STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0039	A. BUILDING _____ B. WING _____	01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL FOUNDATION	521 KENNEDY STREET, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	INITIAL COMMENTS A licensure survey was conducted from January 14, 2014 through January 16, 2013. A sample of two residents was selected from a population of four men with varying degrees of intellectual disabilities. The findings of the survey were based on observations, interviews and review of resident and administrative records. Note: The below are abbreviations that may appear throughout the body of this report. Department of Health, Health Regulation and Licensing Administration - DOH/HRLA Direct Support Professional - DSP Group Home for Individuals with Intellectual Disabilities - GHIID House Manager - HM Individual Program Plan - IPP Individual Support Plan - ISP Intermediate Care Facility - ICF Licensed Practical Nurse - LPN Medication Administration Record - MAR Qualified Intellectual Disabilities Professional - QIDP Registered Nurse - RN	I 000	RECEIVED 2/11/14 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
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.	I 206	See page 2.	

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W 104	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the governing body failed to ensure effective implementation of the facility 's transportation services to ensure clients' safety, for four of four clients residing in the facility . (Clients #1, #2, #3 and #4) The findings include: I. Facility staff failed to ensure client safety while transporting clients in the community , as follows: A. On January 14, 2014, at 8:46 a.m., Client #1 was observed being escorted onto the back area of the facility van . A direct support staff (DSP #1) locked the front wheels on the client's motorized wheelchair, closed the door and began assisting DSP #2 with other clients up front. Observations had not revealed DSP #1 fastening the wheelchair with tie down straps. At 8:50 a.m., upon request from this surveyor, DSP #1 re-opened the back door of the van, confirmed the aforementioned observations and stated they routinely transported Client #1 without using the tie down straps. After this surveyor expressed concern, DSP #1 attempted to secure a strap but the staff did not appear to know the procedure. Eventually, DSP #1 clamped a strap directly to the metal frame of the wheelchair , near the left front wheel. DSP #1 clamped another strap to the frame in a similar fashion , near the right front wheel. He did not secure the back of the wheelchair before closing the back door of the van. It was noted that DSP #1 did not ask DSP #2 for assistance with the tie down procedure. At 9:08 a.m., DSP #1 was observed driving the van away from the facility.	W 104	All staff have been trained on 1/15/2014, and 1/16/2014 on Transportation Safety, seat belt and how to tie down the wheelchair at all times. The house manager will ensure the effective implementation of the facility's transportation services to ensure individual #1, #2, #3 and #4 safety at all times and the QIDP will monitor weekly. The Governing Body has also rented a new van on 2/5/2014 for transportation pending the availability of Symbral's new purchased van. The new purchased van is being sent in for AOA Modification , and will be ready by 4/30/2014.	1/15/2014 and 1/16/2014 and ongoing 2/5/2014

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W 104	Continued From page 2 The facility's QIDP arrived at approximately 9:30 a.m. When informed of the aforementioned observations, QIDP #1 said staff were expected to use all four of the tie down straps, adding "I'm surprised they don't." He further indicated that HM #1 handled transportation. At approximately 11:50 a.m., interview with HM #1 revealed that she had conducted staff in-service training in December 2013; however, documentation of said training was unavailable for review. She presented a signature sheet for training conducted on September 2, 2013; DSP #1's signature was on it, indicating he had been in attendance. B. Also on January 14, 2014, at 8:53 a.m., Client #3 was observed seated in the van with no seatbelt across his lap. When asked if the client had a seatbelt, DSP #2 attempted to secure him but was unable to do so. DSP #1 also tried to secure the client but determined the seatbelt was broken. The two staff told this surveyor that Client #3 would be moved to the seat normally used by DSP #2, which had a functioning seatbelt. At 9:08 a.m., however, the van left abruptly with Client #3 observed still seated in the same spot. Interviews later that day revealed that the client had not been secured with a seatbelt prior to departure. Subsequent interviews with QIDP #1 and HM #1, at 9:40 a.m. and 11:50 a.m. respectively, revealed that staff had been trained to always use seatbelts. Review of the signature sheet for in-service training provided on September 2, 2013, revealed that both DSP #1 and DSP #2 were in attendance.	W 104	Continued from page 2.	

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W 104	Continued From page 3 On January 15, 2014, at 10:15 a.m., review of the facility's transportation policy, dated October 17, 2013, revealed "all wheelchairs must be properly tied down... to ensure individuals safety" and "all individuals onboard transportation must be secured by seatbelts at all times when in transit." Observations on the morning of January 14, 2014 revealed that transportation-related training provided for staff prior to the survey had not been effective. II. Facility staff failed to demonstrate competency in implementing vehicle maintenance policies and procedures, as follows: On January 14, 2014, beginning at 8:46 a.m., observation of the facility van revealed numerous passenger seats had severely torn and/or missing upholstery and one seatbelt was inoperable. On January 14, 2014, at approximately 9:30 a.m., interview with QIDP #1 revealed that staff were expected to complete a vehicle maintenance checklist prior to each use of the facility van. He further indicated that HM #1 handled transportation. At approximately 11:50 a.m., interview with HM #1 revealed that it was her understanding that staff were only expected to complete a maintenance checklist if /when there was a change (example: if something was broken). HM #1 said staff had turned in two maintenance checklists during the eight months that she had worked in the facility (the most recent checklist had been turned in during the	W 104	Continued from page 3. The House Manager and all the staff were trained on 1/17/2013 on how to complete a vehicle maintenance checklist form prior to each use of the facility van according to the company policy. The House Manager will monitor weekly and the QIDP will review monthly. The Governing Body have developed a clear policy in regards to the maintenance checklist, and the house manager/all staff have been trained.	1/17/2013 and ongoing 2/5/2014

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W 104	Continued From page 4 week prior to the survey). Further interview with the HM revealed that she could not determine when the seat belt broke. On January 15, 2014, at 10:15 a.m., review of the facility's transportation policy, dated October 17, 2013, revealed "each driver must complete a pre-check before use." The policy did not clearly outline when staff were required to complete a checklist. There was no evidence that staff prepared a vehicle maintenance checklist on January 14, 2014. At the time of the survey, there was no evidence that the governing body had developed clear policies regarding the maintenance checklist and trained managers to ensure compliance with the facility's transportation policy.	W 104	Continued from page 4.	
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to ensure that each client's self-medication training program was implemented consistently and the facility QIDP failed to ensure implementation of training programs as outlined in each client's ISP, for two	W 249	See page 6.	

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W 249	Continued From page 5 of two clients in the sample. (Clients #1 and #2) The findings include: I. Facility nurses did not consistently implement Client #1's and #2's self-medication training programs, as follows: A. On January 14, 2014, at 7:56 a.m., the medication nurse (LPN #1) punched Client #2's medications into a cup while in the kitchen. LPN #1 carried the medication cup to the client, who had been seated at the dining room table eating breakfast since 7:20 a.m. On January 14, 2014, at 3:00 p.m., review of Client #2's MAR revealed that he had a self-medication training program. The program included: "With verbal prompts, <Client #2's name> will punch his medication during the medication administration, 60% of all opportunities for six consecutive months." The tasks outlined included: - Get water; - Punch medication; Observations on the morning of January 14, 2014, at 7:56 a.m., revealed that LPN #1 did not provide Client #2 the opportunity to get his water or assist with punching his medications out of the blister packs, in accordance with the training program. B. On January 14, 2014, at 8:04 a.m., LPN #1 punched Client #1's medication (Keppra 1000 mg) and a multivitamin supplement from their	W 249	The Director of Nursing have trained the facility nurse on 1/24/2014 on the self medication training for individual #1 and # 2. The Nurse Supervisor will monitor weekly and the DON will review Monthly.	1/24/2014 and ongoing

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W 249	Continued From page 6 respective blister packs into a medication cup, poured 8 ounces of spring water and carried them to the client's bedroom. LPN #1 handed the medications to Client #1 and he consumed them. He immediately reached for water and drank it independently. LPN #1 returned to the nurse's area in the kitchen and initialed the client's MARs. On January 14, 2014, at 3:10 p.m., review of Client #1's MAR revealed that he had a self-medication training program. The program included: "With verbal prompts, <Client #1's name> will identify his medication (Keppra) for med pass at 70% of all opportunities for three consecutive months." Observations on the morning of January 14, 2014 revealed that LPN #1 did not provide Client #1 the opportunity to identify his medication by name, in accordance with the training program. On January 16, 2014, interviews with the LPN Coordinator (LPN #2) and QIDP #1, at 10:00 a.m. and 11:07 a.m. respectively, revealed that both had observed the morning medication nurse implement the clients' self-medication training programs in the past. At the time of the survey, however, facility nurses failed to show evidence they consistently provided opportunities for the clients to develop and maintain their skills. II. The QIDP failed to ensure that training programs recommended by Client #1's and Client #2's IDTs were developed and implemented in accordance with their ISPs, as follows:	W 249	Continued from page 6.	

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W 249	Continued From page 7 On January 14, 2014, Client #1 and Client #2 were observed in the home from 7:11 a.m. - 8:45 a.m. and again from 3:45 p.m. - 7:06 p.m. Morning observations revealed neither client was provided the opportunity to engage in their self-medication training programs (see above). Evening observations revealed Client #1 spent most of his time listening to music and/or watching television in his bedroom. Staff periodically knocked on his bedroom door and engaged Client #1 in conversation. The client joined his peers for dinner at 6:38 p.m. then returned to his bedroom at 6:50 p.m. after finishing his meal. He was watching television when this surveyor left at 7:06 p.m. Also on January 14, 2014, from 3:45 p.m. - 5:30 p.m., Client #2 was observed seated on a living room sofa, holding (but not looking in) a magazine. At 5:30 p.m., Client #2 was offered a jigsaw puzzle, which he worked on in the dining room until staff informed him that they were about to have dinner. Staff was then observed setting the dinner table while Client #2 and a peer watched from the living room. Review of the two clients' annual ISPs and training programs revealed the following: A. On January 15, 2014, beginning at 12:12 p.m., review of Client #1's ISP (dated April 8, 2013) revealed several training programs that were recommended by his interdisciplinary team that were not reflected in the quarterly summary reports prepared by the QIDP. For example, there was no evidence that the facility implemented the following:	W 249	The DDS Service Coordinator and the QIDP and the Interdisciplinary Team has concluded to make a correction/addendum to the ISP pending individual #1's ISP to reflect only the goals being tracked in individual #1 residence and day program on 2/7/2014. Individual #2 just had a new ISP completed on 1/29/2014. All staff have been trained on 1/30/2014 on the new IPP in accordance with active treatment and as recommended by the interdisciplinary team. The House Manager will monitor every other day and the QIDP will review monthly.	2/7/2014 1/30/2014 and ongoing

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W 249	Continued From page 8 - "In a group setting, after staff have read a story to him, <client's name> will explain what he understood to his peers for five consecutive minutes on 80% of the opportunities provided for six consecutive months within a year;" - "<Client's name> will chose two activities of daily living of his choice (brushing his teeth, dust furniture/ table, and empty trash can) to complete them with 100% independence three out of four trials for six consecutive months in one year;" - "Staff will show <client's name> the clock and will ask him to tell them the time (the time identified is associated with routine schedule of activities in the home) monthly;" and, - "After reviewing sales paper/ catalogues, <client's name> will make a budget of $5 on items significant to him on 100% of the opportunities provided for six consecutive months within one year." The QIDP was interviewed in the facility on January 15, 2014, beginning at 1:12 p.m., to ascertain the status of the aforementioned goals. QIDP #1 stated that the goals were "not formal goals, not targeted goals" and staff, therefore were not documenting their implementation. The client's DDS service coordinator (SC) participated in the Exit Conference, by telephone, on January 16, 2014, beginning at 1:05 p.m. She stated that ISPs did not include "informal goals" and the expectation was that the facility would implement ISP goals unless the facility sought to amend the client's ISP, via communications with the SC.	W 249	Continued from page 8.	

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W 249	Continued From page 9 B. Similarly, on January 15, 2014, at 2:55 p.m., review of Client #2's ISP (dated January 30, 2013) revealed his interdisciplinary team had recommended a program where the client would dress himself after using the bathroom (raise his pants, fasten the belt, etc.). The team also recommended an exercise program for the upper and lower body, using 4-pound cuff weights. Review of QIDP #1's third quarterly review, dated November 5, 2013, and those earlier in the ISP year did not reflect the implementation of the two goals. At 4:05 p.m., interview with QIDP #1 confirmed that neither goal had been implemented. He said this was his "first time seeing" the programs. At the time of the survey, the facility failed to show evidence that each client's active treatment goals and objectives were implemented as recommended by the interdisciplinary team.	W 249	Continued from page 9.	

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

PRINTED: 01/30/2014
FORM APPROVED
OMB NO. 0938-0391

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W 000	INITIAL COMMENTS A recertification survey was conducted from January 14, 2014 through January 16, 2013. A sample of two clients was selected from a population of four men with varying degrees of intellectual disabilities. This survey was conducted utilizing the fundamental survey process. The findings of the survey were based on observations, interviews and review of client and administrative records. Note: The below are abbreviations that may appear throughout the body of this report. Department of Health, Health Regulation and Licensing Administration - DOH/HRLA Direct Support Professional - DSP Group Home for Individuals with Intellectual Disabilities - GHIID House Manager - HM Individual Program Plan - IPP Individual Support Plan - ISP Intermediate Care Facility - ICF Licensed Practical Nurse - LPN Medication Administration Record - MAR Qualified Intellectual Disabilities Professional - QIDP Registered Nurse - RN	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.	W 104	See page 2.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] RN CEO

TITLE: 2/10/2014

(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 disclosable90 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 disclosable14 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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I 206	Continued From page 1 This Statute is not met as evidenced by: Based on interview and record review, the GHIID failed to ensure that all employees and health care professionals had current health certificates on file, for 3 of 11 nonlicensed employees and 1 of 9 consultants. (DSPs #3, #5 and #7; and the occupational therapist) The findings include: I. On January 16, 2014, at 11:50 a.m., review of personnel records in the facility revealed no evidence of a physician's health inventory/ certificate for DSP #3. According to his file, DSP #3 had been employed since 2003. II. On January 16, 2014, at 12:08 p.m., review of the personnel records revealed no evidence of a physician's health inventory/ certificate for DSP #5. According to her file, DSP #5 had been employed since December 2012. III. On January 16, 2014, at 12:50 p.m., review of the personnel record maintained for the occupational therapist (OT) consultant revealed that a nurse had performed a health inventory on August 26, 2013. There was no evidence, however that the OT's health status had been certified by a physician. At approximately 12:41 p.m., the director of nursing spoke by telephone with the corporate office. She was told there were updated health certificates, orientation checklists, professional licenses and other information being sent via facsimile. Review of the faxed materials, however failed to show evidence of the three	I 206	DSP #3 has completed a physician health certificate on 1/20/2014. DSP #5 has completed a physician health certificate on 1/14/2014. The Occupational Therapist has completed a physician health certificate on 2/4/2014.	1/20/2014 1/14/2014 2/4/2014

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I 206	Continued From page 2 aforementioned health certificates. At the time of the survey, the facility failed to show evidence that all employees and consultants obtained a physician's certification of health status prior to employment and annually thereafter.	I 206	The Governing Body of Symbral Foundation will ensure that all employees and consultants obtained a physician's certification of health status prior to employment and annually thereafter.	2/4/2014 and ongoing
I 271	3513.1(b) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (b) Personnel records for all staff including job descriptions either at the GHMRP or in a central office and made available upon request; This Statute is not met as evidenced by: Based on interview and record review, the GHIID failed to make available for inspection personnel records for each employee, for 1 of 9 direct support staff. (DSP #7) The finding includes: On January 14, 2014, at approximately 2:50 p.m., DSP #7 was observed entering the GHIID. He was observed working alongside DSP #6 throughout the evening shift. HM #1 indicated that DSP #7 was "shadowing" DSP #6, as part of his new-staff orientation training. DSP #7 was again observed working in the GHIID on January 15, 2014. Personnel records were reviewed in the GHIID on January 16, 2014, beginning at 11:26 a.m. There was no evidence of a file being maintained for DSP #7. At 12:41 p.m., the director of nursing	I 271	All personnel records for DSP #7 are attached.	2/4/2014 and ongoing

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL FOUNDATION	521 KENNEDY STREET, NE WASHINGTON, DC 20011

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I 271	Continued From page 3 was observed speaking by telephone with the corporate office, requesting evidence of DSP #7's job description, health certificate and other relevant documentation. No additional information was made available for review before the survey ended later that afternoon.	I 271	Continued from page 3.	
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 review of resident records, including incident reports and investigations, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that all incidents that present a risk to residents' health and safety were reported in writing to DOH/HRLA, for one of the four residents of the facility. (Resident #1) The finding includes: On January 14, 2014, at 10:30 a.m., interview with QIDP #1 and HM #1 revealed that emergency 911 was called on July 19, 2013, and Resident #1 was taken to a hospital emergency	I 379	The Governing Body will ensure that all incidents shall be reported to Department of Health (HFD) of any unusual incident or event which substantially interferes with an individual's health, well being or in any other way places the individual at risk via telephone and followed up in writing within 24 hours or the next work day.	1/23/2014 and ongoing

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I 379	Continued From page 4 room via ambulance after he sustained a prolonged seizure. Review of the corresponding incident report revealed that a telephone message had been left at DOH/HRLA on the same day as the incident. Pre-survey review of incident notifications had not, however reflected any written notifications received by DOH/HRLA from the facility within the past 10 months. On January 15, 2014, at 11:05 a.m., interview with the LPN Coordinator (LPN #2) revealed that he was the staff that called and left a message. LPN #2 immediately telephoned the GHIID's corporate office to ask if management had submitted anything in writing. Moments later, he confirmed that the facility had not submitted written notification of the incident, in accordance with this regulation.	I 379	Continued from page 4.	
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHIID staff failed to implement each resident's self-medication training programs and programs that were included in ISPs, for two of two residents in the sample. (Residents #1 and #2) The findings include: I. Facility nurses did not consistently implement Resident #1's and #2's self-medication training programs, as follows:	I 422	The DDS Service Coordinator and the QIDP and the IDT has concluded to make a correction/addendum to the ISP pending individual #1's ISP to reflect only the goals being tracked in individual #1 residence and day program on 2/7/2014. Individual #2 just had a new ISP completed on 1/29/2014. All staff have been trained on 1/30/2014 on the new IPP in accordance with active treatment and as recommended by the interdisciplinary team. The House Manager will monitor every other day and the QIDP will review monthly.	2/7/2014 1/30/2014 and ongoing

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1 422	Continued From page 5 A. On January 14, 2014, at 7:56 a.m., the medication nurse (LPN #1) punched Resident #2's medications into a cup while in the kitchen. LPN #1 carried the medication cup to the resident, who had been seated at the dining room table eating breakfast since 7:20 a.m. On January 14, 2014, at 3:00 p.m., review of Resident #2's MAR revealed that he had a self-medication training program. The program included: "With verbal prompts, <Resident #2's name> will punch his medication during the medication administration, 60% of all opportunities for six consecutive months." The tasks outlined included: - Get water; - Punch medication; Observations on the morning of January 14, 2014, at 7:56 a.m., revealed that LPN #1 did not provide Resident #2 the opportunity to get his water or assist with punching his medications out of the blister packs, in accordance with the training program. B. On January 14, 2014, at 8:04 a.m., LPN #1 punched Resident #1's medication (Keppra 1000 mg) and a multivitamin supplement from their respective blister packs into a medication cup, poured 8 ounces of spring water and carried them to the resident's bedroom. LPN #1 handed the medications to Resident #1 and he consumed them. He immediately reached for water and drank it independently. LPN #1 returned to the nurse's area in the kitchen and initialed the resident's MARs.	1 422	Continued from page 5.	

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I 422	Continued From page 6 On January 14, 2014, at 3:10 p.m., review of Resident #1's MAR revealed that he had a self-medication training program. The program included: "With verbal prompts, <Resident #1's name> will identify his medication (Keppra) for med pass at 70% of all opportunities for three consecutive months." Observations on the morning of January 14, 2014 revealed that LPN #1 did not provide Resident #1 the opportunity to identify his medication by name, in accordance with the training program. On January 16, 2014, interviews with the LPN Coordinator (LPN #2) and QIDP #1, at 10:00 a.m. and 11:07 a.m. respectively, revealed that both had observed the morning medication nurse implement the residents' self-medication training programs in the past. At the time of the survey, however, facility nurses failed to show evidence they consistently provided opportunities for the residents to develop and maintain their skills. II. The QIDP failed to ensure that training programs recommended by Resident #1's and Resident #2's IDTs were developed and implemented in accordance with their ISPs, as follows: On January 14, 2014, Resident #1 and Resident #2 were observed in the home from 7:11 a.m. - 8:45 a.m. and again from 3:45 p.m. - 7:06 p.m. Morning observations revealed neither resident was provided the opportunity to engage in their self-medication training programs (see above). Evening observations revealed Resident #1 spent most of his time listening to music and/or watching television in his bedroom. Staff	I 422	Continued from page 6.	

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I 422	Continued From page 7 periodically knocked on his bedroom door and engagaed Resident #1 in conversation. Resident #1 joined his peers for dinner at 6:38 p.m. then returned to his bedroom at 6:50 p.m. after finishing his meal. He was watching television when this surveyor left at 7:06 p.m. Also on January 14, 2014, from 3:45 p.m. - 5:30 p.m., Resident #2 was observed seated on a living room sofa, holding (but not looking in) a magazine. At 5:30 p.m., Resident #2 was offered a jigsaw puzzle, which he worked on in the dining room until staff informed him that they were about to have dinner. Staff was then observed setting the dinner table while Resident #2 and a peer watched from the living room. Review of the two residents' annual ISPs and training programs revealed the following: A. On January 15, 2014, beginning at 12:12 p.m., review of Resident #1's ISP (dated April 8, 2013) revealed several training programs that were recommended by his interdisciplinary team that were not reflected in the quarterly summary reports prepared by the QIDP. For example, there was no evidence that the facility implemented the following: - "In a group setting, after staff have read a story to him, <resident's name> will explain what he understood to his peers for five consecutive minutes on 80% of the opportunities provided for six consecutive months within a year;" - "<Resident's name> will chose two activities of daily living of his choice (brushing his teeth, dust furniture/ table, and empty trash can) to complete them with 100% independence three	I 422	Continued from page 7.	

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I 422	Continued From page 8 out of four trials for six consecutive months in one year;" - "Staff will show <resident's name> the clock and will ask him to tell them the time (the time identified is associated with routine schedule of activities in the home) monthly;" and, - "After reviewing sales paper/ catalogues, <resident's name> will make a budget of $5 on items significant to him on 100% of the opportunities provided for six consecutive months within one year." The QIDP was interviewed in the facility on January 15, 2014, beginning at 1:12 p.m., to ascertain the status of the aforementioned goals. QIDP #1 stated that the goals were "not formal goals, not targeted goals" and staff, therefore were not documenting their implementation. The resident's DDS service coordinator (SC) participated in the Exit Conference, by telephone, on January 16, 2014, beginning at 1:05 p.m. She stated that ISPs did not include "informal goals" and the expectation was that the facility would implement ISP goals unless the facility sought to amend the resident's ISP, via communications with the SC. B. Similarly, on January 15, 2014, at 2:55 p.m., review of Resident #2's ISP (dated January 30, 2013) revealed his interdisciplinary team had recommended a program where the resident would dress himself after using the bathroom (raise his pants, fasten the belt, etc.). The team also recommended an exercise program for the upper and lower body, using 4-pound cuff weights. Review of QIDP #1's third quarterly review, dated November 5, 2013, and those	I 422	Continued from page 8.	

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I 422	Continued From page 9 earlier in the ISP year did not reflect the implementation of the two goals. At 4:05 p.m., interview with QIDP #1 confirmed that neither goal had been implemented. He said this was his "first time seeing" the programs. At the time of the survey, the facility failed to show evidence that each resident's active treatment goals and objectives were implemented as recommended by the interdisciplinary team..	I 422	Continued from page 9.	

GOVERNMENT OF THE DISTRICT OF COLUMBIA

CRFMR
Rev. 9/02

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING ADMINISTRATION

Mailing Address
899 North Capitol St., NE
Washington DC 20002
2nd Floor
202-724-8800

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Facility:	Street Address, City, State, ZIP Code:	Survey Date:
Symbral Foundation For Community Services, Inc.	521 Kennedy St. NE Washington, DC	1/16/14 Follow-up Dates(s):

Regulation Citation	Statement of Deficiencies	Ref. No.	Plan of Correction	Completion Date
4701.2	**4701** **Background Check Requirement** **Each facility…shall cause each prospective employee or contract worker who will have, or foreseeably may have direct patient, resident or client access, to undergo a criminal background check that shall reveal the criminal history, if any, in the District of Columbia and the fifty (50) states. Finger printing or live scan shall be performed in the District of Columbia utilizing the Metropolitan Police department (MPD) or a private agency. The criminal background check shall be performed, following finger printing or live scan, by the MPD and Federal Bureau of Investigation (FBI) in an FBI-approved environment. The results of the criminal background checks shall be forwarded to the Department of Health.**			

Roland Tolbert — Name of Inspector

1/30/14 — Date Issued

Facility Director/Designee

Date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	Based on review of the staff schedule and personnel records and interviews with management staff, it was determined that the facility failed to obtain a finger print or live scan, for three of five employees hired since December 2012. (DSP #4, DSP #5 and DSP #7) The findings include: On January 16, 2014, beginning at 11:26 a.m., review personnel records revealed the facility had nine direct support professionals (DSP) working directly with residents. Five DSPs had been hired since the Chapter 47 regulations were amended. Of those five, there was no evidence that three DSPs had been finger printed for an FBI background check, as follows: 1. According to the application form, DSP #4 applied for employment on November 18, 2013. There was no evidence of an FBI finger print or live scan performed at the time of hire. The record showed the employee had obtained a background check through a private company on October 7, 2013. Telephone interview with an administrative representative at the corporate office on January 16, 2014, at approximately 1:02 p.m. confirmed the surveyor's findings. The record showed that DSP #4 began working with the residents on November 28, 2013.	An FBI Fingerprint /Live Scan for DSP #4 was completed on 1/7/2014, DSP #5 was completed on 1/7/2014 and DSP #7 is eligible (attached). House Manager will review personnel records prior to new staff assuming duty. File will be checked for completeness in back check. QIDP will be notified of new staff and review personnel within seven (7) business days of new staff assignment to ensure compliance with background check requirement. QA will review all new hires on a monthly basis.	1/7/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

2. DSP2 #5's personnel record reflected a November 5, 2012 application date and the date of hire was December 28, 2012. There was no evidence of an FBI finger print or live scan. The record showed the employee had obtained a background check through a private company on February 17, 2012 (10 months before she was hired). Telephone interview with an administrative assistant at the corporate office on January 16, 2014, at approximately 1:02 p.m., revealed that the agency did not think the amendments requiring an FBI finger print or live scan were in effect at the time DSP #5 was hired.

3. DSP #7 was observed working in the facility on January 14 and 15, 2014. There was no personnel record made available for review for DSP #7, therefore his FBI finger print or live scan could not be verified. The house manager stated that DSP #7 had reported for duty on the week prior to this survey. On January 16, 2014, at approximately 12:40 p.m., the director of nursing spoke by telephone with the corporate office and was told that additional documentation was being sent by fax. Review of those materials, however failed to show evidence of an FBI finger print or live scan application.

It should be noted that Chapter 47 was amended to require FBI finger printing, effective December 1, 2012.