

Health Regulation & Licensing Administration				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/16/2014
NAME OF PROVIDER OR SUPPLIER SYMBRAL FOUNDATION		STREET ADDRESS, CITY, STATE, ZIP CODE 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
1 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from January 14, 2014 through January 16, 2014. A sample of two residents was selected from a population of four men with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations, interviews and review of resident and administrative records.</p> <p>Note: The below are abbreviations that may appear throughout the body of this report.</p> <p>Department of Health, Health Regulation and Licensing Administration - DOH/HLA 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</p>	1 000		
1 206	<p>3509.6 PERSONNEL POLICIES</p> <p>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.</p>	1 206	See page 2.	

Health Regulation & Licensing Administration
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Shondra A. [Signature]

TITLE
 CEO

(X6) DATE
 2/25/2014

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

PRINTED: 01/30/2014
FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/16/2014
NAME OF PROVIDER OR SUPPLIER SYMBRAL FOUNDATION		STREET ADDRESS, CITY, STATE, ZIP CODE 521 KENNEDY STREET, NE WASHINGTON, DC 20011	

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WV 104	<p>Continued From page 1.</p> <p>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).</p> <p>The findings include:</p> <p>I. Facility staff failed to ensure client safety while transporting clients in the community, as follows:</p> <p>A. On January 14, 2014, at 8:45 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.</p>	WV 104	<p>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 QJDP will monitor weekly.</p> <p>The Governing Body has also rented a new van on 2/5/2014 for transportation pending the availability of Symbra's new purchased van.</p> <p>The new purchased van is being sent in for AOA Modification, and will be ready by 4/30/2014.</p>	<p>1/15/2014 and 1/16/2014 and ongoing</p> <p>2/5/2014</p>

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W 104	<p>Continued From page 2</p> <p>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.</p> <p>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.</p> <p>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.</p>	W 104	Continued from page 2.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G058	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(K3) DATE SURVEY COMPLETED: 01/16/2014
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W-104	<p>Continued From page 3</p> <p>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 individual's safety" and "all individuals onboard transportation must be secured by seatbelts at all times when in transit."</p> <p>Observations on the morning of January 14, 2014 revealed that transportation-related training provided for staff prior to the survey had not been effective.</p> <p>II: Facility staff failed to demonstrate competency in implementing vehicle maintenance policies and procedures, as follows:</p> <p>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.</p> <p>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</p>	W-104	<p>Continued from page 3.</p> <p>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.</p> <p>The Governing Body have developed a clear policy in regards to the maintenance checklist, and the house manager/all staff have been trained.</p>	<p>1/17/2013 and ongoing</p> <p>2/5/2014</p>

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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	All staff has been trained on 1/30/2014 on individual #1 New ISP goals on how to implement and document on the new IPP. The House Manager will monitor the goals implementation and documentation weekly and the QIDP will monitor monthly and review quarterly. The QIDP will review the ISP upon approval and correct all mistakes before implementation.	1/30/2014 and ongoing	

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W 249	<p>Continued From page 5 of two clients in the sample. (Clients #1 and #2)</p> <p>The findings include:</p> <p>I. Facility nurses did not consistently implement Client #1's and #2's self-medication training programs, as follows:</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> - Get water; - Punch medication; <p>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.</p> <p>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</p>	W 249	<p>The Director of Nursing have trained the facility nurse on 1/24/2014 on the self medication training for individual #1 and # 2.</p> <p>The Nurse Supervisor will monitor weekly and the DON will review Monthly.</p>	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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2014
NAME OF PROVIDER OR SUPPLIER SYMBRAL FOUNDATION			STREET ADDRESS, CITY, STATE, ZIP CODE 621 KENNEDY STREET, NE WASHINGTON, DC 20011		
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W 249	<p>Continued From page 8</p> <ul style="list-style-type: none"> - "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." <p>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.</p>	W 249	Continued from page 8.		

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W 249	<p>Continued From page 9</p> <p>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.</p> <p>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.</p>	W 249	Continued from page 9.	

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W 000	<p>INITIAL COMMENTS</p> <p>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.</p> <p>The findings of the survey were based on observations, interviews and review of client and administrative records.</p> <p>Note: The below are abbreviations that may appear throughout the body of this report.</p> <p>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</p>	W 000			
W 104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p>	W 104	See page 2.		

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

Thondal A. [Signature]

TITLE

CEO

(X6) DATE

2/25 2014

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 disclosed 30 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 disclosed 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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1208	Continued From page 1 This Statute is not met as evidenced by: Based on interview and record review, the GHHD 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	1208	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 Symbtral 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	<p>3513.1(b) ADMINISTRATIVE RECORDS</p> <p>Each GHMRP shall maintain for each authorized agency's inspection, at any time, the following administrative records:</p> <p>(b) Personnel records for all staff including job descriptions either at the GHMRP or in a central office and made available upon request;</p> <p>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)</p> <p>The finding includes:</p> <p>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.</p> <p>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</p>	I 271	<p>The human resources will check all staff files for certifications every two (2) weeks, the QIDP and DON will monitor monthly.</p> <p>All personnel records for DSP #7 are attached.</p>	2/4/2014 and ongoing

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/16/2014
NAME OF PROVIDER OR SUPPLIER SYMBRAL FOUNDATION		STREET ADDRESS, CITY, STATE, ZIP CODE 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
1271	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.	1271	Continued from page 3.	
1379	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 (GHID) 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	1379	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. The QIDP will follow-up in writing within twenty-four (24) hours notifying Department of Health of every incident.	1/23/2014 and ongoing

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/16/2014
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NAME OF PROVIDER OR SUPPLIER SYMBRAL FOUNDATION	STREET ADDRESS, CITY, STATE, ZIP CODE 521 KENNEDY STREET, NE WASHINGTON, DC 20911
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1379	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 GHID'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.	1379	Continued from page 4.	
1422	3521.9 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 GHID 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: 1. Facility nurses did not consistently implement Resident #1's and #2's self-medication training programs, as follows:	1422	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

Health Regulation & Licensing Administration

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NAME OF PROVIDER OR SUPPLIER SYMBAL FOUNDATION	STREET ADDRESS, CITY, STATE, ZIP CODE 521 KENNEDY STREET, NE WASHINGTON, DC, 20011
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1-422	<p>Continued From page 5</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> - Get water; - Punch medication; <p>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.</p> <p>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.</p>	1-422	Continued from page 5.	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/16/2014
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NAME OF PROVIDER OR SUPPLIER: **SYMBRAL FOUNDATION**
STREET ADDRESS, CITY, STATE, ZIP CODE: **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
1422	<p>Continued From page 6</p> <p>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."</p> <p>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.</p> <p>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.</p> <p>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:</p> <p>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</p>	1422	Continued from page 6.	

Health Regulation & Licensing Administration

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NAME OF PROVIDER OR SUPPLIER SYMBAL FOUNDATION	STREET ADDRESS, CITY, STATE, ZIP CODE 521 KENNEDY STREET, NE WASHINGTON, DC 20011
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I-422	<p>Continued From page 7</p> <p>periodically knocked on his bedroom door and engaged 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.</p> <p>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 6:30 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.</p> <p>Review of the two residents' annual ISP and training programs revealed the following:</p> <p>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:</p> <ul style="list-style-type: none"> - "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.	

Health Regulation & Licensing Administration

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1422	<p>Continued From page 8</p> <p>out of four trials for six consecutive months in one year;"</p> <ul style="list-style-type: none"> - "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." <p>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.</p> <p>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</p>	1422	Continued from page 8.	

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NAME OF PROVIDER OR SUPPLIER SYMBAL FOUNDATION	STREET ADDRESS, CITY, STATE, ZIP CODE 521 KENNEDY STREET, NE WASHINGTON, DC 20011
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1422	<p>Continued From page 9</p> <p>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.</p> <p>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.</p>	1422	Continued from page 9.	



GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH HEALTH REGULATION & LICENSING ADMINISTRATION

Mailbox Address 999 Ninth Capital S., NE Washington DC 20002 2nd Floor 202-724-6000

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Facility: Symbal Foundation For Community Services, Inc.		Street Address, City, State, ZIP Code: 521 Kennedy St. NE Washington, DC		Survey Date: 1/16/14			
Regulation Citation: 4701.2		Statement of Deficiencies: 4701 <u>Background Check Requirement</u> 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.		Ref. No.		Plan of Correction	
				Follow-up Date(s):			
				Completion Date			

Name of Inspector: [Signature] Date Issued: 1/30/14

Facility Director/Designee: _____ Date: _____



GOVERNMENT OF
THE DISTRICT OF
COLUMBIA

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING
ADMINISTRATION

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 of five 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 2/7/2014 and DSP #7 is eligible (attached).

1/12/2014
2/7/2014 *

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.

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING
ADMINISTRATION

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 hired 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 2/7/2014, DSP #5 was completed on 2/7/2014 and DSP #7 is eligible (attached).

2/7/2014

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.



GOVERNMENT OF
THE DISTRICT OF
COLUMBIA

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING
ADMINISTRATION

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.

INSERVICE TRAINING

DATE: January 14th, 2014

INSTRUCTOR: Ademola Davis (QIDP)

TOPIC OF TRAINING: TRANSPORTATION SAFETY - SEAT BELT AND TIE DOWN USAGE

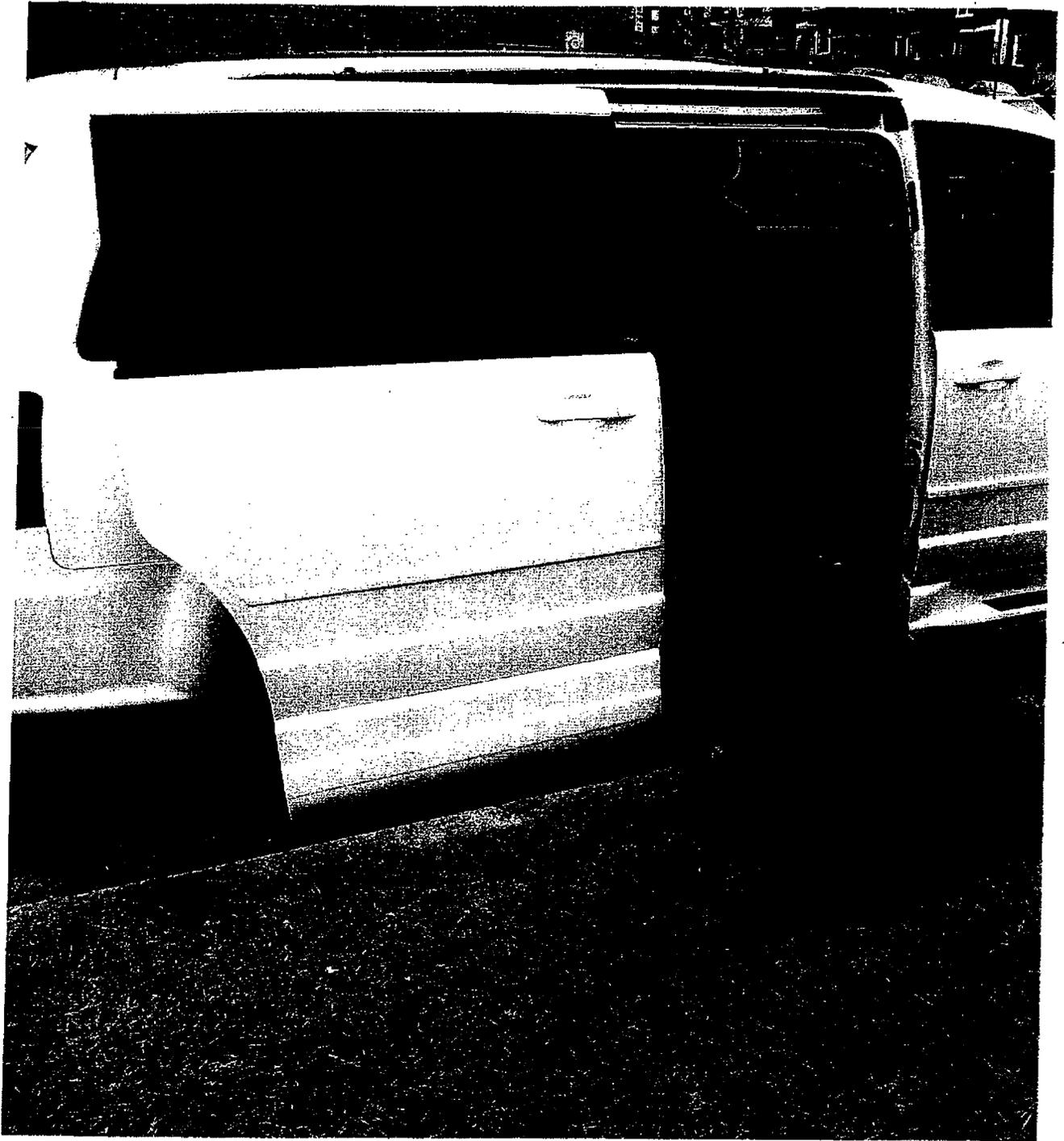
SUMMARY OF TRAINING: REVIEW TRANSPORTATION POLICY, EMPHASIS ON:
 THE DRIVER AND PASSENGER OF THE VAN MUST BE SECURELY SEATED AND THE DRIVER WILL RE-CHECK TO
 OPERATION. THE DRIVER AND OR DRIVER WILL RE-CHECK TO
 SEAT BELT. IF A SEAT BELT CAN NOT SECURE THE INDIVIDUAL
 SHOULD ANOTHER SEAT BELT BE NOT AVAILABLE, THE INDIVIDUAL
 TRANSFERRED TO ANOTHER VEHICLE. OPERATING A VEHICLE WITHOUT A SEAT BELT IS
 NEGLECT (EVEN THOUGH NOT ONE IS INJURED).

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Kennedy Folder*

VEHICLE IS IN
ARE USING A
ER SEAT BE.
T AND IS TO BE
SEAT BELT IS

DEFECTIVE SEAT BELT AND OTHER EQUIPMENT DEFECT MUST BE REPORTED TO THE HOUSE MANAGER,
 QIDP AND DIRECTOR OF OPERATIONS (MR. MOHAMMED) BEFORE THE VEHICLE IS MOVED. IF AN
 INDIVIDUAL IS USING A WHEEL CHAIR WHILE BEING TRANSPORTED, THE CHAIR MUST BE EQUIPPED WITH
 A SEAT BELT AND SECURE WITH TIE-DOWN. INDIVIDUAL/S WHO USE A WHEEL CHAIR, AND IS ABLE TO
 TRANSFER TO A REGULAR SEAT IN THE VAN MUST BE SECURED BY A SEAT BELT.

PRINT NAME	SIGNATURE
Gemma Mohammed	<i>Gemma</i>
Sulaiman Jalloh	<i>Sulaiman</i>
Abraham Shobalov	<i>Abraham</i>
Alpha Meeha	<i>Alpha</i>
PESTUS NUSARI	<i>Pestus</i>
Delmar Miller	<i>Delmar</i>
ZENEBECH GEMEDA	<i>Zenebech</i> 1/15/14
Desmond Sterling	<i>Desmond</i> 1/16/14
Haddijaton Hydera	<i>Haddijaton</i> 1/16/14
Rosemary Okolie	<i>Rosemary</i> 1/16/14



SYMBRAL FOUNDATION FOR COMMUNITY SERVICES, INC.

TAX ID. 52-1348838

P.O. Box 60672
WASHINGTON, D.C. 20039

TELEPHONE #: (301) 650-5722

914 SILVER SPRING AVENUE,
SUITE 103
SILVER SPRING, MARYLAND 20910
FAX NUMBER: (301) 650-5729

February 10, 2014

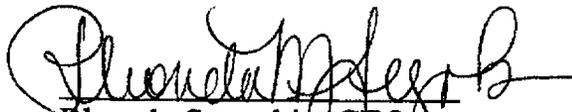
Ms. Kimberly James
Department on Disability Services
1125 15th Street, N.W.
Washington, D.C. 20005

Dear Ms. James:

Please find enclosed, the Plan of Corrections for the survey completed on 1/16/2014 for Harmony Group Home, located at 521 Kennedy Street, NE, Washington, DC 20011.

Should you need further information please contact Ademola Davis (QIDP) on (301) 674-7702.

Sincerely,


Rhonda Seegobin, CEO

SYMBRAL FOUNDATION FOR COMMUNITY SERVICES, INC.

TAX ID. 52-1348838

P.O. Box 60672
WASHINGTON, D.C. 20039

TELEPHONE #: (301) 650-5722

914 SILVER SPRING AVENUE,
SUITE 103
SILVER SPRING, MARYLAND 20910
FAX NUMBER: (301) 650-5729

February 10, 2014

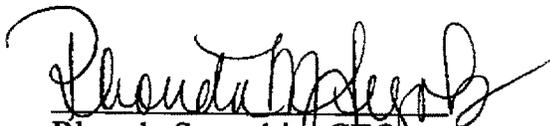
Mr. Ervin Henderson, Resource Specialist
Department on Disability Services
1125 15th Street, N.W.
Washington, D.C. 20005

Dear Mr. Henderson:

Please find enclosed, the Plan of Corrections for the survey completed on 1/16/2014 for Harmony Group Home, located at 521 Kennedy Street, NE, Washington, DC 20011.

Should you need further information please contact Ademola Davis (QIDP) on (301) 674-7702.

Sincerely,


Rhonda Seegobin, CEO

SYMBRAL FOUNDATION FOR COMMUNITY SERVICES, INC.

TAX ID. 52-1348838

P.O. Box 60672
WASHINGTON, D.C. 20039

TELEPHONE #: (301) 650-5722

914 SILVER SPRING AVENUE,
SUITE 103
SILVER SPRING, MARYLAND 20910
FAX NUMBER: (301) 650-5729

February 10, 2014

Ms. Audrey Lester
Department on Disability Services
1125 15th Street, N.W.
Washington, D.C. 20005

Dear Ms. Lester:

Please find enclosed, the Plan of Corrections for the survey completed on 1/16/2014 for Harmony Group Home, located at 521 Kennedy Street, NE, Washington, DC 20011.

Should you need further information please contact Ademola Davis (QIDP) on (301) 674-7702.

Sincerely,


Rhonda Seegobin, CEO

SYMBRAL FOUNDATION FOR COMMUNITY SERVICES, INC.

TAX ID. 52-1348838

P.O. Box 60672
WASHINGTON, D.C. 20039

TELEPHONE #: (301) 650-5722

914 SILVER SPRING AVENUE,
SUITE 103
SILVER SPRING, MARYLAND 20910
FAX NUMBER: (301) 650-5729

February 10, 2014

Mr. Roland Follot
Department of Health
825 North Capitol Street, N.E.
Washington, D.C. 20002

Dear Mr. Follot:

Please find enclosed, the Plan of Corrections for the survey completed on 1/16/2014 for Harmony Group Home, located at 521 Kennedy Street, NE, Washington, DC 20011.

Should you need further information please contact Ademola Davis (QIDP) on (301) 674-7702.

Sincerely,


Rhonda Seegobin, CEO

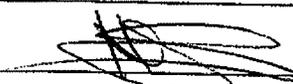
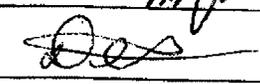
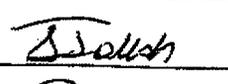
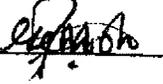
SYMBRAL FOUNDATION FOR COMMUNITY SERVICES, INC.

P.O. Box 60672
WASHINGTON, D.C. 20039

914 SILVER SPRING AVENUE,
SUITE 103
SILVER SPRING, MARYLAND 20910
TELEPHONE #: (301) 650-5722
FAX NUMBER: (301) 650-5729

INSERVICE TRAINING

TOPIC: Vehicle Maintenance checklist/ Van log book.	
INSTRUCTOR: Ademola Davis/olphed	DATE: 01/17/14
SUMMARY OF TRAINING: All staff must complete a Vehicle Maintenance checklist form prior to each use of the Facility van. And also must complete a van log form before and after every use of the facility van.	

Printed Name of Participants	Signature of Participants
Haddijabou Hyden	
Zenebech Gameda	
Brookem Shogalou	
Bradley Erowele	
Desmond Stealy	
FESTUS MOHAMMED	
Delmar Miller	
Sumner Taiob	
HEMMA MOHAMMED	

Sample

914 SILVER SPRING AVENUE, SUITE 103
SILVER SPRING, MARYLAND 20910
TELEPHONE: (301) 650-5722

VEHICLE SAFETY AND MAINTENANCE REPORT

House #: Harmony Odometer Reading: 116894 License Plate #: BD717E

INSTRUCTIONS: Inspect all times and answer all questions. Check all satisfactory inspection items. All unsatisfactory items should be marked and give description of unsatisfactory condition in the space.

INSPECT		UNSATISFACTORY ITEMS		INSPECT
Head Lights	✓		✓	Bumpers/ Slash Pans
High Beam	✓		✓	Grill Work
Rear Lights	✓		✓	Hood
Stop Lights	✓	Scratches on both sides	←	Fenders
Back-up Lights	✓	Cracks on the roof	←	Roof
Side Lights	✓		✓	Trunk Lid
Emergency Flashers	✓		✓	Quarter Panels
Turn Signal Lights	✓	Scratches on paintwork	←	Paint Finish
Windshield/ Window Glass	✓		✓	Hub Caps
Windshield Wipers/ Wash	✓		✓	Bright Work Trim
Defroster/ Heater	✓	need one seat belt of broken	←	Seat Belt/ Sld. Harness
Rear Window Defogger	✓		✓	Upholstery
Brakes	✓		✓	Ceiling Carpeting
Parking Brake	✓		✓	Trunk Interior
Motor	✓		✓	Muffler
Motor Oil Level	✓		✓	Air Conditioning
Transmission	✓	Has cracks	←	Door and Trunk Locks
Transmission Fluid Level	✓		✓	Front Tires
Radiator Level	✓		✓	Rear Tires
Power Steering Fluid Lvl.	✓		✓	Spare and Snow Tires
Steering	✓		✓	Emergency Flares
Speedometer/ Odometer	✓		✓	Jack and Lug Wrench

Inspector's Opinion of Safety & Care: ___ Average ___ Above Average ✓ ___ Below Average

Inspector's Signature: [Signature] Title: HL manager

Date of Inspection: 11/7/14

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TELEPHONE: (301) 650-5722
FAX NUMBER: (301) 650 -5729

Reviewed : 10/17/2013

TRANSPORTATION POLICY

1. The driver and all passengers must use a seat belt at all time. If the seat belt is not working, the individual/s must be transferred to another van.
2. Each Vehicle must have its basic operational and safety systems (brake, fluids, steering, heating, cooling, lifts, seatbelts, wheelchair tie-downs etc) checked on a weekly basis.
3. All individuals onboard transportation must be secured by seatbelts at all times when in transit, should an individual remove the seat belt, the drive must pull over and the seat- belt must be re-secured by the escort.
4. All wheelchairs must be properly tied down as per wheelchair instructions to ensure individuals safety.
5. Any suspected mechanical malfunction (brakes, fluid leaks, engine noise, steering problems, heating and cooling systems) must be reported to the Director of Operations immediately. The vehicle will be removed from service until the repair is completed.
6. Each driver must complete a pre-check and complete a checklist before every use, and complete a defect malfunction report to maintenance and the Director of Operations immediately.
7. Each van will have a driver and an escort when transporting more than (2) individuals to the day program / event appointment etc.
8. Only management personnel at the position of a Manager and above will authorize any change of (item #5). Taking into consideration the consumer/s functional level, community survival skills and the kind of supervision required to provide for the safe transportation of the individual.
9. Each vehicle will have the oil changed bi-monthly or every 3000 miles.
10. The escort will sit with the individuals and not in the front passenger seat when individuals are being transported.
11. Alternative transportation (lease, metro-access, taxi) will be utilized should a vehicle be removed from service for a mechanical / safety concern.
12. Day Program and the individual/s will be informed of any delay in departure or arrival times.
13. After each use of the van; before the van is locked, staff must check to see that no one is left in it.

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TRANSPORTATION POLICY

Wheelchair Ramp Requirement

- All transport vans must have a retractable access ramp able that lifts and lowers smoothly. This ramp will be equipped with a guardrail system to prevent a wheelchair from rolling off while the ramp is in motion. While in motion the ramp will be attended by an assistant to monitor the wheelchair. The wheelchair has to be locked (brakes on) while the ramp is in motion. The ramp also will have a manual retraction or extension system in addition to an automatic system, in case the van suffers a power failure. For ramps longer than 30 inches, the load capacity will be 600 pounds; under 30 inches, the capacity will be 300 pounds.

Wheelchair Tie Downs

- After the wheelchair is in place on the van, the chair must have the brakes on and be firmly secured to prevent rolling. This is accomplished by four tie downs near each wheel. The tie downs will be anchored firmly to the floor of the van and wrapped around the frame of the wheelchair near each wheel. The belts must secure firmly but be able to be quickly disconnected. This is accomplished by having a seat belt-like latch on the tie downs.

Seat Belts

- **All persons on the van (driver included) will wear a seat belt or a shoulder belt while the van is in motion. If a person cannot fasten the seat belt by herself (due to the disability), then the driver or the attendant must fasten and undo the belt. This belt must meet all safety requirements of the Federal Motor Vehicle Safety Standards (FMVSS) Section 49 CFR part 571.**

Lighting

- The van will be well lit when loading and unloading passengers at night. The lighting requirements are that all areas must have at least 2 foot-candles of illumination at all points during the loading/unloading process. This includes all steps, ramps, and stairwells. The 2-foot candles of illumination must be at the floor level.

The vehicle shall be used for transporting individual's on official business i.e. day program, community and social activities, and appointments, family visits etc. and any other business in the individual/s interest as directed by the administration.

Note: This policy will be reviewed at least annually and will be revised as necessary.

UPDATED: 2/5/2014

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GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department on Disability Services
Developmental Disability Administration

Friday, February 07, 2014

Attn: Mr. Ademola Davis
 Symbra Foundation for Community Services, Inc.
 521 Kennedy St. NE
 Washington, DC 20011

RE: BRIAN DEWITT ISP AMENDMENT

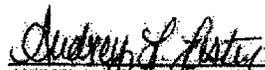
To Whom It May Concern:

The residents of 521 Kennedy St. NE, Washington, DC 20011 underwent an annual Department of Health Review during January 2014. Brian Dewitt's case was surveyed. On January 16, 2014, SC (Audrey Lester) teleconferenced with team members for survey closing. DOH Surveyor noted Brian Dewitt's ISP contained "informal goals" which were not being tracked in his residence. SC, Audrey Lester, suggested "informal goals" be removed from Mr. Dewitt's ISP and residential team members agreed.

On Friday, February 07, 2014, SC amended Mr. Dewitt's ISP to reflect only goals being tracked in his residence and day program. Mr. Davis has received Brian's amended ISP via e-mail from SC. Team members are also scheduling Mr. Dewitt's Pre-ISP Meeting in preparation for his upcoming ISP in April 2014.

If you have additional questions or concerns, please feel welcome to contact me by e-mail at Audrey.Lester@dc.gov or phone at 202.618.0541.

Thank you,


 Audrey L. Lester, CSW
 Service Coordinator



1125 16th Street N.W. Washington, D.C. 20005
 202.730-1700 www.dds.dc.gov

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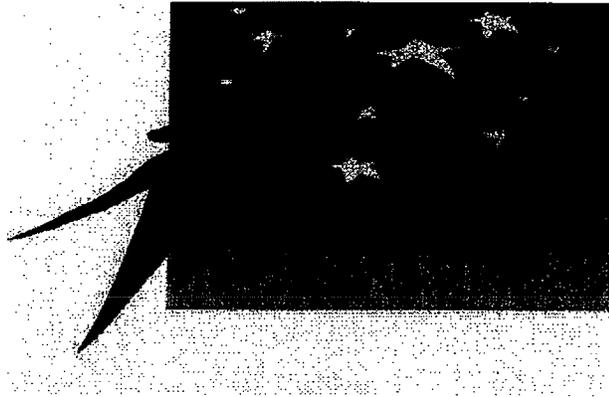
Calendar

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Yahoo!

INDIVIDUAL SUPPORT PLAN

District of Columbia Department on Disability Services



Individual:	BRIAN DEWITT
Service Coordinator:	Audrey Laeter
Date of ISP Meeting:	2013-04-08
Effective Date:	2013-05-08 To 2014-06-07
Evans Class Member:	No
Court Number:	1802-MRE-38
Type of ISP:	AMENDMENT
Date Created:	2014-02-07



Phone must be in
condition.
up to 2 weeks
take-in.

Individual: BRIAN DEWITT

Page 1 of 31

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P.O. Box 60672
WASHINGTON, D.C. 20039

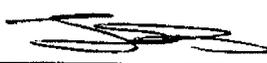
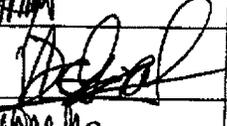
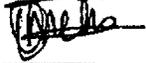
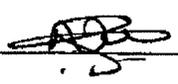
TELEPHONE #: (301) 650-5722

914 SILVER SPRING AVENUE,
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SILVER SPRING, MARYLAND 20910
FAX NUMBER: (301) 650-5729

MEETING SIGN IN SHEET

INDIVIDUAL'S NAME: Gregory Andrews
DATE: 01/29/14

- Types of Meeting**
- Intake Meeting
 - 30 Day Review
 - Annual ISP
 - Case Conference
 - Human Rights Meeting
 - Exit Meeting
 - Other

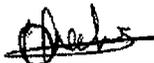
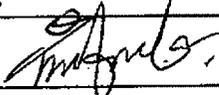
Participants (Print Name)	Participants Signature	Agency / Title	Telephone Number
Joseph Josc		Adkins	301 907 4100
James Williams, PhD	James Williams	RPT	2/291-0912
Elaine Morris	E Morris	API	202-291-0912
BERNARD ANDREWS	Bernard Andrews	FATHER/GUARDIAN	3/346-6856
Audrey hester	Audrey Lester	DDS	615-0541
Shirley Williams	(via Telephone)	Social Worker	(703) 581-7863
Ayala Getzler		Symbal / Nurse	3/343 4804
Victoria Debad		RALPHONIA Symbal	3/455-9116
Oliver Meeks		Symbal / Manager	301 257 0834
Immaculate Nwofor		Phd. II. Day Program Case Manager	2/291-3672

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TELEPHONE #: (301) 650-5722
FAX NUMBER: (301) 650-5729

INSERVICE TRAINING

TOPIC: ISP/IPP for Gregory Andrews	
INSTRUCTOR: Ademola Davis	DATE: 1/30/14
SUMMARY OF TRAINING: All staff will actively implement and document Mr. Andrews goals (IPP) as stated in his ISP. (see Attached)	
(Self Medication, Ambulation Endurance, Personal Hygiene Skills, ADL Skills, Recreation/Social Community activities and Gross Motor Exercise).	
Printed Name of Participants	Signature of Participants
Ibrahim Shobayo	
Opher Mecha	
LEMMA MOHAMMED	
Sulaiman Sallah	
FESTUS ALWAZIRI	
Dalmar Miller	
Zenebech Gemeeda	
Haddijatou Hyolara	

SYMBRAL INDIVIDUAL SUPPORT PLAN

NAME: Gregory Andrews

ISP DATE: 01/30/14

DOMAIN: Self Medication.

ACTION PLAN

GOAL 1	SUPPORT STRATEGY	FREQUENCY/ EVALUATION	TARGET DATE.
<p>With Verbal Prompts, Mr. Andrews will get his own water for his own Medication during the Medication Administration, 80% of all opportunities for 6 consecutive months.</p>	<p>During the PM Medication Pass, The Staff will verbally notify Mr. Andrews that it is time to get his Medication. .</p> <p>During the Medication Process, Staff will observe Mr. Andrews when getting his Water, punching of the Medication and document after completion.</p> <p>In other for Mr. Andrews to successfully accomplish this goal, Staff will give verbal prompts to assistance Mr. Andrews.</p> <p>Staff will always praise Mr. Andrews after every completion and encourages him as needed.</p>	<p>Symbra Staff will document Mr. Andrew's participation Five times a week (7 times a week). (PM)</p>	<p>01/30/15</p>

MONITORING OF PLAN: QMRP will monitor the progress of this goal on a quarterly basis using the following schedule: 04/30/14, 07/30/14, 10/30/14 and 01/30/15.

**PROJECT
IMPLEMENTATION DATE:** 02/30/14

**PROJECT
COMPLETION DATE:** 01/30/15

SYMBRAL INDIVIDUAL SUPPORT PLAN

NAME: Gregory Andrews

ISP DATE: 01/30/14

DOMAIN: Ambulation Endurance.

ACTION PLAN

GOAL 2	SUPPORT STRATEGY	FREQUENCY/ EVALUATION	TARGET DATE.
<p>With Verbal Prompt, Mr. Andrews will participate in Ambulating in the Community for 20 minutes 3 days per week for 6 consecutive months.</p>	<p>With Staff encouragement and support, Mr. Andrews will engage in a Simple Physical Ambulation Exercise in the Community to improve ambulation endurance.</p> <p>During the Ambulation Exercise, Staff will encourage and assist Mr. Andrews as much at all time.</p> <p>In other for Mr. Andrews to successfully benefit from this goal, Staff will give verbal praises during Ambulation and after the completion.</p>	<p>Symbral Staff will document Mr. Andrew's participation Three times a week (3 times a week). <u>(Monday, Wednesday and Friday).</u></p>	<p>01/30/15</p>

MONITORING OF PLAN: QMRP will monitor the progress of this goal on a quarterly basis using the following schedule: 04/30/14, 07/30/14, 10/30/14 and 01/30/15.

**PROJECT
IMPLEMENTATION DATE:** 02/30/14

**PROJECT
COMPLETION DATE:** 01/30/15

SYMBRAL INDIVIDUAL SUPPORT PLAN

NAME: Gregory Andrews

ISP DATE: 01/30/14

DOMAIN: Personal Hygiene Skills.

ACTION PLAN

GOAL 3	SUPPORT STRATEGY	FREQUENCY/ EVALUATION	TARGET DATE.
<p>With Verbal Prompt, Mr. Andrews will brush his tooth to improve his Dental Hygiene 80% of all opportunities for 6 consecutive months.</p>	<p>Staff will make sure that all tools are available during the cause of this goal (Tooth Brush, Tooth paste and Water).</p> <p>Staff will assist/support Mr. Andrews during the Tooth Brushing.</p> <p>In other for Mr. Andrews to be successful, Staff will give verbal praises during the cause and at the completion of this goal.</p>	<p>Symbtral Staff will document Mr. Andrew's participation seven days a week (7 times a week).</p>	<p>01/30/15</p>

MONITORING OF PLAN: QMRP will monitor the progress of this goal on a quarterly basis using the following schedule: 04/30/14, 07/30/14, 10/30/14 and 01/30/15.

**PROJECT
IMPLEMENTATION DATE:** 02/30/14

**PROJECT
COMPLETION DATE:** 01/30/15

SYMBRAL INDIVIDUAL SUPPORT PLAN

NAME: Gregory Andrews

ISP DATE: 01/30/14

DOMAIN: ADL Skills.

ACTION PLAN

GOAL 4	SUPPORT SRATEGY	FREQUENCY/ EVALUATION	TARGET DATE.
<p>With Staff assistance, Mr. Andrews will take his plates to the dish washer in the kitchen after each meal 80% of all opportunities for 6 consecutive months</p>	<p>Staff will verbally tell Mr. Andrews to take his plates to the Kitchen after completing his Meal. ("Mr. Andrews, can you please take your plates to the Dish Washer for cleaning please").</p> <p>Staff will encourage Mr. Andrews to take his plates to the kitchen <u>right after his Meal</u>. (This will also discourage his Ghost eating).</p> <p>In other for Mr. Andrews to be successful in this goal, Staff will give verbal praises for every compliance.</p>	<p>Symbral Staff will document Mr. Andrew's participation five times a week (5 times a week, Mon-Fri. Dinner Time).</p>	<p>01/30/15</p>

MONITORING OF PLAN: QMRP will monitor the progress of this goal on a quarterly basis using the following schedule: 04/30/14, 07/30/14, 10/30/14 and 01/30/15.

**PROJECT
IMPLEMENTATION DATE:** 02/30/14

**PROJECT
COMPLETION DATE:** 01/30/15

SYMBRAL INDIVIDUAL SUPPORT PLAN

NAME: Gregory Andrews

ISP DATE: 01/30/14

DOMAIN: Recreation/Social Community Activities.

ACTION PLAN

GOAL 5	SUPPORT STRATEGY	FREQUENCY/ EVALUATION	TARGET DATE.
<p>Mr. Andrews will participate in a Social Community Activities of his choice twice a week, 80% of all opportunities for 12 consecutive months.</p>	<p>Every month a schedule of Social Community Activities/Recreational Activities will be developed.</p> <p>Staff will verbally prompt Mr. Andrews that it is time to choose a Social community activity of his choice, presenting to him a couple of choices and possibly provide him with a Catalog, Weekender etc to choose from</p> <p>In other for Mr. Andrews to successfully accomplish this goal, he will be given a lot of choices to choose from weekly by Symbal Staff.</p>	<p>Symbal Staff will document Mr. Andrews's participation twice a week (2 times a week).</p>	<p>01/29/14</p>

MONITORING OF PLAN: QMRP will monitor the progress of this goal on a quarterly basis using the following schedule: 04/30/13, 07/30/13, 10/30/13 and 01/30/14.

**PROJECT
IMPLEMENTATION DATE:** 02/30/14

**PROJECT
COMPLETION DATE:** 01/30/15

SYMBRAL INDIVIDUAL SUPPORT PLAN

NAME: Gregory Andrews

ISP DATE: 01/30/13

DOMAIN: Gross Motor Exercise.

ACTION PLAN

GOAL	SUPPORT STRATEGY	FREQUENCY/ EVALUATION	TARGET DATE.
<p>Mr. Andrews will complete upper body and lower body conditioning exercise with the use of 4Lbs Cuff weights 5/5 trials 4 times a week for 6 months</p>	<p>Staff will make sure that the 4Lbs Cuff Weights is available, and when time for the exercise, staff is will tell Mr. Andrews that it is time to exercise with the Cuff.</p> <p>Staff will assist, support and encourage Mr. Andrews during the exercise.</p> <p>In other for Mr. Andrews to be successful in this goal, Staff will give verbal praises during the cause and completion of this goal.</p>	<p>Symbtral Staff will document Mr. Andrew's participation five times a week (5 times a week). <u>(Monday, Tues, Weds, Fri and Sunday.</u></p>	<p>01/29/14</p>

MONITORING OF PLAN: QMRP will monitor the progress of this goal on a quarterly basis using him following schedule: 04/30/13, 07/30/13, 10/30/13 and 01/30/14.

**PROJECT
IMPLEMENTATION DATE:** 02/30/13

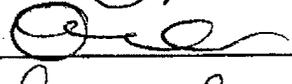
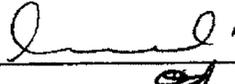
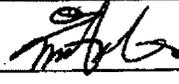
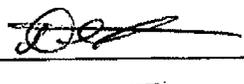
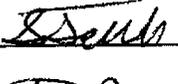
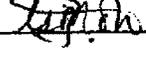
**PROJECT
COMPLETION DATE:** 01/29/14

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SILVER SPRING, MARYLAND 20910
TELEPHONE #: (301) 650-5722
FAX NUMBER: (301) 650-5729

INSERVICE TRAINING

TOPIC: Active Treatment	
INSTRUCTOR: Ademola Davis	DATE: 1/30/14
SUMMARY OF TRAINING:	
All staff will follow the Individual Program Plan 24 hrs as written in the IPP. The on-going training/programming will include but not limited to Communication, Interaction, Socialization, Socialization, coaching and teaching. (etc).	
Printed Name of Participants	Signature of Participants
Haddysou Hydan	
Zenebech Gameda	
Beahem Shobab	
Bradley Erwele	
RESTUS NWATTARI	
Delmar Miller	
Selaimon Jalleh	
HEMMA MOHAMMED	

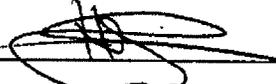
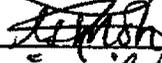
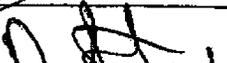
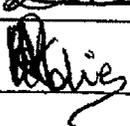
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SILVER SPRING, MARYLAND 20910
TELEPHONE #: (301) 650-5722
FAX NUMBER: (301) 650-5729

INSERVICE TRAINING

TOPIC: Incident Reporting.	
INSTRUCTOR: Ademola Davis	DATE: 1/22/14
SUMMARY OF TRAINING: All incidents shall be reported to Department of Health of any unusual incidents via telephone and followed up in writing within 24 hours or the next day.	

Printed Name of Participants	Signature of Participants
Haddiyatu Hydera	
Lemma Mohammed	
Zenebech Gameda	
PBSTUS Alwathari	
Wahabun Shokabys	
Desmond Atuly	
Delmar Miller	
Rosemary Okolie	

**GOVERNMENT OR THE DISTRICT OF COLUMBIA
INCIDENT REPORT FORM**

DDS Report Number: _____

DATE OF INCIDENT REPORT: _____

PRIMARY Individual IDENTIFYING INFORMATION

Name of Person (s) Involved in Incident (Individual): 1. _____ 2. _____

Date of Birth: _____

Individual's Residential Address: _____

Evans Class Member Yes No

Waiver: Yes No

Provider Name: Symbral Foundation

Phone: (301) 650-5722

LOCATION OF INCIDENT:

Address of Incident (if different from above) _____

OTHER Individual/s INVOLVED:

Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____

STAFF INVOLVED:

Name: _____ Title: _____
Name: _____ Title: _____

Name and Title of Person Reporting the Incident: _____

Title: _____
Phone: _____
Fax: _____

Section 1 Incident Categorization (Circle all that apply)

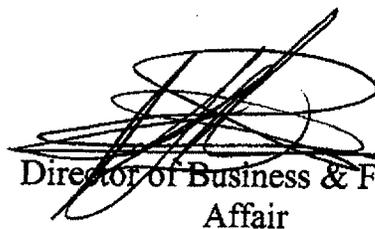
SERIOUS REPORTABLE	Alleged abuse / neglect Categories	REPORTABLE	PRIMARY LOCATION
<ul style="list-style-type: none"> 1. Death 2. Allegation of Abuse 3. Neglect 4. Exploitation 5. Serious physical injury 6. Serious Medication error 7. Inappropriate use of approved restraints that results in injury 8. Unplanned or emergency inpatient Hospitalization 9. Suicide Attempt 10. Missing Person 11. Repeated emergency use of restricted controls 12. Use of unapproved restraints 13. Other 	<ul style="list-style-type: none"> a. Physical b. Sexual c. Verbal d. Psychological e. Self Abuse f. Mistreatment <p>For abuse and neglect allegations, staff must be removed from all customer contact immediately. Please indicate below that this action has been taken.</p> <p>Name of Supervisor certifying that action has been taken (print): _____ Title: _____ Signature: _____</p>	<p>(Report written and maintained in-house for internal investigation and trending/ tracking report)</p> <ul style="list-style-type: none"> 1. Property Destruction 2. Medication Error 3. Emergency use of restrictive controls 4. Suicide Threat 5. Fire 6. Vehicle Accident 7. Incidents involving the Police 8. Emergency Relocation 9. a. Emergency Room Visit b. Urgent Care Visit 10. Physical Injury 11. Inappropriate use of approved restraint (no injury) 12. Other 	<ul style="list-style-type: none"> 1. Residential Facility <ul style="list-style-type: none"> a. ICF/DD b. Supervised Apartment c. Residential Habilitation d. Respite 2. Day Treatment Program 3. Supportive Employment 4. Community Outing 5. Transportation Vehicle 6. Natural Home 7. Hospital 8. Nursing Home 9. Other

SYMBRAL FOUNDATION FOR COMMUNITY SERVICES, INC.

**914 SILVER SPRING AVENUE, SUITE 103
SILVER SPRING, MARYLAND 20910
TELEPHONE: (301) 650-5722**

Sulaiman Jalloh _____ Symbral Foundation for Community Services
agrees to contract your services, for ICF/MR/WAIVER/MR/SUPERVISED
APARTMENT under the conditions and the purpose(s) stated below:

1. Position Title: Direct Support Professional
2. Effective period of employment, from 01/09/2014 to 01/08/2015
3. Salary for the period of employment: (\$8.00 first 40hrs.) \$12.50 per hr.
4. Probationary period procedures: 90 days from the date hired
5. Payment schedule: 15th and the ending of each month
6. The applicant agrees to adhere to all established policies and procedures of Symbral Foundation (applicable job description and available benefits are attached to this contract.)
7. This contract will automatically be renewed unless employer or employee decide to end same.
8. The Applicant/Employee must attend all in-services in order to continue employment.



Director of Business & Fiscal
Affair

Executive Director

I, ~~the~~ undersigned, have accepted the position at Symbral Foundation under the conditions and for the purpose(s) stated.

Signature: Sulaiman Jalloh _____

Date: 1-9-2014 _____

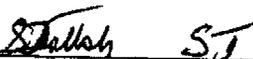
SYMBRAL FOUNDATION FOR COMMUNITY SERVICES, INC.

P.O. Box 60672
WASHINGTON, D.C. 20039

914 SILVER SPRING AVENUE,
SUITE 103
SILVER SPRING, MARYLAND 20910
TELEPHONE #: (301) 650-5722
FAX NUMBER: (301) 650-5729

ORIENTATION CHECKLIST

1. Welcome
2. Goal, Philosophy and Missions
3. Incident Management and Reporting
4. Household Operations
 - (a) Discussion of Job Description
 - (b) Job Duties and Expectations of all staff
 - (c) Data Collection - logs, reports, etc.
5. ICF vs Waiver
6. Household Maintenance
7. Discussion of Individuals - Review ISP's
8. Programming
 - (a) How to train the MR person
 - (b) Documentation procedures
9. Emergency Plans and Procedures
 - (a) Fire and Disaster Evacuations
 - (b) Medical Emergencies
 - (c) AWOL
 - (d) Individual Aggressive Behavior
 - (e) Death of a Group Home Resident
 - (f) Other unusual occurrences involving Group Home Individual
10. Work Schedules
 - (a) Requesting and Reporting leave
 - (b) Absenteeism
11. Grievance Procedures
 - (a) Initial Review
 - (b) Internal Appeal
 - (c) External Appeal
12. Confidentiality of Information
 - (a) Access Rights
 - (b) Record of Access
 - (c) Record Keeping
 - (d) Destruction of Information
13. Resident Rights
14. Personnel Benefits
 - (a) Status
 - (b) Leave
 - (c) Medical
 - (d) Travel Insurance
 - (e) Pay



Signature of Staff Person

1-10-14

Date

SYMBRAL FOUNDATION FOR COMMUNITY SERVICES, INC.

P.O. Box 60672
WASHINGTON, D.C. 20039
Email: symbрал@aol.com

914 SILVER SPRING AVENUE,
SUITE 103 SILVER SPRING,
MARYLAND 20910
TELEPHONE: (301) 650-5722
FAX NUMBER: (301) 650-5729

JOB DESCRIPTION

POSITION: Direct Support Professional

SUPERVISOR: House Manager/Residential Director

QUALIFICATIONS: Incumbent must be at least eighteen (18) years of age, have a High School Diploma and one (1) years experience with mentally retarded citizens.

Suitable Applicants may be trained.

Additional Education in a closely related field may be substituted for experience.

SPECIFIC RESPONSIBILITIES:

1. Assist residents in the refinement of independent living skills.
 - (a) Such skills are:
 1. Appropriate behavior, dress, hygiene and grooming
 2. Meal preparation, shopping and nutrition
 3. Effective communication
 4. Money management
 5. Appropriated sexual behavior
 6. Traveling independently
 7. Housekeeping
 8. Clothing purchases and maintenance
 9. Socialization
 10. Use of phone, clock, calendar, etc.
 11. Personal responsibility
 12. Basic reading, writing and math
 13. Recreation
 14. Motivation for personal development.
 - (b) Assists new residents in adjusting to the residence as easily as possible.
2. Manage day to day operation of the Residence:
 - (a) Does so according to the principles of normalization.
 - (b) Reads as follows all relevant program standards and policies and in particular, those of SYMBRAL and the licensing agencies.

- (c) Assists the residents in purchasing household items as necessary, within their budget limits, and only with the approval of the Director of Residential Services.
 - (d) Ensures, that grounds and interior of house are appropriately maintained and utilized.
 - (e) Ensures, that the residence and yard are properly maintained.
3. Ensures, that residents use appropriate community resources (e.g. educational, pools, parks, etc.).
4. Prepare and maintain records, written reports, correspondence and files regarding:
- (a) Residents evaluations.
 - (b) Resident Individual Habilitation and Program Plans.
 - (c) Fire Safety checklist.
 - (d) Conducts monthly fire drill and complete log report, to the Director of Residential Services.
 - (e) Visitors log.
 - (f) Reports on residents, meetings attended, staff issues, evaluations, etc., as requested.
 - (g) Safeguards the confidentiality of all residents records and information.
5. Participates in meetings and training sessions as needed.
6. Strives for the health, safety, and welfare of the residents:
- (a) follows proper procedures and take appropriate precautions for the security and safety of the residence, occupants and furnishings.
 - (b) ensures, that all residents are trained in fire safety and evacuation.
7. Assists with Public Relations and Community Education by sharing program information with family, officials, etc., as requested by the Director of Residential Services.
8. And all other duties as required.

S. Jalloh
Employee Signature

1-9-2014
Date

SYMBRAL FOUNDATION FOR COMMUNITY SERVICES, INC.
914 SILVER SPRING AVE., SUITE 103, SILVER SPRING, MD 20910

TELEPHONE: (301) 650-5722

EMPLOYEE WORK AGREEMENT

PLEASE READ THE AGREEMENT BELOW AND SIGN YOUR NAME IN THE APPROPRIATE SPACE. IF YOU HAVE ANY QUESTIONS CONCERNING THE AGREEMENT, FEEL FREE TO CONTACT THE ADMINISTRATOR OF THE GROUP HOME.

1. I shall be employed on a salary/ hourly basis.
2. My employment shall be governed under the provisions by the Fair Labor Standards Act of 1939, as amended.
3. My working schedule is based according to the staffing need of the home.
4. I will document on my Time Sheet as to the reason for hours worked above and my normally scheduled work hours.
5. Holidays recognize by SYMBRAL FOUNDATION are: (1) **New Year's Day** (2) **Memorial Day** (3) **independence Day** (4) **Labor Day** (5) **Veterans Day** (6) **Thanksgiving Day** (7) **Christmas Day** (8) **Birthdays.**
6. I will receive Vacation and Sick Leave in the line with SYMBRAL FOUNDATION Personnel Policies, for Community Homes. My Annual Vacation and Sick Leave pay will be based upon normal working hourly rate. All Vacation and Sick Leave pay will be issued at straight time.
7. I have read my Job Description and the Policy Procedure Manual. I agree to the duties, responsibilities, and policies as outlined.
8. I agree to be responsible for any petty cash refund provided to me. I further agree to allow SYMBRAL FOUNDATION to reduce my final pay cheque to any liabilities, that I may have occurred in relation to a petty cash fund or any outstanding telephone bills, that I may have made.
9. I agree to provide the Administrator with a written notice of my resignation at least 30 days in advance of my last day of work.
10. I have read and understood the SYMBRAL FOUNDATION'S Personnel Policies and Procedures for Community Homes, and agree to have my employment subject to the provisions thereof.

S. Jalloh
Employee's Signature

1-9-2014
Date

SYMBRAL FOUNDATION FOR COMMUNITY SERVICES, INC.

914 SILVER SPRING AVENUE, SUITE 103
SILVER SPRING, MARYLAND 20910
TELEPHONE: 301 650 5722

CERTIFICATION

REGARDING A DRUG-FREE WORK PLACE

The unlawful manufacture, distribution, dispensing, possession or use of controlled substance is prohibited at Symbra Foundation facilities.

A random drug test will be administered to find out if the staff are drug-free.

Any staff who is found dispensing, using drugs or refuses to take a drug test will be terminated.

Name of Employee: Sulaiman Jalloh

Signature of Employee: S. Jalloh

Date: 1-9-2014

Sjallioh88@yahoo.

SYMBRAL FOUNDATION FOR COMMUNITY SERVICES, INC.
914 SILVER SPRING AVENUE, SUITE 103
SILVER SPRING MARYLAND, 20910

Tel: (301) 650-5722
Fax: (301) 650-5729

APPLICATION FOR EMPLOYMENT

Date: 11-13-2013
Full Name: Sulaiman Jarrah
Address: 13024 6th Street
City: Bowie State: Maryland Zip Code: 20720
Social Security Number: 578-31-9828
Date of Birth: 06-01-1989 T. B. Test: _____
Phone No: 202-957-0766

Applicant must be physically able to lift Residents in and out of wheelchairs, Bath tubs, etc.

Do you have any physical health problem (s)? Yes _____ No If Yes, please explain: _____

Do you have a valid Drivers License? Yes No _____

EDUCATION:

High School: Durvet High (Name) _____
Degree: Bachelor/Diploma (City, State & Zip) Greenbelt MD 20706
Date of Graduation: _____
College/ Other: Bowie State University Date/Certificate: May 17, 2015 Date of Graduation: May 17, 2015

INITIAL AFTER READING: Employment is contingent upon passing a basic literacy and arithmetic test with at least 70 % accuracy.

* Will like to see degree from BSU for 2012

Person to notify in case of Emergency: Soric Taliah Phone: 290-535-1657
 Name: Soric Taliah Address: 12215 Kings Ford Ct

WORK EXPERIENCE: Please list the places you are presently or have been employed.

Institute Name & Number	Address	Supervisor Name & Number	Position FT/PT	Date Held	Salary
Dollar General	6934 Laurel-Bowie	Cindy - 301-352-2365	FT	08-9-2013	191.00
Code 3 Security	3273 Pine Orchard	Jackson - 301-710-3269	PT	04-10-11	19.65

mail
FAX

Note: Please use last page of application to elaborate on work experience.

REFERENCES: Please list names, addresses, telephone numbers, below.

- Personal: Umaru Kamara 4406 Hatties Progress Dr 301-642-4295 umaru.kamara90@hotmail.com
- Personal: Rosaline Samura 4406 Hatties Progress Dr 301-642-4295
- Job Related: Libby-Dollar General 301-807-1186
- Job Related: Ashley Code 3 Security 301-613-9871

SYMBRAL FOUNDATION FOR COMMUNITY SERVICES, INC.
914 SILVER SPRING AVENUE, SUITE 103
SILVER SPRING, MARYLAND 20910
TELEPHONE: (301) 650-5722

CONFIDENTIAL REFERENCE REQUEST

CONCERNING (NAME): Suleiman Jallah
ADDRESS: 13024 6th Street Bowie MD 20720

Dear Sir/Madam:

The above-named applicant has indicated that he/she was previously employed by you. Your evaluation of him/her will be sincerely appreciated, and will be held completely in confidence. Both the applicant and I will benefit from an early reply, since his/her employment is pending.

Thank You.

NAME: _____
TITLE: _____
FACILITY: _____
ADDRESS: _____

I, the undersigned, give permission to the above agency to release employment information from my personal file to Symbra Foundation.

SIGNATURE: S. Jallah

PERIOD OF EMPLOYMENT: _____ TO _____

TITLE: _____

REASON FOR SEPARATION: _____

WOULD YOU RE-HIRE? YES NO IF NOT, WHY NOT? _____

APPLICANT'S HEALTH:	<input type="checkbox"/> ABOVE AVERAGE	<input type="checkbox"/> AVERAGE	<input type="checkbox"/> BELOW AVERAGE
QUALITY OF WORK:	<input type="checkbox"/> ABOVE AVERAGE	<input type="checkbox"/> AVERAGE	<input type="checkbox"/> BELOW AVERAGE
PRODUCTIVE OUTPUT:	<input type="checkbox"/> ABOVE AVERAGE	<input type="checkbox"/> AVERAGE	<input type="checkbox"/> BELOW AVERAGE
ATTENDANCE:	<input type="checkbox"/> ABOVE AVERAGE	<input type="checkbox"/> AVERAGE	<input type="checkbox"/> BELOW AVERAGE
COOPERATION:	<input type="checkbox"/> ABOVE AVERAGE	<input type="checkbox"/> AVERAGE	<input type="checkbox"/> BELOW AVERAGE

Other comments (your remarks are the most important part of this questionnaire):

SIGNED: _____
TITLE: _____
DATE: _____

me: _____
ation Requested: DS P
e available: Immediately

PLEASE FURNISH THE FOLLOWING ITEMS:

- Minimum of 2 references from former employers (professional) or university professors.
- Copies of all relevant certification.
- Complete resume.
- Must furnish a report of a physical examination given by a registered physician before signing a contract.
- Police Clearance.

NOTE: Any false statements will be cause for termination of employment, at any time if hired.

As soon as all proper credentials are received and there are openings for a position in which you are interested, and qualified, you will be invited to an interview.

SIGNATURE: Stallone
DATE: 11-13-2013

SYMBRAL FOUNDATION FOR COMMUNITY SERVICES, INC.

DISCLOSURE

**ALL APPLICANTS TO FILL VACANCIES ARE REQUIRED TO
DISCLOSE CURRENT EMPLOYER, IF THAT EMPLOYER IS ANOTHER
DDA/DDS PROVIDER.**

(ICR/DD, RESIDENTIAL OR DAY TIME PROVIDER)

**SHOULD AN EMPLOYEE WORK FOR ANOTHER DDA/DDS PROVIDER AND
FAIL TO DISCLOSE EMPLOYMENT WITH OTHER PROVIDER MAY RENDER
THE EMPLOYMENT CONTRACT VOID.**

AUTHORITY: DDS INCIDENT MANAGEMENT POLICY UPDATE 2010.

SIGNATURE: STallor

DATE: 11-13-2013

SYMBRAL FOUNDATION FOR COMMUNITY SERVICES, INC.

P.O. Box 60672
WASHINGTON, D.C. 20039

TELEPHONE #: (301) 650-5722

914 SILVER SPRING AVENUE,
SUITE 103
SILVER SPRING, MARYLAND 20910
FAX NUMBER #: (301) 650-5729

To: Applicant / Staff

From: Training Department

Once you are employed by Symbal, you are required to attend training throughout your employment. Symbal will pay for the following trainings:

First Aid

CPR

Maryland Medication Technician

Maryland Med Tech Refresher

DC Trained Medication

If you decide to leave the company within six (6) months, you are required to pay the full payment of the training back to Symbal.

If you decide to leave the company within one (1) year, you will pay half the amount for your training.

If you have any questions, feel free to contact the Training Department at the above number.

D. J. Salda
Staff Signature

1-9-2014
Date

name: Salemmon TANON

ADDITIONAL COMMENTS

(Optional): Please use this page to elaborate on duties performed for previous positions held professionally, non-professionally and on a volunteer basis. You may also include any additional information you feel is pertinent in being considered for a position at the

Group Home.

volunteer - Bowie Health care center - 2008 - 2010
volunteer - Prince George's Hospital Center - 2011 - 2011
at both volunteer job I helped senior and work
at kitchen cooking meal for the senior

* Call Bowie Health & P-G Hosp. for ref.

SIGNATURE: Stellah

DATE: 11-13-2015

PERSONNEL: Name: Sulaiman Jalloh

No. I hereby certify, that I have not been convicted of a felony in the jurisdiction/s in which I have lived and worked, within the past seven (7) years.

Yes. I hereby certify, that I have been convicted of a felony in the jurisdiction/s in which I have lived and worked, within the past seven (7) years.

Yes, you have been convicted of a felony in the jurisdiction/s in which you have lived and worked within the past seven (7) years, please explain.

Signature: S. Jalloh

DATE: 11-13-2013

**American
Red Cross**



This recognizes that
SULAIMAN A JALLOH
has completed the requirements for
**Adult and Pediatric First
Aid/CPR/AED**
conducted by

New Horizons Consulting

Date completed: **04/06/2013**

The American Red Cross recognizes
this certificate is valid from
completion date for: **2 Years**

Maryland High School Diploma



This is to certify that

SULAIMAN A. JALLOH

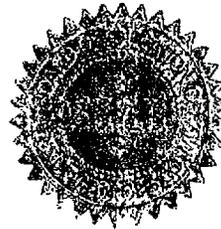
has completed in a satisfactory manner at the

Duval High School

*an approved program of study in accordance with guidelines
established by the Maryland State Board of Education
and is therefore awarded this*

Diploma

IN TESTIMONY WHEREOF, the seal of the Board of Education of
Prince George's County and the signatures required by law are hereunto
affixed this month of June 2006



Nancy S. Thomas
State Superintendent of Schools

W. H. H.
Superintendent of Schools

SYMBRAL FOUNDATION FOR COMMUNITY SERVICES, INC.

TAX ID. 52-1348838

P.O. Box 60672
WASHINGTON, D.C. 20039

TELEPHONE #: (301) 650-5722

914 SILVER SPRING AVENUE,
SUITE 103
SILVER SPRING, MARYLAND 20910
FAX NUMBER: (301) 650-5729

HEPATITIS B VACCINE

I wish to receive the Hepatitis B Vaccine.

I do not wish to received the Hepatitis B Vaccine.

I have been completely vaccinated against Hepatitis B and will provide documentation within ten (10) days.

I have commence vaccination and completed shot # 1 , #2 , and will provide documentation of the shot/s completed and will provide additional documentation of completing the series. Proof of completing all three (3) shots will be provided within six (6) months of date hired.


Signature

01/09/14
Date



GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH CARE REGULATION AND LICENSING ADMINISTRATION



CHILD & RESIDENTIAL
CARE FACILITIES DIVISION

Phone: (202) 442-5929
Fax: (202) 442-9430

MAILING ADDRESS:
825 North Capitol
Street, NE
Second Floor
Washington, DC 20002

PROVIDER HEALTH CERTIFICATE

Name: Sulaiman Talleh

Sex: Male Female

Date of Birth: 06-01-1989

Telephone No: 202-957-0766

Address: 13024 6th Street Bowie

I have examined the above-named person and certify that he/she is:

- Free from disease in communicable form.
- Appears to be in satisfactory physical and mental health condition, capable of doing physical household tasks, supervise and give care to adults.

In addition to a general physical health examination, the following tests have been done:

Tuberculin test (Check One): PPD Chest X-Ray

Date: DEC 12 2013 Result: negative [Signature]
Signature of Recorder

Other: _____

[Signature] MD/NP
Signature of Examining Physician/Nurse Practitioner

Date of Examination: 12/12/13

Robert W. Yancey M.D.
Address: 120 Georgia Avenue, N.W.
Washington, DC 20010
202-722-0122 (p) 202-722-0123 (f)

Telephone No.: 202-722-0122
(Area Code)

PLEASE RETAIN A COPY FOR YOUR RECORDS

MARC

Metropolitan Assessment & Renewal Centers, LLC
3120 Georgia Avenue, NW
Washington, DC 20010
(202) 722-0122 Main (202) 722-0123 Fax

TB TEST (PPD)

Taylor (Print) Last Name Suleiman First Name Middle Initial

Date of Birth 06-01-1989

Date PPD Planted DEC 12 2013 on the Right / Left Forearm

Date PPD Read 12/14/2013

Results 0 mm Negative Positive

Referred for Chest X-ray Yes / No

Comments: _____

Robert Yancey

Robert Yancey, M.D.
Crystal Taylor-Davis, M.D.
Patricia Clark, N.P.



Person Summary

Sulaiman Jalloh, XXX-XX-9828, 6/1/1989
Current Fitness Determination: Eligible for Employment - Valid Through 7/8/2014

[Employment Authorization Form](#)

[Add New Application](#)

[Case Notes](#)

[Profile](#)

[Applications](#)

[Employment](#)

[Documents](#)

Personal and Demographic Information

* Required

* First Name: Sulaiman

SSN: XXX-XX-9828 This is an ITIN: No

Middle Name:

* Date of Birth: 6/1/1989

* Last Name: Jalloh

* Race: Black

Suffix:

* Gender: Male

Permanent/Physical Address

* Eye Color: Brown

* Address Line 1: 13024 6th Street

* Hair Color: Black

Address Line 2:

* Height: 5'7"

* City: Bowie

* Weight: 160 lbs

* State: Maryland

* US Citizen: Yes

* ZIP: 20720

* Place of Birth: Sierra Leone

County:

* Primary Phone: 202-957-0766

Mailing Address

Secondary Phone:

Email Address: sjahhoh88@yahoo.com

Same as Permanent Address: Yes

[History of Changes](#)

[Edit](#)

Aliases/Prior Names (Includes all names by which an applicant is currently known or has been identified as)

This individual does not have any aliases entered.

[Add New](#)

Prior Addresses within the last 7 years

This individual does not have any prior addresses entered.

[Add New](#)

2/6/2014 4:11:29 PM
Symbal Foundation
914 Silver Spring Avenue, Suite 103

Silver Spring, MD 20910

Live Scan Fingerprinting Form

You have applied for a position with a health care employer that requires a fingerprint-based background check. Your fingerprints must be collected by a fingerprint vendor (Live Scan Service Provider) to initiate this background check. Your results will be listed on the state's secure background checking system web site. Authorized health care providers will access this secure site to determine your employment eligibility status. Please take this form with you to the Live Scan location at which you will be fingerprinted and give to the fingerprinting technician.

Applicant Information

Application #:	9496	SSN:	XXX-XX-2126
ORI:	DCLTC009Z	Date Of Birth:	12/28/1972
Name:	Zenebech Gemeda	Race:	Black
Address:	7520 Maple Ave Apt. 410 Takoma Park, MD 20912	Gender:	Female
Country:		Eye Color:	Brown
Place Of Birth: (If not US)	Ethiopia	Hair Color:	Black
		Weight:	150
		Height:	5'0"

If you are scheduling your own appointment:

Appointments can be scheduled on the MorphoTrust web site <https://dc.ibtfingerprint.com/>.

You will need to enter the following ID number when scheduling your appointment: 8538

Fingerprint Appointment Information

You must present this form and a current, valid government-issued photo identification to be fingerprinted (i.e. driver's license, state ID, military ID, etc.). If you are unable to make this appointment, please contact the Live Scan vendor listed below to re-schedule your appointment.

Date: 2.4.14

Time: 9:40A

Live Scan Vendor: Washington-Georgia Ave

Address: 3422 Georgia Ave, NW
Washington, DC

Phone:

Complete and Return

Please have the fingerprinting technician complete the information below. Then return the form to the provider.

TCN: _____ Technician Name (Print):

_____ Technician Name (Signature):

PRODE 827

P. Pope

2/7/14
Date



[Home](#) | [Applications](#) | [Employers](#) | [Search](#) | [Reports](#)

[Home](#) | [Not Yet Submitted](#) | [Determinations in Process](#) | [Determinations Available](#) | [Application Form](#)

Applications: Determination Available

Enter Filter Options

Application #:

Provider:

Last Name:

Determination Date: to

Determination:

Employment:

Results

Locked	App # - Type	Provider	Last	First	SSN	Determination	Determination Date	Employment Status	Actions
	8094	Symbra Foundation	Hydara	Haddijatpi	-7525	Eligible	12/11/2013	<input type="button" value="Hire"/>	<input type="button" value="Close Application"/>

BeverleyW

2/7/2014 9:56:14 AM
Symbal Foundation
914 Silver Spring Avenue, Suite 103

Silver Spring, MD 20910

Live Scan Fingerprinting Form

You have applied for a position with a health care employer that requires a fingerprint-based background check. Your fingerprints must be collected by a fingerprint vendor (Live Scan Service Provider) to initiate this background check. Your results will be listed on the state's secure background checking system web site. Authorized health care providers will access this secure site to determine your employment eligibility status. Please take this form with you to the Live Scan location at which you will be fingerprinted and give to the fingerprinting technician.

Applicant Information

Application #:	9514	SSN:	XXX-XX-0633
ORI:	DCLTC009Z	Date Of Birth:	10/21/1977
Name:	Nnamdi Erowele	Race:	Black
Address:	6221 Spring Hill Court Apt. 302 Greenbelt, MD 20770	Gender:	Male
Country:		Eye Color:	Black
Place Of Birth: (If not US)	Nigeria	Hair Color:	Black
		Weight:	201
		Height:	5'10"

If you are scheduling your own appointment:

Appointments can be scheduled on the MorphoTrust web site <https://dc.ibtfingerprint.com/>.

You will need to enter the following ID number when scheduling your appointment: 8556

Fingerprint Appointment Information

You must present this form and a current, valid government-issued photo identification to be fingerprinted (i.e. driver's license, state ID, military ID, etc.). If you are unable to make this appointment, please contact the Live Scan vendor listed below to re-schedule your appointment.

Date: 10:40A 2-7-14

Time: ↓

Live Scan Vendor: DOH Office

Address: 899 North Capitol St, NE
Lobby Level
Washington DC 20002

Phone:

Complete and Return

Please have the fingerprinting technician complete the information below. Then return the form to the provider.

TCN: _____ Technician Name (Print): PROPE 827
Technician Name (Signature): P. Prope 2/7/14
Date



GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH CARE REGULATION AND LICENSING ADMINISTRATION



CHILD & RESIDENTIAL
CARE FACILITIES DIVISION

Phone: (202) 442-5929
Fax: (202) 442-9430

MAILING ADDRESS:

825 North Capitol
Street, NE
Second Floor
Washington, DC 20002

PROVIDER HEALTH CERTIFICATE

Name: Desmond Sterling

Sex: Male Female

Date of Birth: _____

Telephone No: _____

Address: _____

I have examined the above-named person and certify that he/she is:

Free from disease in communicable form.

Appears to be in satisfactory physical and mental health condition, capable of doing physical household tasks, supervise and give care to adults.

In addition to a general physical health examination, the following tests have been done:

Tuberculin test (Check One): PPD Chest X-Ray

Date: 01/22/14 Result: Neg 01/24/14

Signature of Recorder

Other: _____

W Wilkerson
Signature of Examining Physician/Nurse Practitioner

MD/NP

Date of Examination: 01/22/14

WILKINSON NINALA, MD
344 UNIV. BLV. W. STE 113

Address: **SILVER SPRING, MD 20901**
301-593-3400

Telephone No.: 202 877-7000
(Area Code)

PLEASE RETAIN A COPY FOR YOUR RECORDS



SILVER SPRING MEDICAL CENTER

HEALTH CERTIFICATE

DATE: 01/11/14

NAME: GEMEDA, ZENEBECH ALEMU SEX: FEMALE

ADDRESS: 7520 MAPLE AVENUE #410 TAKOMA PARK, MD 20912

DOB: 12/28/1972

I have examined the above named person and certify that he/she is:

- 1. Free from communicable diseases
- 2. In satisfactory physical condition

In addition to a general physical examination, following test have been performed:

Tubertulin

Type <u>PPD</u>	Date <u>01/13/14</u>	Result <u>NEGATIVE</u>	Other <u>None</u>
Chest X-Ray _____	Date _____	Result _____	_____
VDRL _____	Date _____	Result _____	_____
CBC _____	Date _____	Result _____	_____
Urinalysis _____	Date _____	Result _____	_____

Comments:

NEGATIVE ROUTINE MEDICAL EXAM.

Date of Exam: 01/14/14

Signature of Physician _____

Robert G. Greenfield, M.D.
Silver Spring Medical Center



Volunteers of America
 CHESAPEAKE
 Called to Care™

Intellectual Disability Services

EMPLOYEE HEALTH CERTIFICATE

Date of Exam: 2/4/14 Sex: F
 Name: Patricia Beckington-Brown
 Address: 7408 Wilhelm Dr
Lanham, MD
 Date of Birth: 8/28/68

Height: 5'8 Weight: 170

Vital Signs:

Temp: 98.8 Pulse: 72 Blood/Pressure: 123/80

I have examined Patricia Beckington-Brown and certify that he/she is:

(Circle all that apply)

- 1) Free of communicable diseases
- 2) In satisfactory physical condition
- 3) Able to participate in required job assignments

In addition to a general physical examination, the following test has been performed:

Tuberculin Test

Type: Skin Date given: 8/26/13 Date read: 8/28/13

2/4/14
 Date of Examination

Result: Negative
Charles A. Allen, MD
 M. D. Signature