interview revealed that she routinely performed quarterly audits of each client's funds. She stated that she had not identified any concerns or missing documentation in past audits. During the Exit teleconference held May 6, 2013, beginning at 2:13 p.m., Staff #4 stated that management had since deposited $1499.99 into Client #1's account (after May 3, 2013).	W 140	appropriate amount of receipts to accompany purchases. This audit will start as of 6/1/13 and will be monthly for the first quarter June through August. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur, and How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented: As a systematic change, Marjul Homes is restructuring its financial policies and procedures to include a new financial ledger and monthly statement that is through excel spread sheet. This spread sheet has an automated calculation system which identifies deposits, withdrawals and expenditures spent. This system will be put in place as of 6/1/13. In addition, the QA system to monitor our financial records will include monthly Case Reviews where each home is audited from the entire management team; this was outside entity's looking in have a fresh eye on items that are deficient.	
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management.	W 247	W247 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; Individual #1 will be given the opportunity to self-management medication. As of 5/3/13 LPN's have been trained to let Individuals #1 self-medicate with assistance if needed. How	

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W 247	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's nursing staff failed to ensure client self-management during the medication administration process, for one of three clients in the sample. (Client #1) The finding includes: On May 1, 2013, beginning at 7:02 a.m., Client #1 was observed eating breakfast independently using a built-up handled spoon and a high sided plate. However, during the morning medication administration process, at approximately 8:45 a.m., a licensed practical nurse (Staff #6) was observed to stir Client #1's medications (crushed) with apple sauce and spoon feed her, using a regular teaspoon. During dinner that evening, which began at 6:00 p.m., Client #1 was again observed eating independently, using her built-up handled spoon. On May 2, 2013, at 1:09 p.m., review of Client #1's Occupation Therapy evaluation, dated July 3, 2012, verified that she ate independently, using her prescribed adaptive equipment. moments later, when asked about Client #1's spoon, the qualified intellectual disabilities professional (Staff #1) stated she had always observed the client feeding herself independently. At the time of the survey, facility nurses did not consistently provide clients the opportunity for self-management during the medication administration process.	W 247	will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken: LPN's have been trained to identify individuals who have the ability to perform daily routine activities of living such as self-feeding, independence in food preparation and self-bathing as signs of independence and strengths in adaptive skills that could benefit in self-medication. Training was held on 5/8/13. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur, and How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented: As a systematic update MarJul Homes will complete self-med assessments for all individuals as well as incorporate a Nursing QA system which focuses on LPN Job duties as well as the overall functions of the RN, this system will be put into place as of 6/1/13. W318 (Failure to provide Skilled Nursing) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; MarJul Homes as of 5/3/13 will staff #3 with LPN staffing 24 hours a day 7 days a week until skilled nursing is approved through DDS. The LPN and facility will be competent to address the episodes if #3 becomes unresponsive through specific comprehensive training on #3's HMCP, HP, Recent Hospitalizations and
W 318	483.460 HEALTH CARE SERVICES	W 318		

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W 318	Continued From page 5 The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on interviews and record verification, the facility failed to provide preventive health care services to meet one client's assessed needs [See W322] and failed to ensure skilled nursing services, to ensure one client's health and safety [See W331]. The effects of these systemic practices resulted in the demonstrated failure of the facility to provide health care services.	W 318	Emergency Protocol Procedures. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken: as of 5/8/13 LPN have been trained to identify similar diagnosis and behaviors as well as to follow up and review all FU recommendations given by PCP or any other consultant, doctor and or medical entity that can make a recommendation that could affect or improve the health and or safety of our individuals. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur, and How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented: A temporary schedule to ensure 24hr. LPN Skilled Nursing until Monday has been put into place as of 5/3/13. Once MarJul Homes identifies permanent Skilled Nursing a formal schedule will be implemented and forwarded to your agency. However until that time MarJul Homes will continue to use current LPN Personnel to ensure #3 receives 24hr. skilled nursing. All (Skilled Nursing) Nurses will be trained on Individual #3'a HMCP, HP, Recent Hospitalizations and Emergency Protocol Procedures. Per shift training will start as of 5/3/13 on LPN's providing skilled nursing; training will be continuous until all LPN covering the shifts have completed the necessary training. As a QA measure RN will send prior week's schedule of skilled nursing coverage to Program Director weekly to ensure all 24hrs of skilled nursing is covered. Also RN is required to do daily checks to ensure that 24 hours skilled nursing is in place, if for some reason RN cannot find coverage RN is required to work the shift.	
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide or obtain Skilled Nursing services, for the one client (of five individuals residing in the facility) with the assessed need. (Client #3) The finding includes: [Cross-reference to W331] On May 1, 2013, at 11:20 a.m., concurrent interview with the facility's registered nurse (RN, Staff #5) and the qualified intellectual disabilities professional (Staff #1) revealed that Client #3's primary care physician	W 322		

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W 322	Continued From page 6 (PCP, Staff #7) had recommended that she receive Skilled Nursing services. They indicated that the interdisciplinary team had agreed with the recommendation at the client's annual Individual Support Plan meeting, on April 29, 2013. Later on May 1, 2013, at 4:50 p.m., it was revealed that on January 30, 2013, Client #3 became nonresponsive and 911 was called. She was admitted to the hospital and intubated. She was discharged on February 5, 2013 with diagnosis "Transient altered mental status, still altered, and Hypotension, resolved, etiology unknown." On February 9, 2013, 911 was called when she failed to respond to her name and she appeared slow and sluggish. On April 4, 2013, the client became unresponsive to her name after staff made several attempts to get a response. The facility's house manager (a licensed practical nurse, LPN, Staff #2) initiated cardiopulmonary resuscitation (CPR), as she could not detect a pulse. Client #3 became responsive by the time paramedics arrived. However, she was taken to the emergency room (ER) where there is indication that she "coded" while there. She was subsequently admitted and intubated. She was discharged on April 11, 2013. On May 2, 2013, Client #3's court-appointed medical guardian was interviewed by telephone, beginning at 10:41 a.m. He stated that "within the last couple of weeks" the PCP (Staff #7) informed the team that he thought the client would benefit from having a nurse on site 24 hours/day, 7 days/week due to her episodes of becoming nonresponsive. Observations during the survey, however, revealed the client was without on site skilled nursing 24 hours/day.	W 322	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; MarJul Homes as of 5/3/13 will staff #3 with LPN staffing 24 hours a day 7 days a week until skilled nursing is approved through DDS. The LPN and facility will be competent to address the episodes if #3 becomes unresponsive through specific comprehensive training on #3's HMCP, HP, Recent Hospitalizations and Emergency Protocol Procedures. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken: as of 5/8/13 LPN have been trained to identify similar diagnosis and behaviors as well as to follow up and review all FU recommendations given by PCP or any other consultant, doctor and or medical entity that can make a recommendation that could affect or improve the health and or safety of our individuals. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur, and How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented: A temporary schedule to ensure 24hr. LPN Skilled Nursing until Monday has been put into place as of 5/3/13. Once MarJul Homes identifies permanent Skilled Nursing a formal schedule will be implemented and forwarded to your agency. However until that time MarJul Homes will continue to use current LPN Personnel to ensure #3 receives 24hr. skilled nursing. All	

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W 322	Continued From page 7 Client #3's medical records were reviewed on May 3, 2013, beginning at 11:30 a.m. The PCP performed a complete pre-ISP medical evaluation on March 20, 2013, at which time he recommended Skilled Nursing services, which was interpreted by the ISP team as 24-hour nursing. An Immediate Jeopardy (IJ) was identified on May 3, 2013, at 5:15 p.m., because Client #3 remained without the recommended Skilled Nursing services. The facility's program director (Staff #4) indicated that funding had not been secured.	W 322	(Skilled Nursing) Nurses will be trained on Individual #3'a HMCP, HP, Recent Hospitalizations and Emergency Protocol Procedures. Per shift training will start as of 5/3/13 on LPN's providing skilled nursing; training will be continuous until all LPN covering the shifts have completed the necessary training. As a QA measure RN will send prior week's schedule of skilled nursing coverage to Program Director weekly to ensure all 24hrs of skilled nursing is covered. Also RN is required to do daily checks to ensure that 24 hours skilled nursing is in place, if for some reason RN cannot find coverage RN is required to work the shift.	
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client who had been assessed as needing Skilled Nursing received skilled nursing services in order to protect their health and safety, for the one client (of five individuals residing in the facility) with the assessed need. (Client #3) The finding includes: On May 1, 2013, at 11:20 a.m., concurrent interview with the facility's registered nurse (RN, Staff #5) and the qualified intellectual disabilities professional (Staff #1) revealed that Client #3's primary care physician (PCP, Staff #7) had recommended that she receive Skilled Nursing	W 331	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; MarJul Homes as of 5/3/13 will staff #3 with LPN staffing 24 hours a day 7 days a week until skilled nursing is approved through DDS. The LPN and facility will be competent to address the episodes if #3 becomes unresponsive through specific comprehensive training on #3's HMCP, HP, Recent Hospitalizations and Emergency Protocol Procedures. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken: As of 5/8/13 LPN have been trained to identify similar diagnosis and behaviors as well as to follow up and review all FU recommendations given by PCP or any other consultant, doctor and or medical entity that can make a recommendation that could affect or improve	

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W 331	Continued From page 8 services. The interdisciplinary team reportedly agreed with the recommendation at the client's annual Individual Support Plan meeting, on April 29, 2013. [Note: Client #3 was 81 years old, birth date August 22, 1931.] On May 1, 2013, at 4:50 p.m., review of the facility's incident reports revealed that Client #3 had been taken to the emergency room (ER) on January 30, 2013, after she became nonresponsive and 911 was called. She was admitted to the hospital and intubated. She was discharged on February 5, 2013 with diagnosis "Transient altered mental status, still altered, and Hypotension, resolved, etiology unknown." On February 9, 2013, 911 was called when she failed to respond to her name and she appeared slow and sluggish. When the paramedics arrived, she was stable; therefore, she was not transferred to the ER. Another episode was reported on April 4, 2013, when the client became unresponsive to her name after staff made several attempts to get a response. The facility's house manager (a licensed practical nurse, LPN, Staff #2) was on site and upon evaluation she initiated cardiopulmonary resuscitation (CPR), as she could not detect a pulse. Client #3 became responsive by the time paramedics arrived. However, she was taken to the ER where there is indication that she "coded" while there. She was subsequently admitted and intubated. She was discharged on April 11, 2013. On May 2, 2013, Client #3's court-appointed medical guardian was interviewed by telephone, beginning at 10:41 a.m. He stated that "within the last couple of weeks" the PCP (Staff #7) informed the team that he thought the client would benefit	W 331	the health and or safety of our individuals. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur, and How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented: A temporary schedule to ensure 24hr. LPN Skilled Nursing until Monday has been put into place as of 5/3/13. Once MarJul Homes identifies permanent Skilled Nursing a formal schedule will be implemented and forwarded to your agency. However until that time MarJul Homes will continue to use current LPN Personnel to ensure #3 receives 24hr. skilled nursing. All (Skilled Nursing) Nurses will be trained on Individual #3'a HMCP, HP, Recent Hospitalizations and Emergency Protocol Procedures. Per shift training will start as of 5/3/13 on LPN's providing skilled nursing; training will be continuous until all LPN covering the shifts have completed the necessary training. As a QA measure RN will send prior week's schedule of skilled nursing coverage to Program Director weekly to ensure all 24hrs of skilled nursing is covered. Also RN is required to do daily checks to ensure that 24 hours skilled nursing is in place, if for some reason RN cannot find coverage RN is required to work the shift.	

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W 331	Continued From page 9 from having a nurse on site 24 hours/day, 7 days/week due to her episodes of becoming nonresponsive. The PCP had explained that although staff in the facility were trained and certified in CPR, he felt it prudent to have a nurse there for episodes, after they had called 911 and were awaiting the arrival of paramedics. The guardian further stated that Client #3 may need to transfer to another intermediate care facility if the current provider was unable to secure the funding needed to provide 24-hour nursing in her current home. Client #3's medical records were reviewed on May 3, 2013, beginning at 11:30 a.m. She was evaluated by the PCP (Staff #7) on February 12, 2013. The PCP performed a complete pre-ISP medical evaluation on March 20, 2013, at which time he recommended Skilled Nursing services, which was interpreted by the ISP team as 24-hour nursing. Continued review of the record verified what had been shared in earlier discussions with the RN (Staff #5) and others. Client #3's team met April 29, 2013, and agreed with the recommendation for Skilled Nursing. The DDS Service Coordinator reportedly would pursue funding. Observations during the survey revealed the client was without on site skilled nursing 24 hours/day, which the program director (Staff #4) attributed to the lack of funding. Based on the aforementioned findings, it was determined that conditions existed that posed an immediate and serious risk to Client #3's health and safety. On May 3, 2013, at 5:15 p.m., the administrator was notified that an immediate jeopardy (IJ) existed. It should be noted that the cause of her nonresponsive episodes remained	W 331		

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MARJUL HOMES, INC	5706 14TH STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	Continued From page 10 unknown. The facility presented a plan to address the IJ on May 3, 2013, at 8:15 p.m. The plan was reviewed and approved by the State agency at 8:35 p.m. and the IJ was lifted. The plan included the following: - As of May 3, 2013, the facility will staff Client #3 with licensed practical nurse (LPN) or registered nurse (RN) staffing 24 hours a day, 7 days a week until skilled nursing is approved through the Department on Disability Services (DDS). The LPN and facility will be competent to address the episodes if the client becomes unresponsive through specific comprehensive training on her Health Management Care Plan, Health Passport, recent hospitalizations and Emergency Protocol Procedures. - Long term procedures include identifying and hiring additional LPN's specifically for the increased acuity levels. However, until that time, the facility will continue to use current LPN personnel to ensure Client #3's health and safety through 24-hour skilled nursing. - All nurses, current and future, will be trained on Client #3's Health Management Care Plan, Health Passport, recent hospitalizations and Emergency Protocol Procedures. Per shift training will start May 3, 2013, and will be continuous until all LPN's covering the shifts have completed the necessary training. - All direct support professionals (DSP's) will be in-serviced on Client #3's Health Management Care Plan, Health Passport, recent	W 331		

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W 331	Continued From page 11 hospitalizations and Emergency Protocol Procedures. Training will begin May 3, 2013, with continuous training per shift until all DSP's working at this facility have completed the necessary training. Competency based testing will be given on May 9, 2013, to ensure the training was effective and comprehensive. In addition, henceforth the RN will give monthly refresher training, and comprehensive testing will be put in place as a Quality Assurance tool to ensure DSP's are knowledgeable of Client #3's health concerns and emergency procedures. - As per our intermediate care facility provider agreement, the primary care physician (PCP) is available 24/7 for full contact in cases of emergency or concern. In addition, the PCP has been notified on May 3, 2013, of the implementation of the 24hr. skilled nursing for Client #3. [Note: Although the plan was approved by the State agency and the immediacy was removed, the facility was monitored on the following day (May 4, 2013), at 11:24 p.m., to ensure compliance with the plan of correction submitted. There was a nurse on site and the visit did not reveal any concerns.]	W 331		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, interview and review of client records, the facility failed to ensure that	W 368	W368. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; As a corrective Actions all LPN's as of 5/8/13 have been re-trained on all individuals residing in the 14th street home MAR's HMCP, HP and ISP & BSP. In addition, the RN shadowed the error causing LPN while doing med pass on 5/6/13 & 5/7/13 to ensure the LPN was administering meds properly. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken: As a proactive measure to identify other individuals who could possibly be affected by this same deficient practice, MarJul homes as of 6/1/13 will perform monthly reviews of MAR's in accordance to what the LPN's or	

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W 368	Continued From page 12 clients' medications were administered in accordance with physician's orders, for one of five clients residing in the facility. (Client #1) The findings include: The morning medication administration was observed on May 1, 2013, beginning at 7:30 a.m. At approximately 8:47 a.m., a licensed practical nurse (Staff #6) was observed administering one drop of Artificial Tears (eye drops) into each eye at the end of Client #1's medication administration process. Observation of the medication label revealed the client was supposed to receive 2 drops of Artificial Tears in each eye. This was also in accordance with the client's medication administration record (MAR) and physician's orders for May 2013. After Staff #6 stated that she had completed the morning medication administration process, at 9:10 a.m., she was informed that Client #1 had received one drop Artificial Tears in each eye instead of two. She examined the client's physician's order sheets and MAR and acknowledged she should have given two drops. At approximately 9:13 a.m., she approached Client #1 and administered a second drop into each eye.	W 368	Med tech's are actually administering. This will be completed by the RN and possibly accompanied by the DON. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur, and How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented. As a systematic change, MarJul homes as of 6/1/13 will perform monthly reviews of MAR's in accordance to what the LPN's or Med techs are actually administering. This will be completed by the RN and possibly accompanied by the DON. In addition, to this change this new process will be identified on the Nursing QA Tool to be followed up and checked by the QA team starting 6/1/13.	
W 394	483.460(n)(2) LABORATORY SERVICES If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of service in accordance with the requirements of part 493 of this chapter.	W 394	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; As a corrective action the CLIA certificates have been updated as of 5/3/13.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken: In	

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W 394	Continued From page 13 This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to obtain a Certificate of Waiver as required under the Clinical Laboratory Improvement Amendments of 1988 Act (CLIA) before administering finger stick tests for blood sugar glucose levels, for the one client in the facility (out of five) with diabetes. (Client #3) The finding includes: On May 1, 2013, at 8:18 a.m., the morning medication nurse (Staff #6) was observed lancing Client #3's finger and testing her blood sugar levels on a glucometer. Review of Client #3's medical record at 10:02 a.m. revealed nurses were documenting daily finger sticks at 8:00 a.m. (before breakfast) and at 5:00 p.m. (before dinner). On May 3, 2013, at 12:00 p.m., the facility's registered nurse (Staff #5) was asked if the facility had obtained a Certificate of Waiver, as required under the CLIA. It was her understanding at the time that an application had been submitted; however, she would need to telephone the executive director (Staff #3) to ask for the specific date the application was submitted. At 12:12 p.m., Staff #5 hung up the telephone and stated that she had been informed that they "will submit the CLIA application."	W 394	accordance to chapter 35 MarJul homes performed an environmental inspection on 5/3/13 to ensure that all CLIA certificates are updated. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur, and How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented As of 6/1/13 MarJul Homes will perform this environmental inspection on a quarterly basis to ensure that all other chapter 35 recommendations and mandates are also in accordance. This inspection will be added to our QIDP Quarterly Quality Assurance Tool as of 6/1/13 as a part of proactive measures to ensure safety and quality living.	

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	HFD03-0261		05/03/2013

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I 000	INITIAL COMMENTS A licensure survey was conducted from May 1, 2013 through May 3, 2013. A sample of three residents was selected from a population of five females with various intellectual disabilities. During the survey it was revealed that the facility failed to obtain 24-hour skilled nursing services timely in order to address Resident #3's change in health status (unresponsiveness). Based on the aforementioned information, it was determined that conditions existed that posed an immediate and serious threat to Resident #3's health and safety. On May 3, 2013, at 5:15 p.m., the administrator was notified that an immediate jeopardy (IJ) existed. The facility presented a plan to address the IJ on May 3, 2013, at 8:15 p.m. The plan was reviewed and the IJ lifted at 8:35 p.m. The plan included the following: - As of May 3, 2013, the facility will staff Resident #3 with licensed practical nurse (LPN) or registered nurse (RN) staffing 24 hours a day, 7 days a week until skilled nursing is approved through the Department on Disability Services (DDS). The LPN and facility will be competent to address the episodes if the resident becomes unresponsive through specific comprehensive training on her Health Management Care Plan, Health Passport, recent hospitalizations and Emergency Protocol Procedures. - Long term procedures include identifying and hiring additional LPN's specifically for the increased acuity levels. However, until that time, the facility will continue to use current LPN personnel to ensure Resident #3's health and safety through 24-hour skilled nursing.	I 000		

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Vashaun Gill — Program Director — 6-3-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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I 000	Continued From page 1 - All nurses, current and future, will be trained on Resident #3's Health Management Care Plan, Health Passport, recent hospitalizations and Emergency Protocol Procedures. Per shift training will start May 3, 2013, and will be continuous until all LPN's covering the shifts have completed the necessary training. - All direct support professionals (DSP's) will be in-serviced on Resident #3's Health Management Care Plan, Health Passport, recent hospitalizations and Emergency Protocol Procedures. Training will begin May 3, 2013, with continuous training per shift until all DSP's working at this facility have completed the necessary training. Competency based testing will be given on May 9, 2013, to ensure the training was effective and comprehensive. In addition, henceforth the RN will give monthly refresher training, and comprehensive testing will be put in place as a Quality Assurance tool to ensure DSP's are knowledgeable of Resident #3's health concerns and emergency procedures. - As per our intermediate care facility provider agreement, the primary care physician (PCP) is available 24/7 for full contact in cases of emergency or concern. In addition, the PCP has been notified on May 3, 2013, of the implementation of the 24hr. skilled nursing for Resident #3. [Note: Although the plan was approved by the State agency and the immediacy was removed, the facility was monitored on the following day (May 4, 2013), at 11:24 p.m., to ensure compliance with the plan of correction submitted. There was a nurse on site and the visit did not reveal any concerns. The facility however,	I 000		

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I 000	Continued From page 2 remained out of compliance with the condition of participation in Health Care Services.] The findings of the survey were based on observations in the home and one day program, interviews with two court-appointed medical guardians, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	I 000		
I 075	3503.3(d) BEDROOMS AND BATHROOMS Each bedroom shall be equipped with at least the following items for each resident: (d) Night stand. This Statute is not met as evidenced by: Based on observation and interview, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that each bedroom was equipped with a night stand for each resident, for two of the five residents of the facility. (Residents #1 and #3) The finding includes: During the inspection of the environment on May 3, 2013, at 2:44 p.m., there were no night stands observed in the bedroom being shared by Residents #1 and #3. The qualified intellectual disabilities professional (Staff #1), who was present at the time of the inspection,	I 075	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; as a corrective action on 5/28/13 MarJul Homes purchased two night stands, and two lamps. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken in accordance to chapter 35 MarJul homes performed an environmental inspection on 5/3/13 to ensure that all individuals have at least one night stand and one lamp. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur, and How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented As of 6/1/13 MarJul Homes will perform this environmental inspection on a quarterly basis to ensure that all other chapter 35 recommendations and mandates are also in accordance. This inspection will be added to our QIDP Quarterly Quality Assurance Tool as of 6/1/13 as a part of proactive measures to ensure safety and quality living.	

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I 075	Continued From page 3 acknowledged there were no night stands for the two residents.	I 075		
I 082	3503.10 BEDROOMS AND BATHROOMS Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: Based on observation and interview, the group home for individuals with intellectual disabilities (GHIID) failed to equip each bathroom used by residents with paper cups, for five of the five residents of the facility. The findings include: I. On May 3, 2013, at 2:46 p.m., observation of the restroom located in the bedroom shared by Residents #1 and #3 revealed that there were no paper cups available and no paper cup holder. II. At 2:56 p.m., there were no paper cups available in the restroom located in the main hallway on the second floor. There was, however, an empty cup dispenser on the vanity. The qualified intellectual disabilities professional (Staff #1), who was present at the time of the inspection, said Residents #2, #4 and #5 typically used that bathroom. She acknowledged that there were no paper cups available for resident use in either of the two bathrooms.	I 082	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; As a corrective Action on 5/28/13 MarJul Homes purchased cup dispensers for all bathroom, cups and hand soap as well as placed toilet tissue and paper towels in each bathroom. The cup dispensers will be put up in each bathroom by the maintenance man on 6/1/13. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken: In accordance to chapter 35 MarJul homes performed an environmental inspection on 5/3/13 to ensure that all individuals have at least one cup dispenser and cups in each bathroom, hand soap and toilet paper and paper towels in each bathroom. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur, and How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented As of 6/1/13 MarJul Homes will perform this environmental inspection on a quarterly basis to ensure that all other chapter 35 recommendations and mandates are also in accordance. This inspection will be added to our QIDP Quarterly Quality Assurance Tool as of 6/1/13 as a part of proactive measures to ensure safety and quality living.	

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I 090	Continued From page 4	I 090	I090 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; As a corrective action Bulk trash will be picked up on 5/30/13 the aluminum siding on the back of the house was fixed as well as the wooden ramp was nailed down and the holes were filled on 5/3/13. In addition the toilet on the first floor in individual #1 & #3's room was replaced on 5/3/13 and the toilet on the second floor was fixed on 5/4/13. Also the Living room and dining room walls will be painted on 6/7/13, in addition the chairs causing the scratches on the walls were replaced as of 4/15/13. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken: In accordance to chapter 35 MarJul homes performed an environmental inspection on 5/3/13 to ensure that the interior and exterior of all GHMRP that individuals are living in are safe, clean, orderly, attractive and sanitary manner and be free of accumulations of dirt rubbish and object able odors. In addition, What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur, and How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented As of 6/1/13 MarJul Homes will perform this environmental inspection on a quarterly basis to ensure that all other chapter 35 recommendations and mandates are also in accordance. This inspection will be added to our QIDP Quarterly Quality Assurance Tool as of 6/1/13 as a part of proactive measures to ensure safety and quality living.	
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the group home for individuals with intellectual disabilities (GHIID) maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, with the exception of the following five concerns, for five of the five residents of the facility. (Residents #1, #2, #3, #4 and #5) The findings include: I. Observations during the inspection of the environment on May 3, 2013, at 2:24 p.m. and 2:26 p.m., revealed damage to the paint on walls in the living room and dining room, respectively. The paint had been scraped/scratched by the top edge of the backs of metal chairs. II. At 2:37 p.m., observations in the back yard revealed the following: A. There were five old dining chairs being stored on the back porch. One of the chairs was visibly broken. The qualified intellectual disabilities professional (Staff #1), who was present at the time, said they planned to call "bulk trash" to have them removed; B. One of the boards on the wooden ramp leading from the back porch down to the back	I 090		

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I 090	Continued From page 5 alley was loose when walked on. There were a number of empty holes where nails had once been used to secure the board to the frame; and, C. There were two pieces of aluminum siding that were pulled away and hanging off from the outer wall on the back side of the house. One piece of siding measured approximately 2 feet in length and the other was approximately 8 feet in length. III. The toilet bowl in the the bathroom located off to the side of the bedroom shared by Residents #1 and #3 was observed to be cracked. Staff #1 stated that management had already approached the landlord and plans were underway to replace the toilet. The toilet bowl in the restroom located in the main hallway on the second floor did not completely empty when flushed. Staff #1 stated that she would make maintenance aware of the aforementioned concerns.	I 090		
I 189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents ' funds received and disbursed. This Statute is not met as evidenced by: Based on interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to maintain a system that ensured a complete accounting of each resident's personal funds, for one of three residents in the sample. (Resident #1) The finding includes: On May 3, 2013, beginning at 3:25 p.m., review of Resident #1's financial records revealed that $1,500 dollars was withdrawn from her account	I 189	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; As a corrective action Marjul Homes has replaced the money that was unaccounted for in receipts. As mentioned in deficiency 140, the unaccounted for amount of funds for Individual #1 was 1000.00 after finding receipts for the amounts mentions in 140 which were 182.69 and 317.99 the Surveyor at the time found a total of 500.68 in receipts. As Mentioned in the 140 deficiency the total withdrawal amount was 1500.00 once you minus the 500.68 from 1500.00 the total amount unaccounted for is a total of 999.32. Therefore Marjul Homes deposited on 5/3/13 a total of 1000.00 in #1 Capital One Community Bank Account. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken: Due to the findings of the survey, MarJul Homes will complete a monthly financial audit to ensure that all other	

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I 189	Continued From page 6 on August 30, 2012. There were two receipts dated August 30, 2012 for purchases of $182.69 and $317.99. There was no record of what happened to the balance ($1499.99). On May 3, 2013, at 4:45 p.m., the facility's program director (Staff #4) was asked about Resident #1's bank withdrawal from August 30, 2012. After reviewing Resident #1's financial records, at 4:54 p.m., she confirmed there were no additional receipts indicating other purchases, and no evidence that the balance had been deposited back into the resident's account. Further interview revealed that she routinely performed quarterly audits of each resident's funds. She stated that she had not identified any concerns or missing documentation in past audits. During the Exit teleconference held May 6, 2013, beginning at 2:13 p.m., Staff #4 stated that management had since deposited $1499.99 into Resident #1's account (after May 3, 2013).	I 189	withdrawals have the appropriate amount of receipts to accompany purchases. This audit will start as of 6/1/13 and will be monthly for the first quarter June through August. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur, and How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented: As a systematic change, Marjul Homes is restructuring its financial policies and procedures to include a new financial ledger and monthly statement that is through excel spread sheet. This spread sheet has an automated calculation system which identifies deposits, withdrawals and expenditures spent. This system will be put in place as of 6/1/13. In addition, the QA system to monitor our financial records will include monthly Case Reviews where each home is audited from the entire management team; this was outside entity's looking in have a fresh eye on items that are deficient.	
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that all health care	I 206	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; Marjul Homes will ensure that our health care professionals are in current standards with DOH and DDS regulations, Marjul has requested several times to our Pharmacy as well as to our Social Worker , and other consultants for the current Health Care Certificate. Marjul homes as given all the above names a due date of May 30th to have all current information in the main office. If the information is not given to us by this date, services with consultants who have outdated certificates will be terminated.How you will	

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I 206	Continued From page 7 professionals had current health certificates on file, for 3 of 10 consultants. (Staff #6, #8 and #9) The findings include: On May 2, 2013, beginning at 5:05 p.m., review of the personnel records for licensed professional health consultants, revealed the following: I. The health inventory/certificate on file for the morning medication nurse (Staff #6) was documented on March 6, 2011 (more than two years before the survey); and, II. There was no evidence of a complete physician's health inventory/certificate for the social worker (Staff #8). She did, however, have a documented PPD skin test (results "negative") within the past 12 months; and, III. The physician's health inventory/certificate on file for the pharmacist (Staff #9) was documented in September 2011 (more than 19 months before the survey). On May 3, 2013, beginning at 4:26 p.m., review of additional personnel information/ records that was brought from their corporate office revealed no evidence of current health certificates for the three aforementioned health professionals.	I 206	identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Currently Marjul homes sends a monthly spread sheet out to all QIDDP's informing them of certificates including health which are soon to expire. This process was put in place to inform QIDDP's of which DSP are soon to be out of compliance in regards to scheduling. Therefore if a DSP does not have the current certificates required by DOH and DDS they will not be able to be placed on schedule. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be implemented Identification has been put in place by a Quality Assurance Monitoring tool that will be done monthly by the QIDDP to ensure that all Consultants and DSP; s have current health certificates. This tool we be implemented before 6/1/13.	
I 372	3519.3 EMERGENCIES Each GHMRP shall post by each telephone emergency numbers, which include at least fire and rescue squads, the local police department, each resident ' s physician, and the agency ' s on-duty administrator. This Statute is not met as evidenced by:	I 372	I372 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; As a corrective action, all emergency telephone numbers have been place in each home to include the emergency rescue squads, local police department, physicians of each individual, and agency duty administrative officer. Listings were posted in each home on 5/3/13. How will you identify other residents having the potential to be affected by the same deficient practice and	

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I 372	Continued From page 8 Based on observation and interview, the group home for individuals with intellectual disabilities (GHIID) failed to post by each telephone, emergency numbers, which include at least fire and rescue squads, the local police department, each resident's physician, and the agency's on-duty administrator. The finding includes: Observations on March 3, 2013, at 1:40 p.m., revealed there was no list of emergency numbers, to include all of the numbers required by this regulation, posted by the two telephones in the facility. The qualified intellectual disabilities professional (Staff #1), who was present at the time, acknowledged the deficiency. During the Exit teleconference held May 6, 2013, beginning at 2:13 p.m., Staff #1 stated that an emergency contact list had been posted by each telephone after the surveyor left the facility on May 3, 2013.	I 372	what corrective actions will be taken: Through our environmental checks monthly as of 6/1/13 QIDP is mandated to check for the posted emergency contact sheet and report if then sheet is posted directly to the PD. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur, and How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented As of 6/1/13 MarJul Homes will perform this environmental Inspection on a quarterly basis to ensure that all other chapter 35 recommendations and mandates are also in accordance. This inspection will be added to our QIDP Quarterly Quality Assurance Tool as of 6/1/13 as a part of proactive measures to ensure safety and quality living.	
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that each resident who had been assessed as needing Skilled Nursing received skilled nursing	I 401	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; MarJul Homes as of 5/3/13 will staff ML with LPN staffing 24 hours a day 7 days a week until skilled nursing is approved through DDS. The LPN and facility will be competent to address the episodes if ML becomes unresponsive through specific comprehensive training on ML's HMCP, HP, Recent Hospitalizations and Emergency Protocol Procedures. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective	

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I 401	Continued From page 9 services in order to protect their health and safety, for the one resident (of five individuals residing in the facility) with the assessed need. (Resident #3) The finding includes: On May 1, 2013, at 11:20 a.m., concurrent interview with the facility's registered nurse (RN, Staff 5) and the qualified intellectual disabilities professional (Staff #1) revealed that Resident #3's primary care physician (PCP, Staff #7) had recommended that she receive Skilled Nursing services. The interdisciplinary team reportedly agreed with the recommendation at the resident's annual Individual Support Plan meeting, on April 29, 2013. [Note: Resident #3 was 81 years old, birth date August 22, 1931.] On May 1, 2013, at 4:50 p.m., review of the facility's incident reports revealed that Resident #3 had been taken to the emergency room (ER) on January 30, 2013, after she became nonresponsive and 911 was called. She was admitted to the hospital and intubated. She was discharged on February 5, 2013 with diagnosis "Transient altered mental status, still altered, and Hypotension, resolved, etiology unknown." On February 9, 2013, 911 was called when she failed to respond to her name and she appeared slow and sluggish. When the paramedics arrived, she was stable; therefore, she was not transferred to the ER. Another episode was reported on April 4, 2013, when the resident became unresponsive to her name after staff made several attempts to get a response. The facility's house manager (a licensed practical nurse, LPN, Staff #2) was on site and upon evaluation she initiated cardiopulmonary resuscitation (CPR), as she could not detect a pulse. Resident #3 became	I 401	actions will be taken: as of 5/8/13 LPN have been trained to identify similar diagnosis and behaviors as well as to follow up and review all FU recommendations given by PCP or any other consultant, doctor and or medical entity that can make a recommendation that could affect or improve the health and or safety of our individuals. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur, and How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented: A temporary schedule to ensure 24hr. LPN Skilled Nursing until Monday has been put into place as of 5/3/13. Once MarJul Homes identifies permanent Skilled Nursing a formal schedule will be implemented and forwarded to your agency. However until that time MarJul Homes will continue to use current LPN Personnel to ensure ML receives 24hr. skilled nursing. All (Skilled Nursing) Nurses will be trained on Individual #1'a HMCP, HP, Recent Hospitalizations and Emergency Protocol Procedures. Per shift training will start as of 5/3/13 on LPN's providing skilled nursing; training will be continuous until all LPN covering the shifts have completed the necessary training. As a QA measure RN will send prior week's schedule of skilled nursing coverage to Program Director weekly to ensure all 24hrs of skilled nursing is covered. Also RN is required to do daily checks to ensure that 24 hours skilled nursing is in place, if for some reason RN cannot find coverage RN is required to work the shift.	

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I 401	Continued From page 10 responsive by the time paramedics arrived. However, she was taken to the ER where there is indication that she "coded" while there. She was subsequently admitted and intubated. She was discharged on April 11, 2013. On May 2, 2013, Resident #3's court-appointed medical guardian was interviewed by telephone, beginning at 10:41 a.m. He stated that "within the last couple of weeks" the PCP (Staff #7) informed the team that he thought the resident would benefit from having a nurse on site 24 hours/day, 7 days/week due to her episodes of becoming nonresponsive. The PCP had explained that although staff in the facility were trained and certified in CPR, he felt it prudent to have a nurse there for episodes, after they had called 911 and were awaiting the arrival of paramedics. The guardian further stated that Resident #3 may need to transfer to another intermediate care facility if the current provider was unable to secure the funding needed to provide 24-hour nursing in her current home. Resident #3's medical records were reviewed on May 3, 2013, beginning at 11:30 a.m. She was evaluated by the PCP (Staff #7) on February 12, 2013. The PCP performed a complete pre-ISP medical evaluation on March 20, 2013, at which time he recommended Skilled Nursing services, which was interpreted by the ISP team as 24-hour nursing. Continued review of the record verified what had been shared in earlier discussions with the RN (Staff #5) and others. Resident #3's team met April 29, 2013, and agreed with the recommendation for Skilled Nursing. The DDS Service Coordinator reportedly would pursue funding. Observations during the survey revealed the resident was without on site skilled nursing 24 hours/day, which the program director (Staff #4)	I 401		

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I 401	Continued From page 11 attributed to the lack of funding.	I 401		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the group home for individuals with intellectual disabilities (GHIID) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and federal regulations 42 CFR 483 Sub-Part 1 (for Intermediate Care Facilities for Individuals with Intellectual Disabilities), for one of five residents of the facility. (Resident #3) The finding includes: [483.460(c)] The GHIID failed to ensure that Resident #3, who had been assessed as needing Skilled Nursing, received skilled nursing services in order to protect her health and safety, as follows: On May 1, 2013, at 11:20 a.m., concurrent interview with the facility's registered nurse (RN, Staff #5) and the qualified intellectual disabilities professional (Staff #1) revealed that Resident #3's primary care physician (PCP, Staff #7) had recommended that she receive Skilled Nursing services. The interdisciplinary team reportedly agreed with the recommendation at the resident's annual Individual Support Plan meeting, on April	I 500	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; MarJul Homes as of 5/3/13 will staff #3 with LPN staffing 24 hours a day 7 days a week until skilled nursing is approved through DDS. The LPN and facility will be competent to address the episodes if #3 becomes unresponsive through specific comprehensive training on #3's HMCP, HP, Recent Hospitalizations and Emergency Protocol Procedures. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken: as of 5/8/13 LPN have been trained to identify similar diagnosis and behaviors as well as to follow up and review all FU recommendations given by PCP or any other consultant, doctor and or medical entity that can make a recommendation that could affect or improve the health and or safety of our individuals. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur, and How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be implemented: A temporary schedule to ensure 24hr. LPN Skilled Nursing until Monday has been put into place as of 5/3/13. Once MarJul Homes identifies permanent Skilled Nursing a formal schedule will be implemented and forwarded to your agency. However until that time MarJul Homes will continue to use	

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I 500	Continued From page 12 29, 2013. [Note: Resident #3 was 81 years old, birth date August 22, 1931.] On May 1, 2013, at 4:50 p.m., review of the facility's incident reports revealed that Resident #3 had been taken to the emergency room (ER) on January 30, 2013, after she became nonresponsive and 911 was called. She was admitted to the hospital and intubated. She was discharged on February 5, 2013 with diagnosis "Transient altered mental status, still altered, and Hypotension, resolved, etiology unknown." On February 9, 2013, 911 was called when she failed to respond to her name and she appeared slow and sluggish. When the paramedics arrived, she was stable; therefore, she was not transferred to the ER. Another episode was reported on April 4, 2013, when the resident became unresponsive to her name after staff made several attempts to get a response. The facility's house manager (a licensed practical nurse, LPN, Staff #2) was on site and upon evaluation she initiated cardiopulmonary resuscitation (CPR), as she could not detect a pulse. Resident #3 became responsive by the time paramedics arrived. However, she was taken to the ER where there is indication that she "coded" while there. She was subsequently admitted and intubated. She was discharged on April 11, 2013. On May 2, 2013, Resident #3's court-appointed medical guardian was interviewed by telephone, beginning at 10:41 a.m. He stated that "within the last couple of weeks" the PCP (Staff #7) informed the team that he thought the resident would benefit from having a nurse on site 24 hours/day, 7 days/week due to her episodes of becoming nonresponsive. The PCP had explained that although staff in the facility were trained and certified in CPR, he felt it prudent to have a nurse	I 500	current LPN Personnel to ensure #3 receives 24hr. skilled nursing. All (Skilled Nursing) Nurses will be trained on Individual #3'a HMCP, HP, Recent Hospitalizations and Emergency Protocol Procedures. Per shift training will start as of 5/3/13 on LPN's providing skilled nursing; training will be continuous until all LPN covering the shifts have completed the necessary training. As a QA measure RN will send prior week's schedule of skilled nursing coverage to Program Director weekly to ensure all 24hrs of skilled nursing is covered. Also RN is required to do daily checks to ensure that 24 hours skilled nursing is in place, if for some reason RN cannot find coverage RN is required to work the shift.	

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I 500	Continued From page 13 there for episodes, after they had called 911 and were awaiting the arrival of paramedics. The guardian further stated that Resident #3 may need to transfer to another intermediate care facility if the current provider was unable to secure the funding needed to provide 24-hour nursing in her current home. Resident #3's medical records were reviewed on May 3, 2013, beginning at 11:30 a.m. She was evaluated by the PCP (Staff #7) on February 12, 2013. The PCP performed a complete pre-ISP medical evaluation on March 20, 2013, at which time he recommended Skilled Nursing services, which was interpreted by the ISP team as 24-hour nursing. Continued review of the record verified what had been shared in earlier discussions with the RN (Staff #5) and others. Resident #3's team met April 29, 2013, and agreed with the recommendation for Skilled Nursing. The DDS Service Coordinator reportedly would pursue funding. Observations during the survey revealed the resident was without on site skilled nursing 24 hours/day, which the program director (Staff #4) attributed to the lack of funding. Based on the aforementioned findings, it was determined that conditions existed that posed an immediate and serious risk to Resident #3's health and safety. On May 3, 2013, at 5:15 p.m., the administrator was notified that an immediate jeopardy (IJ) existed. It should be noted that the cause of her nonresponsive episodes remained unknown. The facility presented a plan to address the IJ on May 3, 2013, at 8:15 p.m. The plan was reviewed and approved by the State agency at 8:35 p.m. and the IJ was lifted. The plan included the following:	I 500		

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I 500	Continued From page 14 - As of May 3, 2013, the facility will staff Resident #3 with licensed practical nurse (LPN) or registered nurse (RN) staffing 24 hours a day, 7 days a week until skilled nursing is approved through the Department on Disability Services (DDS). The LPN and facility will be competent to address the episodes if the resident becomes unresponsive through specific comprehensive training on her Health Management Care Plan, Health Passport, recent hospitalizations and Emergency Protocol Procedures. - Long term procedures include identifying and hiring additional LPN's specifically for the increased acuity levels. However, until that time, the facility will continue to use current LPN personnel to ensure Resident #3's health and safety through 24-hour skilled nursing. - All nurses, current and future, will be trained on Resident #3's Health Management Care Plan, Health Passport, recent hospitalizations and Emergency Protocol Procedures. Per shift training will start May 3, 2013, and will be continuous until all LPN's covering the shifts have completed the necessary training. - All direct support professionals (DSP's) will be in-serviced on Resident #3's Health Management Care Plan, Health Passport, recent hospitalizations and Emergency Protocol Procedures. Training will begin May 3, 2013, with continuous training per shift until all DSP's working at this facility have completed the necessary training. Competency based testing will be given on May 9, 2013, to ensure the training was effective and comprehensive. In addition, henceforth the RN will give monthly refresher training, and comprehensive testing will	I 500		

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I 500	Continued From page 15 be put in place as a Quality Assurance tool to ensure DSP's are knowledgeable of Resident #3's health concerns and emergency procedures. - As per our intermediate care facility provider agreement, the primary care physician (PCP) is available 24/7 for full contact in cases of emergency or concern. In addition, the PCP has been notified on May 3, 2013, of the implementation of the 24hr. skilled nursing for Resident #3. [Note: Although the plan was approved by the State agency and the immediacy was removed, the facility was monitored on the following day (May 4, 2013), at 11:24 p.m., to ensure compliance with the plan of correction submitted. There was a nurse on site and the visit did not reveal any concerns.]	I 500		