RECEIVED 9/26/07

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

PRINTED: 09/14/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED R 09/06/2007
NAME OF PROVIDER OR SUPPLIER: SYMBRAL		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)	INITIAL COMMENTS A follow up visit was conducted on September 6, 2007. Two client was selected from the client population of three. This follow up survey was to determine if the facility was in compliance to previous cited Condition Level deficiencies identifeld in the follow-up survey when in Client Protection and Facility Practices, and Governing Body. The findings of this survey were based on interviews at the residence, review of clinical and administrative records to include the facility's incident reports and agency policies. As a result of the survey findings, it was determined that the facility met substantial compliance with requirements in the Conditions of Participation under Client Protection, Facility Practices, and Governing Body. However, additional standard level deficiencies were cited.	(W 000)		
(W 159)	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to adequately monitor, integrate and coordinate each client's active treatment. The finding includes: The QMRP failed to ensure that staff were trained	(W 159)	BSP has been amended to include sleep pattern behavior. Staff have been inserviced on the sleep behavior protocol and data collection. Copies of the form is available within the home and on the van. Staff have been instructed to document all sleep behavior as directed in the protocol. A copy of the protocol and data form has been delivered to the Day Program. Further intervention will be implemented if necessary after reviewing the data. Individual IDT will ensure that all support are available to the individual and his/ her rights are protected. QA will monitor quarterly to ensure compliance.	10/15/2007

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gulane Mohammed TITLE: CEO (X6) DATE: 9/25/07

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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	09G087		R 09/06/2007

NAME OF PROVIDER OR SUPPLIER: SYMBRAL

STREET ADDRESS, CITY, STATE, ZIP CODE: 722 "L" STREET, NE, WASHINGTON, DC 20002

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(W 159)	Continued From page 1 on Client #s2 monitoring of his sleep pattern throughout the day in all settings. [See W189]	(W 159)		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employees to perform his or her duties effectively, efficiently and competently. The finding includes: 1. Interview with the Program Coordinator on September 6, 2007 at 12:00 PM revealed that Client #2's Behavior Support Plan (BSP) had been updated by the consulting psychologist on 8/6/07. Additionally, the Program Coordinator revealed that the Human Rights Committee on August 25, 2007 discussed this behavior and approved a sleep pattern monitoring system. Further interview revealed that a Psychiatric Assessment was completed on August 15, 2007. Interview with the direct care staff indicated that the client continues to have concerns with his sleeping at night. Interview with the House Manager, the psychologist failed to include sleep behavior on the data sheet. According to the house manager the staff were instructed to document the client's sleep behavior in every environment to include transport in the van. Although the psychologist and the psychiatrist	W 189		

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W 189	Continued From page 2 updated their assessment, neither consultant address the behavior of irregular sleep prior to medication being administered for sleep. Further review of the data sheet and the agency's training log failed to evidence that training had occured with the direct care staff, agency driver and/or the day program staff. The facility failed to ensure that accurate sleep data was being documented throughout the client's day in order to be reviewed by the IDT team. Note: It should be further noted that review of the physician's order dated September 1, 2007 revealed the client is prescribed Ambien 10 mg at bedtime for sleep when he is unable to sleep.	W 189		
(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 provide nursing services in accordance with the needs. The finding includes: 1. Interview with the nurse coordinator on September 6, 2007 at approximately 11:00 AM and review of the Medication Administration Record (MAR) revealed that on August 31, 2007, the medication nurse scheduled to dispense the PM medications failed to sign the Medication Administration Record (MAR) for Client #2's medication regimen. Client #2 was scheduled to receive the following medications:	(W 331)		

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	09G087	A. BUILDING B. WING	R 09/06/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	722 "L" STREET, NE WASHINGTON, DC 20002

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{W 331}	Continued From page 3 Keppra 500 mg Haldol 3 mg for behavior Abilify 30 mg for behavior Trilipial 600 mg for seizure disorder Calcarb supplement w vitamins Clonazepam 2 mg for behavior Depakote 1000 mg for seizure disorder Dilantin 50 mg for seizure disorder Gabapentin 600 mg There was no documented evidence that the medication nurse administered these medications as prescribed by the physician. Note: It should be further noted, according to the training records, the agency on August 25, 2007 trained all nurses on the policy and procedure on the administration of client medications and proper documentation. 2. Observation of the medication pass on September 6, 2007 at 8:10 AM revealed that the medication nurse administered Client #2's Clonazepam 2 mg for his maladaptive behaviors. Review of the medication administration records on the same day at 8:50 AM revealed the LPN failed to document this medication on the control substance disposition sheet prior to leaving the facility. Note: It should be further noted that according to the agency's nursing training records, all the nurse working at this facility were trained on administration of client medications and proper medication administration documentation on August 25, 2007. 3. The facility's medication nurse failed to ensure	{W 331}	1. QMRP will ensure that medical follow-up is completed as recommended and in a timely manner. Nursing will monitor to ensure compliance QA will monitor quarterly. 2. PCP will counter sign all telephone orders. RN nurse will monitor to ensure compliance. Director of Nursing will review quarterly to ensure that PCP signature countersigns all telephone orders 3. All assessment will be secure and placed within the clients record. Director of Nursing will ensure that recently purged record are secure within a binder within the home. Records over two (2) years old will be secure in the file at the main office. 4. Nurse has been inserviced on documentation of effectiveness of sedation medication on the MAR.	10/15/2007 and ongoing

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SYMBRAL	722 "L" STREET, NE WASHINGTON, DC 20002

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W 385	Continued From page 5 medication had been administard to a client. Note: It should be further noted that according to the agencu nursing training records, all the nurse working at this facility were trained on administration of client medications and proper medication administration documentation on August 25, 2007.	W 385		
W 454	483,470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a sanitary environment to avoid sources and transmission of infection. The finding includes: The facility's medication nurse failed to ensure safe infection control practices during the medication administration. On September 6, 2007 at approximately 8:20 AM, the medication nurse was observed to reach into the medication cup and take one of Client #2's pills out of the pill cup with his fingers and place it back in the same cup. At 8:23 AM, the nurse was observed to administer Client #2 the same pills for the client to consume. At no time was the nurse observed to remove the contaminated pill and replace it before administering it to the client.	W 454	Cross reference and adopted with W331.	10/15/2007 and ongoing

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(W 331)	Continued From page 4 proper infection control practices. [See W454]	(W 331)		
W 385	483.460(l)(3) DRUG STORAGE AND RECORDKEEPING The facility must maintain records of the receipt and disposition of all controlled drugs. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record verification, the facility failed to maintain records of the receipt and disposition of all controlled drugs for one of the three clients residing in the facility. (Client #2). The finding includes: The facility failed to provide evidence of the disposition of the Controlled Schedule IV Drug (*clonazepam*) prescribed for Client #2 as evidenced by: Observation of the medication pass on September 6, 2007 at 8:10 AM revealed that the Licensed Practical Nurse (LPN) administered Clonazepam 2mg by mouth to Client #2 for his maladaptive behaviors. Review of the Medication Administration Records for verification revealed the the nurse failed to document the administration of this medication on the control substance disposition sheet prior to leaving the facility. Review of the agency's Medication Administration Policy and Procedures require that all Schedule IV medication be monitor an properly dispositioned on the control form after the	W 385	Cross reference and adopted with W331	10/15/2007 and ongoing

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(R 000)	INITIAL COMMENTS A follow-up licensure survey was conducted from September 6, 2007. A random sample of two residents was selected from a residential population of two males with mental retardation and other disabilities. The findings of the survey were based on observations, interviews with residents, staff, and the review of resident and administrative records including incident reports.	(R 000)		
(R 125)	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of records, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. The finding includes: Review of the personnel records on September 6, 2007 at 1:00 PM revealed that the GHMRP failed to provide evidence that ensured criminal background checks were on file and disclosed a seven year history of all the jurisdictions where the employee resided and worked for one staff ([redacted]).	(R 125)	Symbral will ensure that criminal background checks are maintained within the employee/ consultant file. Staff ([redacted]) has provided the criminal background clearance. House Manager will complete cross audit with QA on a quarterly basis. QA will monitor to ensure compliance. All audit will be forwarded to the administration for further corrective action if necessary.	10/05/2007 and ongoing

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Yvonne Mohammed TITLE CEO (X6) DATE 9/25/07

STATE FORM 7WKD13 If continuation sheet: 1 of 1

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(I 000)	INITIAL COMMENTS A follow up licensing survey was conducted on September 6, 2007. Two client's was selected for review. The findings of this survey were based on interviews at the residence, review of clinical and administrative records to include the facility's incident reports and agency policies.	(I 000)		
(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 GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties. The finding includes: Interview with the Qualified Mental Retardation Professional and review of the GHMRP's personnel files on September 6, 2007 at 1:10 PM revealed the GHMRP failed to provide evidence that current health certificates were on file for the Psychiatrist and the Program Coordinator/QMRP.	(I 206)	Symbral will ensure that current health certifications are maintained within the employee/ consultant file. Psychiatrist, QMRP and all staff. House Manager will complete cross audit with QA on a quarterly basis. QA will monitor to ensure compliance. All audit will be forwarded to the administration for further corrective action if necessary.	10/15/2007 and ongoing

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Yvonne Mohammed TITLE CEO (X6) DATE 9/25/07

STATE FORM 7WK013 If continuation sheet 1 of 1