

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

PRINTED: 05/25/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2009
NAME OF PROVIDER OR SUPPLIER SYMBRAL FOUNDATION		STREET ADDRESS, CITY, STATE, ZIP CODE 722 "L" STREET, NE WASHINGTON, DC 20002		
(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	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from 5/7/2009 through 5/8/2009. The survey was conducted utilizing the fundamental survey process. A random sample of two clients was selected from a residential population of three males with mental retardation and other disabilities. The findings of the survey were based on observations, interviews at the facility and at one day program, and a review of records, including the unusual incident reports.</p> <p>W 124 483.420(a)(2) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure psychotropic medications were being administered with the consent of a client's legally appointed guardian or advocate for one of two sampled clients. [Client #1]</p> <p>The finding includes:</p> <p>Observation on 5/7/2009 at 5:45 PM, revealed the attending nurse administered Client #1's PM dosage of 250mg of Chlorpromazine (50mg Tab + 200mg Tab). Record review on 5/8/2009 at approximately 3:05pm verified the administration of 250mg of Chlorpromazine the previous</p>	W 000	<p>The Symbra's Governing Body will exercise oversight over program operations, the implementation and update of all Policies and Procedures.</p> <p>W 124</p> <p><i>Received 6/5/09</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	7/5/09 and ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

[Signature]

6/4/2009

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 124	<p>Continued From page 1 evening was as prescribed.</p> <p>Interview with the facility's Licensed Practical Nurse and record review on 5/8/2009 at approximately 3:30 PM revealed Client #1's psychotropic regimen was adjusted as follows over the past few months:</p> <ol style="list-style-type: none"> 11/06/2008 physician's order: Thorazine (Chlorpromazine) 200mg PO Q PM for 30 days to manage his behavior. 12/04/2008 physician's order: Thorazine 100mg PO Q AM x 30 days for behavior and Thorazine 200mg PO Q PM x 30 days for behavior. 12/26/2008 physician's order: Thorazine 150mg PO Q AM x 30 days for behavior and Thorazine 250mg PO Q PM for 30 days for behavior. <p>According to the Qualified Mental Retardation Professional (QMRP) during an interview on 5/7/2009 at 3:49 PM, Client #1's mother was his legal advocate and she took part in all of his health and habilitation planning. Review of Client #1's legal records verified his mother signed an affidavit on 6/14/2007 which named her as such and was recognized by the courts.</p> <p>Further record review revealed there was no evidence Client #1's mother either took part in the psychotropic medication reviews or was informed of the changes, benefits and attendant risks as it relates to her son's psychotropic medication regimen.</p> <p>The facility failed to ensure psychotropic</p>	W 124	<p>The QMRP has been instructed prior to any recommended adjustment in the individual's psychotropic medication by the psychiatrist, the Medical Guardian or Next of Kin with Consent Authority must provide written consent for the change.</p> <p>The Medical Guardian or Next of Kin will be notified of the meeting two (2) weeks prior and documentation will be kept in the individual's record. If he/ she cannot attend meeting, a written statement from the Medical Guardian or Next of Kin will be placed in the record.</p> <p>The Guardian will be asked to participate via telephone, documentation of the medication change will be faxed to the Medical Guardian or Next of Kin after the telephone conference and will only be prescribed after consent is received.</p> <p>DON/ LPN Charge Nurse will monitor to ensure that consent is provided for al medication changes.</p>	7/5/09 and ongoing	

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W 124	Continued From page 2 medications were being administered and increased with the consent of a parent, legal guardian and/or advocate as required by this section. W 156 483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to complete an investigation into an allegation of exploitation within five (5) days for one of two sampled clients. [Client #1] The finding includes: Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the incident reports and on 5/8/2009 at approximately 1:30pm, revealed an incident report dated 3/8/2009 detailed Client #1's "one-to-one" staff took him out to sell newspapers and did not compensate him for his work. Further record review revealed an investigation into the allegation ensued on 3/13/2009 and was completed on 3/17/2009; nine (9) days after the incident was reported. There was no evidence on file or presented during the survey to substantiate this investigation was completed timely in accordance with this regulation.	W 124 W 156	The investigator conducting the investigation will communicate with Incident Management Coordinator in writing the reason for any delay beyond the five (5) days time. This information will be communicated to DOH/ MAA and DDS. Incident Management Coordinator will monitor to ensure compliance.	6/4/09 and ongoing

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W 157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to implement corrective actions to prevent the recurrence of exploitation for one of two sampled clients. [Client #1]</p> <p>The finding includes:</p> <p>Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the incident reports on 5/8/2009 at approximately 1:30pm revealed, an incident report dated 3/8/2009 detailed Client #1's "one-to-one" staff took him out to sell newspapers and did not compensated him for his work.</p> <p>Further record review revealed an investigation into the allegation ensued on 3/13/2009 and was completed on 3/17/2009. The investigation substantiated the allegation of exploitation and recommended the following preventive measures:</p> <ol style="list-style-type: none"> 1. Develop a protocol for taking individuals out in the community within 30 days. 2. Schedule a Case Conference within 30 days to discuss ways and means to adequately provide him the necessary support needed to ensure safety and prevention of exploitation. <p>Review of the policy and procedures manual and interview with the facility's QMRP on 5/8/2009 at approximately 1:38 PM revealed, there was no</p>	W 157	<p>Policy and Procedure Manual was revised on 3/17/2009 however the updated signature form was not in the record. The protocol and the policy change 5/19/09 and was additionally reviewed on 5/19/2009. QMRP will ensure that documentation of amendment/s (Habituation and Training, One on One (1:1) and Activity Program for Individuals to Policies and Procedures are placed with the record.</p> <p>QA will monitor to ensure compliance.</p>

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<p>W 157 Continued From page 4</p> <p>protocol and/or policy in place to address the procedure for " taking individuals out in the community " . The administrative records reflected the last policy review and/or amendment was signed and dated 8/29/2008 by the facility's Chief Executive Officer.</p> <p>Further record review and interview with the facility's QMRP on the same day at 1:40 PM revealed a case conference was held on 4/17/2009. However, the meeting minutes revealed the team met to address issues and concerns surrounding Client #1's sexuality and habilitation. The issue of providing support to prevent " exploitation " was not addressed during the meeting.</p> <p>At the time of survey, there was no evidence presented or on file to substantiate that a case conference had been held to address the issue of preventing future occurrences of " exploitation " as recommended by the 3/17/2009 investigation.</p>	<p>W 157</p>	<p>A case conference will be scheduled to review the incident, the investigation and the changes in policies and procedure to safe-guard individual #1 from abuse and exploitation.</p> <p>Minutes of meeting on 4/17/2009 only documented 7/5/09 and a comment "Incident - with R.B.". QMRP did not document the details of the discussion.</p> <p>QMRP will ensure that notes are documented in details of issue/s discussed.</p> <p>QA and CEO will receive copies of minutes with clearly outlined topics and discussions.</p>	
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<p>W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination, monitoring, and implementation of a client's habilitation and planning for one of two sampled clients. [Clients #1]</p> <p>The finding includes:</p> <ol style="list-style-type: none"> 1. The QMRP failed to ensure psychotropic 	<p>W 159</p>		
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W 159	Continued From page 5 medications were being administered with the consent of a client ' s legally appointed guardian or advocate. [See W124] 2. The QMRP failed to complete an investigation into an allegation of exploitation within five (5) days. [See W156] 3. The QMRP failed to implement corrective actions to prevent the recurrence of exploitation. [See W157] 4. The QMRP failed to ensure psychotropic medications were being administered with the consent of a client ' s parent, legally appointed guardian and/or advocate. [See W263]	W 159	Cross reference and adopted with (W124), (W156) and (W157).	7/5/09 and ongoing
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure psychotropic medications were being administered with the written consent of a client's parent, legally appointed guardian and/or advocate for one of two sampled clients. [Client #1] The finding includes: Observation on 5/7/2009 at 5:45 PM revealed the attending nurse administered Client #1's PM dosage of 250mg of Chlorpromazine (50mg Tab + 200mg Tab). Record review on 5/8/2009 at approximately 3:05pm verified the administration of 250mg of Chlorpromazine the previous evening, was as prescribed.	W 263		

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<p>W 263 Continued From page 6</p> <p>Interview with the facility's Licensed Practical Nurse and record review on 5/8/2009 at approximately 3:30 PM revealed Client #1 's psychotropic regimen was adjusted as follows over the past few months:</p> <ol style="list-style-type: none"> 11/06/2008 physician's order: Thorazine (Chlorpromazine) 200mg PO Q PM for 30 days to manage his behavior. 12/04/2008 physician's order: Thorazine 100mg PO Q AM x 30 days for behavior and Thorazine 200mg PO Q PM x 30 days for behavior. 12/26/2008 physician's order: Thorazine 150mg PO Q AM x 30 days for behavior and Thorazine 250mg PO Q PM for 30 days for behavior. <p>At the time of survey, there was no evidence on file to substantiate these medication increases had been reviewed and approved with the written informed consent of a legal guardian or advocate acting on behalf of Client #1.</p> <p>Note: According to the Qualified Mental Retardation Professional (QMRP) during an interview on 5/7/2009 at approximately 3:50 PM, Client #1's mother was his legal advocate and took part in all of his health and habilitation planning meetings. [Reference W124]</p>	<p>W 263</p> <p>Cross reference and adopted with (W124).</p>	<p>W 263</p>	<p>7/5/09 and ongoing</p>	
<p>W 368 483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p>		<p>W 368</p>		

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W 368	Continued From page 7 This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure psychotropic medications were administered in accordance with the physician's orders for one of two sampled clients. [Client #1] The finding includes: Observation on 5/7/2009 at 5:45 PM revealed the attending nurse administered Client #1's PM dosage of 250mg of Chlorpromazine (50mg Tab + 200mg Tab). Record review on 5/8/2009 at approximately 3:05pm verified the administration of 250mg of Chlorpromazine the previous evening, was as prescribed. Interview with the facility's Licensed Practical Nurse (LPN) and record review on 5/8/2009 at approximately 3:30 PM revealed Client #1's psychotropic regimen was adjusted as follows over the past few months: 1. 11/06/2008 physician's order: Thorazine (Chlorpromazine) 200mg PO Q PM for 30 days to manage his behavior. 2. 12/04/2008 physician's order: Thorazine 100mg PO Q AM x 30 days for behavior and Thorazine 200mg PO Q PM x 30 days for behavior. 3. 12/26/2008 physician's order: Thorazine 150mg PO Q AM x 30 days for behavior and Thorazine 250mg PO Q PM for 30 days for behavior. Further interview with the LPN verified the	W 368	Psychotropic Medication orders for 30 days are clarified by DDS's to read monthly. All Psychotropic Medications ordered are for the entire month and are not to be packaged or blocked into a 30 day cycle because of discrepancies at the end of the month for months while are shorter than 30 day i.e.: February, and months while are longer than 30 days. DDS has since reviewed their policy to reflect a monthly cycle instead of a 30 day cycle. The Physician's Order for May 09 has been located and filed in the individual's medical record in its proper places. Managers, QMRP and staff have been inserviced into ensuring that all documents removed or reviewed from individuals medical records are properly replaced.	6/1/09 and ongoing

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W 368	<p>Continued From page 8</p> <p>medication was steadily increased from what it was on 11/6/2008 to its current dosage as prescribed on 12/26/2008. Review of the physician's orders on 5/8/2009 at 3:39pm revealed, the medication was ordered as a thirty (30) day regimen.</p> <p>Review of the Medication Administration Record revealed the medication was administered each day in January 2009. However, the physician's order for the January 2009 regimen was not on file at the time of survey for verification.</p> <p>Further interview with the facility's LPN on the same day at approximately 4:12pm verified she could not locate the physician's orders and was not sure where it could have been filed. Additionally, she was unsure as to why the orders were no filed in the medical records.</p>	W 368		

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I 000	INITIAL COMMENTS A re-licensure survey was conducted from 5/7/2009 through 5/8/2009. A random sample of two residents was selected from a residential population of three males with mental retardation and other disabilities. The findings of the survey were based on observations, interviews at the facility and at one day program, and a review of records, including the unusual incident reports.	I 000		
I 183	3508.4 ADMINISTRATIVE SUPPORT Each GHMRP shall have a Residence Director who meets the requirements of § 3509.1 and who shall manage the GHMRP in accordance with approved policies and this chapter. This Statute is not met as evidenced by: Based on staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination, monitoring, and implementation of a resident's habilitation and planning for one of two sampled residents. [Resident #1] The finding includes: 1 The QMRP failed to ensure psychotropic medications were being administered with the consent of a resident's legally appointed guardian or advocate. [See Federal Deficiency Report Citation W124] 2. The QMRP failed to implement corrective actions to prevent the recurrence of exploitation. [See Federal Deficiency Report Citation W157] 3. The QMRP failed to ensure psychotropic medications were being administered with the consent of a resident's parent, legally appointed guardian and/or advocate. [See Federal Deficiency Report Citation W263]	I 183	Symbtral's Governing Body will exercise oversight over program operations, the implementation and update of all Policies and Procedures. Cross reference and adopted with W124. Cross reference and adopted with W157. Cross reference and adopted with W263.	7/5/09 and ongoing 7/5/09 and ongoing

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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If continuation sheet 1 of 8

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1375	<p>Continued From page 1</p> <p>3519.6 EMERGENCIES</p> <p>Each GHMRP shall document each emergency and enter the follow-up actions into the resident's permanent record, which shall be made available for review by authorized individuals.</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to implement corrective actions to prevent the recurrence of exploitation for one of two sampled residents. [Resident #1]</p> <p>The finding includes:</p> <p>Interview with the facility's Qualified Mental Retardation Professional and review of the incident reports on 5/8/2009 at approximately 1:30pm revealed, an incident report dated 3/8/2009 detailed Resident #1's "one-to-one" staff took him out to sell newspapers and did not compensated him for his work.</p> <p>Further record review revealed an investigation into the allegation ensued on 3/13/2009 and was completed on 3/17/2009. The investigation substantiated the allegation of exploitation and recommended the following preventive measures:</p> <ol style="list-style-type: none"> 1. Develop a protocol for taking individuals out in the community within 30 days. 2. Schedule a Case Conference within 30 days to discuss ways and means to adequately provide him the necessary support needed to ensure safety and prevention of exploitation. <p>Review of the policy and procedures manual and interview with the facility's QMRP on 5/8/2009 at</p>	1375 1375	

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(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) COMPLETE DATE
I 375	Continued From page 2 approximately 1:38 PM revealed, there was no protocol and/or policy in place to address the procedure for " taking individuals out in the community " . The administrative records reflected the last policy review and/or amendment was signed and dated 8/29/2008 by the facility's Chief Executive Officer. Further record review and interview with the facility's QMRP on the same day at 1:40 PM revealed a case conference was held on 4/17/2009. However, the meeting minutes revealed the team met to address issues and concerns surrounding Resident #1's sexuality and habilitation. The issue of providing support to prevent " exploitation " was not addressed during the meeting. At the time of survey, there was no evidence presented or on file to substantiate that a case conference had been held to address the issue of preventing future occurrences of " exploitation " as recommended by the 3/17/2009 investigation.	I 375	Cross reference and adopted with W375.	7/5/09 and ongoing
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 staff interview and record review, the GHMRP failed to ensure psychotropic medications were being administered with the consent of a resident's legally appointed guardian or advocate for one of two sampled residents. [Resident #1]	I 500		

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I 500	<p>Continued From page 3</p> <p>The finding includes:</p> <p>A. The GHMRP failed to adhere to the requirements of the Code of Federal Regulations [W124] Section §483.420(a)(2) as presented below:</p> <p>Observation on 5/7/2009 at 5:45 PM revealed the attending nurse administered Resident #1's PM dosage of 250mg of Chlorpromazine (50mg Tab + 200mg Tab). Record review on 5/8/2009 at approximately 3:05pm verified the administration of 250mg of Chlorpromazine previous evening was as prescribed.</p> <p>Interview with the facility's Licensed Practical Nurse and record review on 5/8/2009 at approximately 3:30 PM revealed Resident #1's psychotropic regimen was adjusted as follows over the past few months:</p> <ol style="list-style-type: none"> 11/06/2008 physician's order: Thorazine (Chlorpromazine) 200mg PO Q PM for 30 days to manage his behavior. 12/04/2008 physician's order: Thorazine 100mg PO Q AM x 30 days for behavior and Thorazine 200mg PO Q PM x 30 days for behavior. 12/26/2008 physician's order: Thorazine 150mg PO Q AM x 30 days for behavior and Thorazine 250mg PO Q PM for 30 days for behavior. <p>According to the Qualified Mental Retardation Professional (QMRP) during an interview on 5/7/2009 at 3:49 PM, Resident #1's mother was his legal advocate and she took part in all of his</p>	I 500	<p>1, 2, and 3: Cross reference and adopted with W124. 7/5/09 and ongoing</p>

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1500	<p>Continued From page 4</p> <p>health and habilitation planning. Review of Resident #1's legal records verified his mother signed an affidavit on 6/14/2007 which named her as such and was recognized by the courts.</p> <p>Further record review revealed there was no evidence Resident #1's mother either took part in the psychotropic medication reviews or was informed of the changes, benefits and attendant risks as it relates to her son's psychotropic medication regimen.</p> <p>The facility failed to ensure psychotropic medications were being administered and increased with the consent of a parent, legal guardian and/or advocate as required by this section.</p> <p>B. The GHMRP failed to adhere to the requirements of the Code of Federal Regulations [W263] Section §483.440(f)(3)(ii) as presented below:</p> <p>Observation on 5/7/2009 at 5:45 PM revealed the attending nurse administered Resident #1's PM dosage of 250mg of Chlorpromazine (50mg Tab + 200mg Tab). Record review on 5/8/2009 at approximately 3:05pm verified the administration of 250mg of Chlorpromazine previous evening was as prescribed.</p> <p>Interview with the facility's Licensed Practical Nurse and record review on 5/8/2009 at approximately 3:30 PM revealed Resident #1's psychotropic regimen was adjusted as follows over the past few months:</p> <p>1. 11/06/2008 physician's order: Thorazine (Chlorpromazine) 200mg PO Q PM for 30 days to</p>	1500	<p>1,2, and 3: Cross reference and adopted with W263. 7/5/09 and ongoing</p>

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1500	<p>Continued From page 5</p> <p>manage his behavior.</p> <p>2. 12/04/2008 physician 's order: Thorazine 100mg PO Q AM x 30 days for behavior and Thorazine 200mg PO Q PM x 30 days for behavior.</p> <p>3. 12/26/2008 physician 's order: Thorazine 150mg PO Q AM x 30 days for behavior and Thorazine 250mg PO Q PM for 30 days for behavior.</p> <p>At the time of survey, there was no evidence on file to substantiate these medication increases had been reviewed and approved with the written consent of a legal guardian or advocate acting on behalf of Resident #1.</p> <p>Note: According to the Qualified Mental Retardation Professional (QMRP) during an interview on 5/7/2009 at approximately 3:50 PM, Resident #1's mother was his legal advocate and took part in all of his health and habilitation planning meetings. [Reference W124]</p>	1500	