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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 06/27/2007
NAME OF PROVIDER OR SUPPLIER SYMBRAL	STREET ADDRESS, CITY, STATE, ZIP CODE 722 "L" STREET, NE WASHINGTON, DC 20002		

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I 000	INITIAL COMMENTS A re-licensure survey was conducted from June 26, 2007 through June 27, 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, one parent, staff, and the review of resident and administrative records including incident reports.	I 000		
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence that the supervisor discussed the contents of job descriptions with each employee at the beginning of their employment and annually thereafter. The finding includes: Interview with the Qualified Mental Retardation Professional and review of the GHMRP's personnel files on June 27, 2007 at 6:58 PM revealed the GHMRP failed to provide evidence that eight staff and three nurses had the contents of their job descriptions discussed with them at the beginning of their employment and/or annually thereafter.	I 203	L203 -3509.3 Employees updated Job Descriptions have been placed on file. QMRP/Facility Management will ensure that documentation of all employees' review their job description on an annual basis, and upon hire. Personnel records will be maintained and Updated by the Program Director in conjunction with QMRP/House Manager.	7/16/07-Ongoing
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	I 206	L206 - 3509.6 See response on the next page (#2).	

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TITLE CFD

(X6) DATE 7/24/07

STATE FORM 6899 7WKO11 If continuation sheet 1 of 8

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I 206	Continued From page 1 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 June 27, 2007 at 6:58 PM revealed the GHMRP failed to provide evidence that current health certificates were on file for four staff, one nurse, and four consultants.	I 206	L206 - 3509.6 The health certificates for all staff and consultants have been obtained. Program Director/Human Resources will ensure that all health certifications are updated annually for each staff consultant and maintained in the personnel records. Staff/consultants will be notified of the need to submit a current health certificate within 60-days of the current one's expiration.	7/20/07-ongoing
I 274	3513.1(e) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (e) Signed agreements or contracts for professional services; This Statute is not met as evidenced by: Based on record review, the Group Home for the Mentally Retarded (GHMRP) failed to provide evidence of contracts with each of their consultants.	I 274	L274 –3513.1 See response to L274-3513.1 on the next page (#3).	

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I 274	Continued From page 2 The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the personnel records on June 27, 2007 at 7:30 PM revealed the GHMRP failed to have contract on file for the the physical therapist and the psychiatrist.	I 274	L274 –3513.1 The contracts for the physical therapist and the psychiatrist have been obtained and are on file in the personnel records. Program Director/Human Resources will ensure that the consultant contracts are up to date and maintained on file.	7/20/07-Ongoing
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on Interview and record review, the GHMRP failed to ensure the Department of Health , Health Facilities Division was notified of unusual incidents that substantially interfered with a resident's health, for one of the two residents (Residents #2) included in the sample. The finding includes: 1. Review of the GHMRP's incident reports June 26, 2007 at 10:45 AM revealed the following incidents were not reported to the Department of Health as required: January 2, 2007 Staff reported that Resident #2	I 379	L379 – 3519.5 Cross reference response to Federal Deficiency report citations W149 1a & b. Cross reference response to W153.	7/31/07-ongong

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I 379	Continued From page 3 had two seizures. Continued review of the incident report revealed the resident was taken to the emergency room for evaluation. April 6, 2007 Staff reported that Resident #2 had multiple seizure. The resident was transported to the emergency room and was admitted and then subsequently discharged on April 13, 2007. At the time of the survey, the GHMRP failed to provide evidence that the aforementioned incidents were reported to the Department of Health as required. 2. (See also Federal Deficiency Report Citations W149 and W153)	I 379	L379 – 3519.5 See response to L379-3519.5 on preceding page (#3).	
I 391	3520.2(a) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (a) Medicine; This Statute is not met as evidenced by: Based on record review, the GHMRP failed to provide evidence of licensed professional staff secured by the group home to monitor interventions, in accordance with the goals and objectives of every individual habilitation plan.	I 391	L391-3520.2 The current license for the agencies Pharmacist has been obtained and filed in the personnel record. Program Director/Human Resources will ensure that professional licenses are up to date and maintained on file.	7/11/07-Ongoing

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I 391	Continued From page 4 The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the personnel records on June 27, 2007 at 7:30 PM revealed the GHMRP failed to provide evidence of a current license on file for pharmacist.	I 391	L391-3520.2 See response to L391-3520.2 on preceding page (#4).	
I 424	3521.5(a) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client: (a) Has successfully completed an objective or objectives identified in the Individual Habilitation Plan; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure program revisions were made at least every six months or when a resident successfully completed the objective. The finding includes: (See Federal Deficiency Report-Citation W255)	I 424	L424 – 3521.5 QMRP will review the progress on all goals and objectives on a monthly basis and revise/modify individual program plans based on the Client's progress.	7/31/07-Ongoing
I 473	3522.4 MEDICATIONS The Residence Director shall report any irregularities in the resident ' s drug regimens to the prescribing physician. This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHMRP failed to provide evidence the Residence Director reported irregularities in	I 473	L473 – 3522.4 See response to L473-3522.4 on the next page (#6).	

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I 473	Continued From page 5 the residents' drug regimens to the prescribing physician. The finding includes: (See Federal Deficiency Report Citations W149 and W369)	I 473	L473 – 3522.4 continued Cross reference response to Federal Deficiency report citations W149 1a & b. Cross reference response to W369.	7/31/07-ongong
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 observation, interview and record review, the GHMRP failed to ensure the protections of each clients rights. The findings include: (See Federal Deficiency Report Citations W122, W124, and W263)	I 500	L500 – 3523.1 Cross reference response to Federal Deficiency report citations W122, W124 and W263	

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W 000	INITIAL COMMENTS A recertification survey was conducted from June 26, 2007 through June 27, 2007. Initially, the fundamental survey process was used but observations and interviews revealed concerns in the area of Client Protections and on June 27, 2007 the survey was extended in that condition. A random sample of two clients 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 clients, one parent, staff, and the review of client and administrative records including incident reports. A determination was made that the facility failed to be in compliance with the Condition of Participation in Client Protections.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's Governing Body failed to monitor and revise its operation policies as needed. The findings include: 1. The Governing Body failed to ensure its incident management policy had been implemented and/or operations coincided with the federal requirements. [W149] 2. The Governing Body failed to ensure its	W 104	W104 1-2. Reference response to W149.	7/31/07

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

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 104	Continued From page 1 "Incident Management Policy" and its "Management of Pharmaceutical Preparation" were followed when medications were administered outside of the specified timeframe. [W149]	W 104		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure outside services met the needs of one of the two clients (Client #1) included in the sample. The finding includes: Observation at Client #1's day program on June 27, 2007 at 11:35 AM revealed the client was not at the program. Interview with the client's program aide revealed that the client was out with the work crew. When queried as to where the work crew went the staff member revealed that he/she was unaware of the client's location. Interview was conducted with the program coordinator to ascertain Client #1's location. The program coordinator responded and also revealed the client's location was unknown. Continued interview with the program coordinator revealed that Client #1 was scheduled to return shortly. Further interview was conducted with the program aid that revealed the client was participating with several formal program objectives. The program objectives centered around gaining skills in	W 120	W120 The QMRP has met with the Day Program to discuss Client #1's schedule of activities while at the Day Program. The Day Program Coordinator will develop a daily schedule of planned activities/outings for Client #1.	7/16/07-Ongoing

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W 120	Continued From page 2 money management, learning personal information, interaction skills, cleaning skills, and compliance with tasks. Continued interview and record review revealed the client had been participating with the same objectives since August 2006. The program coordinator was interviewed at 12:10 PM to ascertain information regarding Client #1's success with his program objectives. The program coordinator revealed this information regarding how the client was doing with his program objectives was sent to the residential facility. Further interview with the program coordinator revealed that Client #1's data collection record was purged on a monthly basis and the data collection sheets were thrown away after the data was calculated. Additionally, at the time of the survey, there was no information in Client #1's record that revealed how the client was doing with his established program objectives.	W 120	W120 continued QMRP met with Day Program on 7/11/07 and 7/16/07 to establish a plan of action for maintaining hard copies of all recorded data for Client #1. Day Program agreed to maintain all recorded documentation in Client #1's record and send a copy of the data collection to the Residential program monthly in addition to a Quarterly progress report on all program goals and objectives. Verification of this discussion along with supporting signature sheets is maintained in Client #1's residential record.	7/16/07
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and record review the facility failed to establish and/or implement policies that ensured each clients' health and safety (See W149); failed to ensure all allegations of abuse were immediately reported to the administrator or to the Department of Health in accordance with State law, (See W153); failed to thoroughly investigate required incidents (See W154); and failed to provide evidence that clients were protected from further potential abuse while an allegation of abuse was investigated (W155).	W 122	W122 Reference responses to W149, Cross reference responses to W153, W154 and W155.	7/16/07

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W 122	Continued From page 3	W 122		
	The effects of these systemic practices results in the failure of the facility to protect its clients and to ensure active treatment services.			
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS	W 124		
	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.		W124 1-2. Assessment for legal guardianship will be completed for client #1 and #2 and pursuance for guardianship will occur based on the assessed needs of Clients #1 and #2 Additionally, QMRP will continue to ensure that family members are fully knowledgeable and understand the rights of the clients. QMRP will also ensure documentation of information regarding all efforts to involve family members in the decision making process as well as ongoing measures (i.e., Human Rights Committee Reviews to discuss risk –vs- benefits) to ensure protection of their rights. QMRP will continue to pursue securing legal advocacy, as well as, guardianship resources through the quality trust, courts and other applicable services, based on the individual needs for each client. Documentation of these ongoing efforts will be maintained in the client records.	7/31/07
	This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for two of the two clients (Clients #1 and #2) included in the sample.			
	The findings include:			
	1. Observation of the morning medication administration on June 26, 2007 beginning at 9:55 AM revealed Client #1 received Trileptal for his seizure disorder. Interview with the House Manager (HM) on June 26, 2007 at 10:20 AM and review of the client's Physician's Orders dated March 2007 revealed that the client also received Abilify to assist with managing exhibited behaviors. Observation throughout the survey and further interview with the HM revealed that Client #1 additionally received one to one staffing		Response to W124 continued on page 5 of 22.	

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W 124	Continued From page 4 support 24 hours a day. Continued interview with the HM on June 26, 2007 at 10:20 AM revealed Client #1 had a Behavior Support Plan (BSP) that addressed behavior related to sexual misconduct. The House Manager revealed that Client #1 did not have a legal guardian and did not have the capacity to give informed consent for the use of his medications, habilitation services, treatments and financial matters. This was verified through review of Client #1's Psychological Evaluation dated July 22, 2006 on June 26, 2007 at 5:44 PM. According to the assessment, Client #1 was "not competent to make independent decisions...." At the time of the survey, the facility failed to provide evidence that Client #1's treatment needs, including the benefits and potential side effects associated with the medications, and the right to refuse treatment, had been explained to him and/or a legally authorized representative. 2. Observation of the morning medication administration on June 26, 2007 beginning at 9:55 AM revealed Client #2 received Hydrochlorothiazide 30 mg, Depakote 1000 mg, Calcarb with Vitamin D, Clonazepam 2 mg, Gabapentin 1200 mg, Keppra 1000 mg, Mirtazapine 15 mg and Phenytoin Sodium 100 mg. Interview with the nurse during the medication administration revealed that the Clonazepam and Mirtazapine were to assist with managing the client's behaviors. Continued interview with the HM on June 26, 2007 at 10:20 AM revealed Client #2 had a Behavior Support Plan (BSP) that addressed behavior related to non-compliance. The House	W 124	W124 continued from page 4 Client #1' and #2's psychotropic medication regimen will continue to be evaluated monthly by the psychiatrist and psychiatric evaluations reviewed and updated per individual assessment and need.	7/31/07

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W 124	Continued From page 5 Manager further revealed that Client #1 did have a legal guardian however, record review failed to provide evidence that his legal guardian was informed of the aforementioned medications and corresponding treatment services. At the time of the survey, the facility failed to provide evidence that Client #2's treatment needs, including the benefits and potential side effects associated with the medications, and the right to refuse treatment, had been explained to him and his legally authorized representative.	W 124	W124 continued from page 4 & 5. See responses on pages 4 and 5.	
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to establish and/or implement policies that ensured the health and safety of one of the two clients (Client #2) included in the sample. The finding includes: 1. The facility failed to ensure their incident management policy was developed and/or implemented in accordance with the federal regulations. a. Review of unusual incident reports on June 26, 2007 at 10:45 AM revealed that there was an allegation of abuse involving Client #2 on August 1, 2006. According to the incident report, day program staff went to the lobby to receive Client #2 upon arrival and the client's driver was	W 149	W149 1a & b. The Program Director will revise and clarify the agency's Policies and Procedures to further address identification, classification and handling of incidents following regulatory guidelines. Incidents will be managed in accordance with DC regulation 22 DCMR Chapter 35 Section 3519.10. Staff will be re-trained on the incident reporting procedures.	7/31/07

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	09G087		06/27/2007

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

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W 149	Continued From page 6 observed "physically forcing [Client #2] to enter the door of [the day program]." Client #2 was asked by the day program staff if he wanted to remain at the day program. Client #2 responded by saying no. At that time, the day program's social worker was notified. Continued review of the incident report revealed two witness statements were attached, one from the day program staff that received the client at the day program and one from the day program's supervisory social worker. According to the statement from the day program staff, the driver returned to the van, closed the door and locked it and refused to answer any of the staff's questions. Review of the social worker's statement revealed that the social worker also tried to talk with the driver when the driver returned to the van but the driver ignored the social worker. Reportedly, Client #2 attempted to re-enter the van but the driver refused. The social worker also documented that the driver became "irate and hard to speak with." Additionally, the social worker reported that Client #2 was outside at the time of the incident and the temperature outside was "rising to 100 degrees." Interview was conducted with the facility's House Manager and Qualified Mental Retardation Professional (QMRP) on June 26, 2007 and June 27, 2007 to ascertain information about the incident and find out the facility's policy on required notifications. Interview revealed that the Department of Health and the administrator were to be notified of all allegations of abuse. Additionally, a copy of the facility's incident management policy was provided for review. According to the policy, "Allegations of abuse, neglect and mistreatment are to be reported	W 149	W149 1a & b continued Investigation of the incident involving Client # 2 from the unusual incident report dated 8/6/2006 will be conducted by the QMRP. The report will be forwarded to DOH by 7/31/07 containing as much information relative to the incident as possible considering the time lapse.	7/31/07

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

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FORM APPROVED
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W 149	Continued From page 7 immediately, and no later that eight (8) hours to the DOH..." At the time of the survey, the facility failed to ensure the Department of Health was notified of the aforementioned allegation of abuse. b. Continued review of the facility's incident management policy on June 27, 2007 revealed that the provider was "responsible for initiating agency local investigations of all serious incidents..." The policy further indicated that final investigation reports would be distributed to the Department of Health. Additionally, the policy documented that, "All investigations would be completed within (10) working days of the incident being reported...." At the time of the survey, the facility failed to provide evidence that the allegation of abuse was investigated. Furthermore, the facility failed to ensure its incident management policy had been developed to make certain investigation were completed within five working days as specified in the regulation. 2. The facility failed to ensure its "Incident Management Policy" and its "Management of Pharmaceutical Preparation" were followed when medications were administered outside of the specified timeframe. Observation of the morning medication administration on June 26, 2007 revealed that the administration of medication was conducted by a licensed practical nurse beginning at 9:55 AM. Review of both Clients #1 and #2's Medication Administration Records (MARs) revealed that the morning medication administration was scheduled for 7:00 AM. It should be noted that both Client #1 and #2 received including	W 149	W149 1a & b continued. See responses on page #6 & #7. W149 #2 2. The DON/Designated nurse will re-inservice the medication nurse on the agencies Incident Management and Management of Phamaceutical Preparation policies.	7/31/07

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

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W 149	Continued From page 8 medications for their seizure disorder. Client #1 was observed receiving Trileptal, and Client #2 received Hydrochlorothiazide, Depakote, Calcarb with Vitamin D, Clonazepam, Gabepentin, Keppra, Mirtazapine and Phenytoin Sodium. Furter observation on June 26, 2007 revealed the nurse entered the facility for the evening medication administration at 8:04 PM. Review of the MARs, revealed medications were scheduled for 7:00 PM. Interview was conducted with the House Manager and Qualified Mental Retardation Professional on June 26, 2007 at 5:35 PM regarding the facility's medication administration policy. According to the managers, the timeframe for medications to be administered was one hour before through one hour after the scheduled medication time. The House Manager further specified that medications were supposed to be given between 8:00 AM and 8:00 AM. Additionally, the House Manager revealed that the nurse should have notified the Primary Care Physician (PCP) prior to administering the medications due to exceeding the specified timeframe. Interview with the supervisory licensed practical nurse on June 27, 2007 verified the House Manager's statements and further verified that the administration of the client's medications at 9:55 AM constituted a medication error. Continued interview and record review were conducted on June 27, 2007 to further verify the facility's policy on medication administration. According to the facility's "Incident Management Policy," medication errors constituted an incident that was required to be documented on an incident report form. The policy documented:	W 149	149 2 continued. The DON/Designated Nurse will further ensure that the in-service training with the medication nurse including consequential action as necessary and appropriate to the failure to adhere to medication administration policies and procedures. QMRP will provided training to Direct care staff to include procedures to follow in the event that the Mediation nurse has not arrived within 30 minutes of the 1 hour before/after after medication is scheduled to be administered. Documentation of the training as well as any necessary consequential action will be maintained in the personnel records and/or the staff training records.	7/31/07

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W 149	Continued From page 9 - "When an incident is witnessed or discovered by an employee, management requirers that the Incident report Form be completed by the end of the shift and be forwarded to the Incident Management Coordinator." - "Incidents must be reported immediately." Additionally, review of the facility's "Management of Pharmaceutical Preparation" policy revealed the following: - "Medications errors and untoward drug reactions shall be immediately reported to the physician, charted in detail on the nurse's notes, and described in a full incident report." Interview with the supervisory licensed practical nurse, the QMRP, and the House Manager on June 27, 2007 revealed that the nurse failed to document the medication errors on an incident report. Additionally, there was no evidence, at the time of the survey, that the nurse notified the physician or made an entry into the nursing notes regarding the late medication pass. The facility failed to provide evidence that medications were administered within the specified time frames and in accordance with facility policy. 3. The facility failed to ensure the implementation of its medication destruction policy. Observation of the morning medication administration on June 26, 2007 revealed that the administration of medication was conducted by a Licensed Practical Nurse (LPN) beginning at 9:55 AM. During the medication administration Client #2's Clonazepam was observed to drop on the	W 149	W149 continued 3. The DON/Designated nurse will re-inservice the medication nurse on the instruction for the disposition of wasted medication. Consequential action as necessary and appropriate to the failure to adhere to medication administration policies and procedures.	7/31/07

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

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W 149	Continued From page 10 floor. The nurse was observed to pick the medication up and place it on a shelf in the medication cabinet, punched another Clonazepam and administered the medication to the client. After the medication administration concluded, the nurse was not observed to have discarded the medication. It should be noted however, that the nurse called the house at approximately 10:30 AM and indicated the dropped Clonazepam was placed in the facility's sharps container. Interview with the facility's supervisory LPN and review of the facility's "Disposition of Wasted Medication" policy on June 27, 2007 at 3:45 PM revealed the following regarding medication disposal: - Disposed of by two licensed personnel by flushing it down the toilet. - Write incident report for the wasted medication. - Inform the pharmacy to replace the wasted medication. At the time of the survey, the facility failed to provide evidence that the aforementioned instruction from the "Disposition of Wasted Medication" policy had been completed.	W 149	W149 See responses to W149 on Page 10	
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.	W 153	W153 See responses on next page (#12).	

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W 153	Continued From page 11 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure all allegations of abuse, were immediately reported to the administrator and to other officials in accordance with State Law, for one of the two clients (Client #2) included in the sample. The finding includes: Review of unusual incident reports on June 26, 2007 at 10:45 AM revealed that there was an allegation of abuse involving Client #2 on August 1, 2006. According to the incident report, day program staff went to the lobby to receive Client #2 upon arrival and the client's driver was observed"physically forcing [Client #2] to enter the door of [the day program]." Client #2 was asked by the day program staff if he wanted to remain at the day program. Client #2 responded by saying no. At that time, the day program's social worker was notified. Continued review of the incident report revealed two witness statements were attached, one from the day program staff that received the client at the day program and one from the day program's supervisory social worker. According to the statement from the day program staff, the driver returned to the van, closed the door and locked it and refused to answer any of the staff's questions. Review of the social worker's statement revealed that the social worker also tried to talk with the driver when the driver returned to the van but the driver ignored the social worker. Reportedly, Client #2 attempted to re-enter the van but the driver refused. The	W 153	W153 Reference responses to W149 1a & b.	

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W 153	Continued From page 12 social worker also documented that the driver became "irate and hard to speak with." Additionally, the social worker reported that Client #2 was outside at the time of the incident and the temperature outside was "rising to 100 degrees." Interview was conducted with the facility's House Manager and Qualified Mental Retardation Professional (QMRP) on June 26, 2007 and June 27, 2007 to ascertain information about the incident and find out the facility's policy on required notifications. Interview revealed that the Department of Health and the administrator were to be notified. However, at the time of the survey, the facility failed to provide evidence that the aforementioned incident was reported to both the facility's administrator and the Department of Health as required. (See also W149).	W 153	W153 Reference response to W149 1a & b.	
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that all allegations of abuse were investigated, for one of the two clients (Client #2) included in the sample. The finding includes: (Cross Refer W153) Review of unusual incident reports on June 26, 2007 at 10:45 AM revealed that there was an allegation of abuse involving Client #2 on August 1, 2006. At the time of the survey, the facility failed to provide evidence that the allegation of abuse had been investigated.	W 154	W154 Reference response to W149 1a & b.	

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W 155	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that clients were protected from further potential abuse while an allegation of abuse was investigated, for one of the two clients (Client #2) included in the sample. The finding includes: (Cross Refer W153) Review of unusual incident reports on June 26, 2007 at 10:45 AM revealed that there was an allegation of abuse involving Client #2 on August 1, 2006. Continued review of the incident report failed to identify the name of the driver. Interview was conducted with the facility's House Manager on June 26, 2007 to determine if the allegation of abuse was substantiated. According to the House Manager, the driver was terminated as a result of the incident. At the time of the survey, however, there was no evidence that the incident had been investigated. Additionally, there was no evidence that the systems were implemented to ensure Client #2 was protected from further potential abuse.	W 155	W155 Reference response to W149 1a & b.	
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.	W 159	W159 See responses on next page (#15).	

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W 159	Continued From page 14 This STANDARD is not met as evidenced by: Based on observation, 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 findings include: 1. The QMRP failed to ensure outside services met the needs of each client. (See W120) 2. The QMRP failed to ensure that the Client #1's individual program plan included objectives to address targeted behaviors. (See W227)	W 159	W159 1. Cross references response to W120 2. Cross reference response to W227.	
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 was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. The finding includes: 1. The facility failed to provide evidence that staff were effectively trained on the facility's incident management policy. (See W149, 1 and 2) 2. The facility failed to ensure nursing staff were effectively trained on procedures to use when medications were administered outside the	W 189	W189 1-2. Cross reference response to W149 1a b & 2.	

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W 189	Continued From page 15 specified timeframe. (See W149, 2) 3. The facility failed to ensure nursing staff were effectively trained on the medication destruction policy. (See W149, 3)	W 189	W189 continued 1-2. Cross reference response to W149 2 and 3.	
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on interview and the record review, the facility failed to ensure that the Client #1's individual program plan included objectives to address targeted behaviors. The finding includes: Interview with the House Manager (HM) on June 26, 2007 at 10:20 AM and review of the client's Physician's Orders dated March 2007 revealed that Client #1 received Abilify to assist with managing exhibited behaviors. Observation throughout the survey and further interview with the HM revealed the client additionally received one to one staffing support (arm's length distance) 24 hours a day. The HM also revealed Client #1 had a Behavior Support Plan (BSP) that addressed behaviors related to sexual misconduct. Review of Client #1's BSP dated August 1, 2006 on June 27, 2007 at 5:46 PM revealed the plan addressed targeted behaviors of non-compliance, tantrums, and inappropriate sexual	W 227	W227 See response to W227 on next page (#17).	

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W 227	Continued From page 16 behaviors/sexual suggestions. The plan however, failed to incorporate written program objectives designed to reduce the targeted behaviors. Further review of the plan revealed a section entitled "Proactive Procedures for the Residence." Within that section, it was documented that "staff will maintain close proximity and activity monitoring at all times." The plan did not document information regarding the one to one staffing support outside of the residence. It should be noted that on June 27, 2006 at 12:15 PM, Client #1 and his one to one staff were observed at the client's day program.	W 227	W227 continued QMRP met with the Client #1's IDT on 7/9/07 and 7/16/07. The BSP for Client #1 will be revised to include the necessity for 1:1 supports in both the residential. A copy of the revised BSP will be submitted to and maintained on file in both settings. Staff in both settings will be trained on the BSP and the provision of 1:1 supports for Client# 1. A copy of the training as well as the 1:1 specific duties will be kept in the staff training record and the Daily program record for Client #1.	7/31/07
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to provide evidence that Individual Program Plans (IPP)s were reviewed and revised once the client had successfully completed an objective, for one of the two clients (Client #1) included in the sample. The finding includes: Review of Client #1's habilitation records on June 27, 2007 at 5:33 PM revealed the client had a Individual Support Plan (ISP) dated July 25, 2006. According to the ISP, the interdisciplinary team	W 255	W255 See response to W255 on the next page (#18).	

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W 255	Continued From page 17 recommended the following program objective to be increase the clients meal preparation and dental hygiene skills. Interview with the QMRP and continued review of Client #1's record revealed that the client had been completing the objectives since July 2006 and August 2006, respectively. At the time of the survey, the facility failed to ensure Client #1's program objectives had been revised once he had achieved the objective.	W 255	W255 An ISP meeting was held for Client #1 on 7/16/07 at which time new recommendations for goals and objectives were presented and agreed upon by the IDT. The new goals and objectives have been put in place for Client#1. The QMRP will review the progress on all goals and objectives on a monthly basis and revise/modify individual program plans as needed based on the Client's progress.	7/31/07-Ongoing
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that Client #1's behavior support plan including the use of one to one staffing support had been reviewed and approved by the Human Rights Committee (HRC). The finding includes: Interview with the QMRP and review of the facility's available Human Rights Committee meeting minutes dated May 30, 2007 on June 27, 2007 at 5:00 PM failed to provide evidence that Client #1's behavior support plan had been reviewed and approved prior to its implementation.	W 262	W262 The QMRP will present new and/or revised BSP's to the HRC for approval/consent prior to the implementation of the new or revised BSP. Documentation of the HRC meetings will be maintained in the HRC records.	7/31/07-Ongoing
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE	W 263	W263 See response to W263 on the next page (#19).	

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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 263	Continued From page 18 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 observation, interview and record review, the facility's Human Rights Committee (HRC) failed to ensure written informed consent had been obtained from the client and/or their legal guardian for the use of behavior support plans, for two of the two clients (Clients #1 and #2) included in the sample. The finding includes: 1. Observation of the morning medication administration on June 26, 2007 beginning at 9:55 AM revealed Client #1 received Trileptal for his seizure disorder. Interview with the House Manager (HM) on June 26, 2007 at 10:20 AM and review of the client's Physician's Orders dated March 2007 revealed that the client also received Ability to assist with managing exhibited behaviors. Observation throughout the survey and further interview with the HM revealed that Client #1 additionally received one to one staffing support 24 hours a day. Continued interview with the HM on June 26, 2007 at 10:20 AM revealed Client #1 had a Behavior Support Plan (BSP) that addressed behavior related to sexual misconduct. The House Manager revealed that Client #1 did not have a legal guardian and did not have the capacity to give informed consent for the use of his medications, habilitation services, treatments and financial matters. This was verified through	W 263	W263 Cross reference response to W124 and W262	7/31/07-Ongoing

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

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	09G087		06/27/2007

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

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W 263	Continued From page 19 review of Client #1's Psychological Evaluation dated July 22, 2006 on June 26, 2007 at 5:44 PM. According to the assessment, Client #1 was "not competent to make independent decisions...." At the time of the survey, the facility failed to provide evidence that its Human Rights Committee had obtained written informed consent for the use of Client #1's behavior support plan. (See also W124) 2. Observation of the morning medication administration on June 26, 2007 beginning at 9:55 AM revealed Client #2 received Hydrochlorothiazide 30 mg, Depakote 1000 mg, Calcarb with Vitamin D, Clonazepam 2 mg, Gabapentin 1200 mg, Keppra 1000 mg, Mirtazapine 15 mg and Phenytoin Sodium 100 mg. Interview with the nurse during the medication administration revealed that the Clonazepam and Mirtazapine were to assist with managing the client's behaviors. Continued interview with the HM on June 26, 2007 at 10:20 AM revealed Client #2 had a Behavior Support Plan (BSP) that addressed behavior related to non-compliance. The House Manager further revealed that Client #1 did have a legal guardian however, record review failed to provide evidence that his legal guardian was informed of the aforementioned medications and behavior support plan. At the time of the survey, the facility failed to provide evidence that its Human Rights Committee had obtained written informed consent for the use of Client #2's behavior support plan. (See also W124)	W 263	W263 continued Cross reference response to W124 and W262.	
W 331	483.460(c) NURSING SERVICES	W 331	W331 Response to W331 on Page 21.	

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

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W 331	Continued From page 20 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 of two of the two clients (Clients #1 and #2) included in the sample. The finding includes: 1. The facility's nursing services failed to adhere to the facility's incident management and medication destruction policy as outlined. (See W149) 2. The facility's nursing services failed to ensure nursing Client #1 received a quarterly nursing assessment. (See W336)	W 331	W331 1. Cross reference response to W149 2. Cross reference response to W336.	
W 336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the health status was reviewed by the Registered Nurse (RN) staff on a quarterly or more frequent basis for one of the two clients(Client #1) included in the sample. The finding includes:	W 336	W336 See response to W336 on Page 22	

Amended

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W 336	Continued From page 21	W 336		
	Interview with the facility's supervisory Licensed Practical Nurse (LPN) on June 27, 2007 revealed that the Registered Nurse (RN) should complete quarterly nursing exams. Review of Client #1's medical record on June 27, 2007 at 1:41 PM revealed a quarterly nursing assessment dated January 20, 2007 with the next quarterly scheduled April 2007. There was no evidence that the client's health status had been reviewed quarterly by the RN as scheduled.		W336 DON/Designated Nurse has completed the quarterly nursing report for Client #1 and placed it on file in Client #1's medical records. DON/Designated Nurse will ensure that the clients health status is reviewed on a quarterly basis and evidence of the review s documented and maintained on file in the Client's medical record.	7/26/07-Ongoing
W 369	483.460(k)(2) DRUG ADMINISTRATION	W 369		
	The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.		W369 Cross reference response to W149 #s 1 & 2.	7/31/07-Ongoing
	This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that medications were administered without error, for two of the two clients (Clients #1 and #2) included in the sample.			
	The finding includes:			
	The facility failed to ensure medications were administered without error. (See W149, 2)			

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Health Regulation Administration

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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R 000	INITIAL COMMENTS A re-licensure survey was conducted from June 26, 2007 through June 27, 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, one parent, 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 June 27, 2007 at 6:58 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 the eight staff.	R 125	R125-4701.5 Police clearances disclosing a seven year history of all jurisdictions where employees resided have been obtained for all staff are on file.	7/16/07