

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

PRINTED: 02/24/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/14/2010
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NAME OF PROVIDER OR SUPPLIER SYMBRAL FOUNDATION	STREET ADDRESS, CITY, STATE, ZIP CODE 4422 20TH STREET, NE WASHINGTON, DC 20011
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(W 000)	INITIAL COMMENTS A revisit was conducted on January 13, 2010 and January 14, 2010, to verify the facility's compliance with condition-level deficiencies cited during the December 8, 2009 complaint investigation. Five out of five clients remained in the sampled residential population from the previous investigation. The findings of the survey were based on observations in the home and one day program, interviews with day program staff, direct care, administrative and nursing staff in the home, as well as a review of the clinical, administrative, and habilitation records, including unusual incident reports. The revisit resulted in a determination that the facility had regained compliance with the Condition of Participation in Active Treatment Services. However, some standard-level deficiencies remained, as evidenced by the citations in the report that follows.	(W 000)	The governing body of Symbra Foundation has established a QA Team which conducts monthly monitoring of our facilities to identify deficiency practices and implement appropriate interventions in a timely manner to ensure compliance to standards.	2/26/10 and ongoing
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that outside services met the needs of one of five clients in the sample. (Client #4) The finding includes: The facility failed to ensure that day program staff implemented infection control practices. [See W455]	W 120	<i>Rec'd 3/4/10</i> GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002 QMRP visited Day Program on 1/29/10 and met with case worker for individual #4. Deficiency cited was discussed. QMRP received copy of Training sheet dated 2/15/10 which showed that training on Infection control specific individual #4 was done. QMRP, House Manager and Day Program Case Worker, Staff will monitor to ensure compliance.	1/29/10 and ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Theresa M. Lopez* TITLE *CEO* (X6) DATE *3/4/10*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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(1 000) INITIAL COMMENTS

A revisit was conducted on January 13, 2010 and January 14, 2010, to verify the facility's compliance with deficiencies cited during the December 8, 2009, complaint investigation. Five out of five residents remained in the sampled residential population from the previous investigation. The findings of the survey were based on observations in the home and one day program, interviews with day program staff, direct care, administrative and nursing staff, as well as a review of the clinical, administrative, and habilitation records, including unusual incident reports.

(1 000)

The governing body of Symbal Foundation has established a QA Team which conducts monthly monitoring of our facilities to identify deficiency practices and implement appropriate interventions in a timely manner to ensure compliance to standards.

2/26/10 and ongoing

1 082 3503.10 BEDROOMS AND BATHROOMS

Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting.

1 082

This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to equip all bathrooms used by residents with paper cups.

The findings include:

1. On January 14, 2010, at 9:00 a.m., there was no paper cup dispenser and no paper cups available in the restroom located in the basement. At 9:05 a.m., the qualified mental retardation professional (QMRP) acknowledged that there were no cups available. She indicated that Resident #3 had been known to destroy paper cup holders, and staff were maintaining baseline data. Further interview, however,

Interdisciplinary Team met on 2/17/10. The recommendation was made for an informal program (no need for documentation) is implemented where individual #3 helps to replace cups into dispensers with the thought process that he will learn not to destroy cup holders.

2/17/10 and ongoing

Informal program is in place and staff training was done on 2/17/10.

Health Regulation Administration

[Handwritten Signature]

TITLE CEO

(X8) DATE 3/4/10

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

STATE FORM

9999 T99G12

If continuation sheet 1 of 5

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W 130	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure privacy during personal needs, for one of the five clients in the sample. (Client #4)</p> <p>The finding includes:</p> <p>On January 13, 2010, at 5:35 p.m., Client #4 was observed sitting on the toilet with the door wide open while his assigned 1:1 staff was observed standing in the same bathroom washing his hands. A female staff walked by and verbally prompted staff to close the door. When interviewed moments later, at approximately 5:42 p.m., the client's 1:1 staff acknowledged that Client #4 was not provided privacy while using the bathroom.</p> <p>There was no evidence that staff ensured privacy during Client #4's personal care.</p>	W 130	<p>All staff on schedule at this facility received re-training on 1/13/10 privacy as highlighted as one of the individuals' fundamental rights.</p> <p>In addition a disciplinary action was given to staff (1:1) working with individual #4 as observed on 1/13/10.</p> <p>QA Team, QMRP and House Manager will monitor to ensure compliance.</p>	1/13/10 and ongoing
(W 331)	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility's nursing services failed to notify the primary care physician timely following an assessed change in a client's swallow safety</p>	(W 331)		

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{W 331}	<p>Continued From page 2 needs, for one of five clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>On January 14, 2010, at approximately 3:15 p.m., review of an incident report dated December 30, 2009, revealed that Client #1 was admitted to a hospital on that day. This followed a modified barium swallow study that was performed on December 29, 2009. Review of the December 29, 2009, consultation form revealed that the Speech/Language Pathologist wrote the following: "Patient with frank, silent aspiration of pureed consistency. Recommend nothing by mouth; consider alternate means of nutrition/hydration." The findings, however, were not relayed to the primary care physician (PCP) until the following day.</p> <p>At 3:21 p.m., interview with the LPN revealed that upon Client #1's return home from the swallow study that afternoon, the house manager (HM) handed her the consultation form that summarized the findings. The LPN immediately telephoned the RN and the qualified mental retardation professional (QMRP); however, both the RN and QMRP were in a meeting and unavailable. According to the LPN, the RN did not call back that evening, and Client #1 was fed dinner and breakfast the next morning by mouth (ground foods, as previously ordered) before an attempt was made to reach the PCP.</p> <p>Further interview revealed that when the LPN called the PCP the next day, he advised her to telephone the gastro-intestinal (GI) specialist. The LPN called the GI specialist's office; however, her telephone message went without a</p>	{W 331}	<p>Symbtral's nursing team have established a protocol which outlines procedures to be taken when individuals do Barium Swallow studies and recommendation are made, specific to NPO.</p> <p>In addition LPN Case Manager received disciplinary action to this effect.</p> <p>QA Team, DON, RN, LPN Case Manager, QMRP and House Manager will monitor to ensure compliance.</p>	2/26/10 and ongoing

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(W 331)	Continued From page 3 response. She, therefore, called the PCP back, and he ordered the client taken to the hospital for further evaluation. The QMRP and HM were present at the time of this interview and corroborated the LPN's account. The LPN presented progress notes she had entered in Client #1's medical record on December 29, 2009 and December 30, 2009. The progress notes documented telephone calls made to the PCP at approximately 9:30 a.m. and 10:30 a.m. on December 30, 2009. Client #1 was taken to the hospital at approximately 2:30 p.m. The LPN's progress notes also indicated that a Speech/Language consultant was expected to visit the facility on the morning of December 30, 2009. The consultant, however, had not come before the client's departure for the hospital. It should be noted that upon further evaluation, the PCP recommended on December 31, 2009 insertion of a peg. It should be further noted that a chest x-ray taken in the hospital on December 31, 2009 revealed no evidence of food infiltrate in the lungs.	(W 331)			
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement infectious control procedures to prevent communicable infectious diseases, for one of the five clients in the sample. (Client #4)	W 455	All staff received in-service on Infection Control (hand washing) on 1/13/10. Staff working with individual #4 as cited received disciplinary action to the effect of deficiency practice as cited by DOH.	1/13/10 and ongoing	

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W 455	<p>Continued From page 4 The findings include:</p> <p>1. Evening observations conducted on January 13, 2010, at 6:18 p.m., revealed Client #4 staff was observed sitting on the basement sofa with his hands inside a plastic container filled with different magic markers/crayons. Moments later, staff verbally prompted Client #4 to go upstairs to the dining table. They did not remind him to wash his hands. At approximately 6:26 p.m., Client #4 was observed to scoop brown rice and sweet peas onto his spoon using his left hand. The client also used his hands to eat his bread (bite size). When interviewed, at approximately 6:33 p.m., the client's 1:1 staff acknowledged that he had not encouraged the client to wash his hands before dinner.</p> <p>2. On January 14, 2010, at approximately 11:50 a.m., the direct support staff person working with Client #4 and his peers at his day program stood up and walked away from their table. Immediately, Client #4 put his right hand down his pants and began fondling his privates. The client removed his hand from his pants just moments later, when he saw the staff person returning to the area. This surveyor discretely described the client's actions/behavior to the day program case manager and to the staff person. The client, however, was not instructed to wash his hands in the period that followed.</p>	W 455	Crossed referenced and adopted with W120.	1/29/10 and ongoing
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I 082	Continued From page 1 revealed that staff monitored the client's use of the bathroom and to date, the interdisciplinary team had not prescribed a training program. 2. Similarly, at approximately 9:25 a.m., there were no cups available for use in the bathroom located on the main floor, adjacent to the kitchen. Staff found an empty cup dispenser stored on the top shelf of the medicine cabinet in that bathroom. Later that day, at 1:53 p.m., the QMRP presented two paper cup dispensers and a box of disposable paper cups. Staff subsequently made cups available in both bathrooms; therefore, the deficiency was abated during the survey.	I 082	2. Cup dispenser was re-filled with cups as per surveyor's observation. A memo has been issued to house manager and staff highlighting the need for cup dispensers to have cups at all times. QA Team, QMRP, House Manager and Staff will monitor to ensure compliance.	1/24/10 and ongoing	
(I 401)	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP's nursing services failed to notify the primary care physician timely following an assessed change in a resident's swallow safety needs, for one of five residents in the sample. (Resident #1) The finding includes: On January 14, 2010, at approximately 3:15 p.m., review of an incident report dated December 30, 2009, revealed that Resident #1 was admitted to	(I 401)			

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(I 401)	Continued From page 2 a hospital on that day. This followed a modified barium swallow study that was performed on December 29, 2009. Review of the December 29, 2009, consultation form revealed that the Speech/Language Pathologist wrote the following: "Patient with frank, silent aspiration of pureed consistency. Recommend nothing by mouth; consider alternate means of nutrition/hydration." The findings, however, were not relayed to the primary care physician (PCP) until the following day. At 3:21 p.m., interview with the LPN revealed that upon Resident #1's return home from the swallow study that afternoon, the house manager (HM) handed her the consultation form that summarized the findings. The LPN immediately telephoned the RN and the qualified mental retardation professional (QMRP); however, both the RN and QMRP were in a meeting and unavailable. According to the LPN, the RN did not call back that evening, and Resident #1 was fed dinner and breakfast the next morning by mouth (ground foods, as previously ordered) before an attempt was made to reach the PCP. Further interview revealed that when the LPN called the PCP the next day, he advised her to telephone the gastro-intestinal (GI) specialist. The LPN called the GI specialist's office; however, her telephone message went without a response. She, therefore, called the PCP back, and he ordered the resident taken to the hospital for further evaluation. The QMRP and HM were present at the time of this interview and corroborated the LPN's account. The LPN presented progress notes she had entered in Resident #1's medical record on December 29, 2009 and December 30, 2009.	(I 401)	Symbra's nursing team have established a protocol which outlines procedures to be taken when individuals do Barium Swallow studies and recommendation are made, specific to NPO. In addition LPN Case Manager received disciplinary action to this effect. QA Team, DON, RN, LPN Case Manager, QMRP and House Manager will monitor to ensure compliance.	2/26/10 and ongoing

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{I 401}	Continued From page 3 The progress notes documented telephone calls made to the PCP at approximately 9:30 a.m. and 10:30 a.m. on December 30, 2009. Resident #1 was taken to the hospital at approximately 2:30 p.m. The LPN's progress notes also indicated that a Speech/Language consultant was expected to visit the facility on the morning of December 30, 2009. The consultant, however, had not come before the resident's departure for the hospital. It should be noted that upon further evaluation, the PCP recommended on December 31, 2009, insertion of a peg. It should be further noted that a chest x-ray taken in the hospital on December 31, 2009, revealed no evidence of food infiltrate in the lungs.	{I 401}		
{I 500}	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District and federal laws that govern the care and rights of persons with mental retardation, for two of the five residents of the facility. (Residents #1 and #4) The findings include:	{I 500}	Symbra's nursing team have established a protocol which outlines procedures to be taken when individuals do Barium Swallow studies and recommendation are made, specific to NPO. In addition LPN Case Manager received disciplinary action to this effect. QA Team, DON, RN, LPN Case Manager, QMRP and House Manager will monitor to ensure compliance.	2/26/10 and ongoing

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(I 500)	Continued From page 4 1. Based on interview and record review, the GHMRP's nursing services failed to notify the primary care physician timely following an assessed change in a Resident #1's swallow safety needs, as follows: Cross-refer to I401. According to interviews with the LPN, the house manager (HM) and the qualified mental retardation professional (QMRP), followed by record review, Resident #1 had a modified barium swallow study performed on December 29, 2009. The Speech/Language Pathologist wrote the following: "Patient with frank, silent aspiration of pureed consistency. Recommend nothing by mouth; consider alternate means of nutrition/hydration." The findings of the swallow study, however, were not relayed to the resident's primary care physician (PCP) until the following day. In the mean time, Resident #1 was fed a dinner and breakfast by mouth (ground foods, as previously ordered) without advisement from the PCP. 2. Based on observation and interview, the GHMRP failed to ensure Resident #4's privacy during personal needs, as follows: On January 13, 2010, at 5:35 p.m., Resident #4 was observed sitting on the toilet with the door wide open while his assigned 1:1 staff was observed standing in the same bathroom washing his hands. A female staff walked by and verbally prompted staff to close the door. When interviewed moments later, at approximately 5:42 p.m., the resident's 1:1 staff acknowledged that Resident #4's right to privacy while using the bathroom had not been protected.	(I 500)	All staff on schedule at this facility received re-training on 1/13/10 privacy as highlighted as one of the individuals' fundamental rights. In addition a disciplinary action was given to staff (1:1) working with individual #4 as observed on 1/13/10. QA Team, QMRP and House Manager will monitor to ensure compliance.	1/13/10 and ongoing	