STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETI DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from May 7, 2008 through May 12, 2008. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a resident population of five men with various disabilities. In addition, a focused review was conducted of a fourth client's behavior support plan and psychotropic medications. The findings of the survey were based on observations, interviews with one parent and staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's governing body provided general operating direction over the facility, except in the following areas: The findings include: 1. The governing body failed to ensure that facility staff secured all clients with seat belts in accordance with State law, to ensure client safety. On May 8, 2008, at 8:18 AM, three direct support staff and a driver were observed loading clients into the facility van. None of the clients were buckled in. Of the four staff, only the driver secured his seat belt before they closed the doors and were about to depart. After this surveyor	W 104	A memo reminding staff to secure individuals with seat belts at all times has been placed on all vehicles transporting the individuals. Staff have been inserviced on the importance of ensuring the safety of all individuals on board providers vehicles by securing seat belts at all times. Symbral has re-implemented its safety policy for transporting individuals safety. QMRP, House Manager and Driver will conduct random audit for the next thirty days (30) at least twice weekly. Thereafter audits will be conducted randomly at least once per month.	6/10/08 and ongoing 7/30/08 and ongoing

RECEIVED
2008 JUN 17 P 3:23
DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Yvonne McKennedy | TITLE: CEO | (X6) DATE: 6/17/08

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETI DATE
W 104	Continued From page 1 asked about seat belts, staff buckled the clients' seat belts. On May 12, 2008, at 9:33 AM, interview with the Qualified Mental Retardation Professional (QMRP) and the House Manager revealed that there had been training provided on securing wheel chairs and seat belt safety after a similar citation at another facility operated by the agency. The House Manager agreed to find the facility's applicable policy and documentation regarding the recent training. At 11:05 AM, a signature sheet was presented for a March 12, 2008 training for House Managers and drivers. The signature sheet indicated that the training was presented by a wheel chair vendor, on "strapping down wheel chairs." The House Manager, QMRP and the driver on duty the morning of May 8, 2008 had all signed for attendance. The signature sheet included notations stating that persons in wheel chairs as well as other individuals were to be secured. Further review revealed"House Managers are to ensure that this is done." Observations on May 8, 2008, however, revealed that said training had not been effective. There was no evidence of any administrative follow-up regarding seat belts and driver safety in the months since the March 2008 training was held. The QMRP acknowledged that she had not observed seat belt procedures since the March 2008 training. 2. The governing body failed to ensure that injuries of unknown origin were reported and investigated.	W 104	**Managers and Staff have been re-inserviced on Safety during transportation on 6/10/08.** **Symbral will effect disciplinary procedures for all staff who fail to adhere to safety guidelines.**	**6/10/08 an ongoing**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	06/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETIC DATE
W 104	Continued From page 2 Cross-refer to W153.B. The survey revealed Nurse Progress Notes in which nursing staff had documented providing treatment for injuries of unknown origin for which there was no evidence of a corresponding incident report. There were 6 such injuries indicated in Clients #1 and #2s' records since December 2007. On May 12, 2008, the facility's Incident Management Policy (policy not dated) was reviewed. It included "Injury" in the list of incidents that require reporting. The policy also "requires that the Incident Report Form be completed by the end of the shift., must be reported immediately." It also listed "non-serious injury" in its "mandatory pre-service training" for all employees. It should be noted that the facility documented having provided additional training for one medication nurse, as a result of the March 26, 2008 investigation into Client #2's fall and injury to his face. However, there was no comparable training provided for the other nurses on staff. In addition, there was no evidence of a Quality Assurance system designed to identify injuries of unknown origin that were not reported in accordance with facility policies: 3. The governing body failed to document that allegations of neglect were reported to the administrator and/or State agency and investigated within five (5) business days, in accordance with federal and state regulations. (See W153 and W156) 4. The governing body failed to provide oversight of, and direction to the facility's medical team, to ensure the effective delivery of appropriate	W 104	**All medication nurses and staff have been inserviced on Symbral Incident Reporting Policy in Compliance with DDS Standards.** **A protocol is in place for nurses in charting and reporting treatment given and classified as injuries of unknown origin.** **QMRP will follow up to ensure that Symbral IC is notified and can conclude investigation in a timely manner as per DDS policy on incident of unknown origin. QA, QMRP, DON, Nurses and House Managers will monitor to ensure compliance.**	**6/10/08 & 6/11/08 and ongoing** **6/10/08 & 6/11/08 and ongoing**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETIC DATE
W 104	Continued From page 3 nursing care. (See W322 and W331)	W 104		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to establish and/or implement policies to ensure and protect client safety. The findings include: Cross-refer to W153.2. The survey revealed Nurse Progress Notes in which nursing staff had documented treatment of injuries of unknown origin for which there was no evidence of a corresponding incident report. There were 6 such injuries indicated in Clients #1 and #2s' records since December 2007. On May 12, 2008, the facility's Incident Management Policy (policy not dated) was reviewed. It included "Injury" in the list of incidents that require reporting. The policy also "requires that the Incident Report Form be completed by the end of the shift.. must be reported immediately." It also listed "non-serious injury" in its "mandatory pre-service training" for all employees. It should be noted that the facility documented having provided additional training for one medication nurse, as a result of the March 26, 2008 investigation into Client #2's fall and injury to	W 149	**Symbral Incident Management Policy was revised on 7/23/07 this date was posted on its policy. However at the time of survey, this revised policy with date was not the one seen. This has sinced been posted in the facility's on 8/7/08.** **QA, IMC, QMRP, DON will continue to monitor to ensure compliance.**	**8/7/08 and ongoing**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETION DATE
W 149	Continued From page 4 his face. There was no comparable training provided for the other nurses on staff. In addition, there was no evidence of a Quality Assurance system designed to identify injuries of unknown origin that were not reported in accordance with facility policies.	W 149	Cross reference and adopted with w-104 #2.	6/8/08 and ongoing
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and review of incident reports and resident records, the facility failed to ensure that all injuries of unknown origin and/or allegations of neglect were reported immediately to the administrator and other officials in accordance with District law (22 DCMR, Chapter 35, Section 3519.10), for two of the three clients in the sample. (Clients #1 and #2) The findings include: A. The facility failed to notify the State agency immediately of an allegation of neglect, as follows: Incident records in the facility and at the State agency consistently documented that on Monday, March 10, 2008, at approximately 1:31 PM, the facility notified the State agency by telephone that on Friday, March 7, 2008, Client #2 had sustained an injury to his face after a fall to the floor in the	W 153	Symbral's Incident Management Coordinator has conducted training on DDS Incident Management Policy re: Reporting of incidents of allegation of neglect for QMRP and House Managers. Incident Management Coordinator monitor for compliance.	6/8/08 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETION DATE
W 153	Continued From page 5 facility. He was subsequently taken to a hospital emergency room. The exact cause of the fall was not stated over the telephone and there was no mention of staff neglect. An incident report was to follow. The March 7, 2008 incident report was not submitted to the Department of Health (DOH) timely. It was sent on March 25, 2008, two weeks after the QMRP made her preliminary allegations of neglect. It should be ntoed that on May 7, 2008, at 5:19 PM, interview with the Qualified Mental Retardation Professional (QMRP) revealed that she had initiated an investigation on March 10, 2008. She then met with the administrator and Incident Management Coordinator later that evening at their corporate office. She reportedly informed them that staff on duty at the time of the incident had left the client alone even though he had been sedated earlier that day for a medical procedure. The House Manager reportedly had given instructions to provide close supervision to the client that afternoon. The QMRP further stated that she was "very upset" by her preliminary findings and recommended the suspension of 3 staff, pending the outcome of a more thorough investigation. The QMRP documented her preliminary findings and recommendations in an Internal Investigation Summary, dated March 11, 2008. The QMRP's allegation of neglect was not reflected on the incident report that was submitted two weeks later. B. There was no evidence that six (6) recent injuries of unknown origin were immediately reported to the administrator and to the State agency, as follows:	W 153	When Serious Reportable Incidents change categorization with the range from one serious reportable incident to another. Verbal communication to DOH/ DCRA, DDS, family member/s, Attorney and the Individual are to be updated of the change immediately or within twenty-four (24) hours of the determination. Written documentation should follow-up with in twenty-four (24) to forty-eight (48) hours.	6/8/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETI DATE
W 153	Continued From page 6 Pre-survey review of State agency records did not reveal any reported injuries of unknown origin. On May 7, 2008, at approximately 4:00 PM, interview with the Qualified Mental Retardation Professional (QMRP) revealed there had been no injuries of unknown origin reported within the past twelve months. Subsequent review of incident reports confirmed that neither of the two incidents that were reported (emergency room visits) were related to injuries of unknown origin. At 5:00 PM, the QMRP stated that according to their policies, every injury of unknown origin must be reported immediately to their administrator and investigated. 1) On May 8, 2008, at approximately 2:30 PM, review of Client #2's day program Quarterly report, dated February 11, 2008, revealed staff had discovered blood in his underwear and they had notified the home. An Inter-Agency Communication (IAC) form, dated January 11, 2008, written by the the day program nurse included: "12:30 PM... showed me <client's name> undershorts. Approximately 2 inches by 1 1/2 inch area of blood noted on seat of underwear. Material not heavily saturated. Called group home, spoke with Nurse <LPN name>. Home will monitor for further episodes..." The cause of the bleeding was not noted on either the IAC or the Quarterly review. On May 9, 2008, at approximately 7:10 AM, the facility's LPN stated that she recalled Client #2 having blood in his underpants in January and said the appropriate documentation would be found in his medical records. However, at 7:55 AM, review of his Nurse Progress Notes revealed no evidence that the LPN documented having received the January 11, 2008 telephone call	W 153	**Symbral have provided training on 6/10/08 for ICF/MR staff on its incident reporting policy with emphasis on reporting incidents of unknown origin.** **QA, IMC, QMRP, DON, Nurses, House Managers and staff will continue to monitor to ensure compliance.**	**6/30/08**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETION DATE
W 153	Continued From page 7 from the day program. There was no corresponding incident report. In addition, there was no evidence of the January 11, 2008 IAC in the client's chart. It should be noted that on May 12, 2008, at 11:22 AM, the QMRP and LPN indicated that they both recalled seeing the January 11, 2008 IAC. "We looked at it. It wasn't blood, it was stool." They further stated that the day program nurse "reported what staff had told them, but had not looked at " the client's underpants. However, there was no documentation available in Client #2's record to verify the QMRP and LPNs' account. 2) On May 9, 2008, at approximately 7:58 AM, review of Client #2's residential Nurse Progress Notes revealed a note dated December 26, 2007 in which the LPN documented having received a call from the House Manager (HM). The HM reported that the client "was sent from the day program with a swollen nose." The LPN further documented "assessed this evening... nose remains swollen... ice pack applied..." The cause of the swollen nose was not indicated. There was no evidence of a corresponding incident report. 3) On May 9, 2008, at approximately 5:50 PM, review of Client #1's Nurse Progress Notes revealed four (4) recent injuries of unknown origin, as follows: a. March 18, 2008, 7PM - nurse assessed a "superficial scrape 2 cm by 2 cm" after staff reported observing blood on his right shin; b. April 3, 2008, 6AM - nurse documented having cleaned and applied dressing to an open area on	W 153	**Cross reference and adopted with w-153.3.** **Day Program will be requested to complete incident report forms as required by DDS Policy when notifying Provider of any such injury.** **Day Program Providers will fax the Incident Report and or an Inter-Agency Correspondence Form to the main office within 24-48 hours.**	**6/8/08 and ongoing** **8/16/08**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETI DATE
W 153	Continued From page 8 his left leg; c. April 3, 2008 and April 4, 2008 - nurse documented having cleaned and applied dressing to an abrasion on his right mid leg; and, d. April 11, 2008 - nurse cleaned and dressed a cut on the client's right 4th toe. At 6:03 PM, when asked whether she knew the cause of the 4 recent injuries to Client #1's legs, right shin and/or right toe, the LPN replied that the answer(s) would be found on the corresponding incident reports. A minute later, however, the facility's incident report book was reviewed for a second time and again, there was no evidence that incident reports pertaining to Client #1's recent leg or foot injuries had been prepared.	W 153	**A memo dated 6/12/08 has been circulated to all Managers and Nurses that all correspondence medical and non medical sent home from the Day Program must be filed within 2-3 days of receiving in the Individuals file under 'Day Program'.** **QA, IMC, QMRP, LPN and House Manager will monitor to ensure compliance.**	6/30/08
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that investigations were reported to the administrator within five working days of the incident, for one of the three clients in the sample. (Client #2) The finding includes: Cross-refer to W153.A. On May 7, 2008, interview with the Qualified Mental Retardation Professional revealed that the facility had	W 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETION DATE
W 156	Continued From page 9 Investigated Client #2's March 7, 2008 fall and subsequent emergency room visit. Further interview and review of the corresponding documentation, however, revealed that the investigation report was dated March 26, 2008, 12 business days after the incident. It should be noted that the investigation substantiated staff neglect and recommended termination of the three staff on duty at that time. It should be further noted that on May 12, 2008, review of the facility's Incident Management Policy (policy not dated) revealed "all investigations would <sic> be completed within five (5) working days of being reported unless an extension is approved by the DHS/DDS Incident management Unit..." There was no evidence that such extension had been sought. In fact, the QMRP stated on May 12, 2008, at 11:02 AM, that "the case manager was the first person" informed of the investigation's finding of neglect. The DDS case manager was informed when she was in the facility for Client #3's pre-ISP meeting, held on May 7, 2008.	W 156	**Staff were placed on suspension on 3/10/08. Initial incident reports were on file. However, staff became un-cooperative and as a result the investigation process was delayed. In future documentation of requested extension will be attached to the investigation report.** **Symbral will ensure through QA, IMC and QMRP monitoring that investigation reports are forwarded in a timely manner.**	**3/16/08 and ongoing**
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the Qualified Mental Retardation Professional (QMRP) failed to coordinate and monitor programs and services, for two of the three clients in the sample. (Clients #1 and #2)	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETION DATE
W 159	Continued From page 10 The findings include: 1. Cross-refer to W153. The QMRP failed to ensure that one (1) allegation of neglect as well as 6 injuries of unknown origin were reported to the administrator and/or the State agency, in accordance with facility policies and State law. 2. Cross-refer to W249. The QMRP failed to ensure that Client #1 consistently received needed staff reminders or verbal promting to wipe his mouth and chin during meals. 3. Cross-refer to W322. The QMRP failed to ensure that the medical team developed and implemented a post-operative plan of care to ensure the integrity of Client #2's surgical wound for proper healing. 4. Cross-refer to W153.B.1 On January 11, 2008, Client #2's day program nurse documented having made a direct observation of the client's underpants and observed blood. The nurse then notified the home. However, on May 12, 2008, the QMRP and LPN both alleged that there had been feces, not blood, in the client's underpants. They further alleged that the day program nurse had reported what staff had described, without having made a direct visual observation. Client #2's record failed to show evidence that the client and/or his underpants were assessed on January 11, 2008 or that the QMRP had addressed this alleged discrepancy with the day program. 5. The QMRP failed to ensure that all staff received additional training on the facility's incident management policies, as per the recommendations included in a March 26, 2008	W 159	**Cross reference and adopted with w-153.** **Individual #1 meal time protocol has been updated to include specific information relating to wiping mouth to alleviate spillage when eating. Staff has been inserviced. QMRP, House Manager will ensure compliant.** **Cross reference and adopted with w-322.** **Cross reference and adopted with w-153.b.1**	**6/30/08** **6/11/08 and ongoing** **6/13/08 and ongoing**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETION DATE
W 159	Continued From page 11 investigation report that substantiated staff neglect, as follows: The facility conducted an internal investigation into a March 7, 2008 incident in which Client #2 sustained an injury to his face after a fall. The investigation revealed variations in the accounts given by the direct support staff and the nurse who arrived on duty that afternoon to administer medications. The facility investigation substantiated staff neglect and recommended: "2. Review with nurse the requirement on incident reporting," and "3. Remind all staff on the requirement of timely incident reporting and cooperation in the investigation process." On May 9, 2008, at 1:00 PM, the QMRP presented a signature sheet documenting that on March 27, 2008, the Director of Nursing reviewed the facility's policies and procedures on the reporting of incidents with the medication nurse. However, when asked whether all staff had been reminded of their role in timely reporting of incidents and cooperating with investigation, she indicated that she was unaware of additional training on that topic. On May 12, 2008, beginning at 3:28 PM, review of staff in-service training records revealed a signature sheet dated May 7, 2008 indicating that direct support staff had been in-serviced on the facility's incident management policy. When asked about this later, the QMRP stated that she had presented the training in response to this surveyor's inquiries on that day (the first day of the survey). She further clarified that the training had been with and for newly-hired staff that were working the evening of May 7, 2008. Other staff,	W 159	**Staff at the time of incident involving individual #2 have been terminated.** **All other staff have been re-trained on Symbral's Incident Reporting Policy as per DDS requirements.**	**6/10/08 and ongoing**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETION DATE
W 159	Continued From page 12 however, including those employed at the time of the neglect incident, were not in attendance.	W 159		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently. The findings include: 1. Cross-refer to W104.1. Even though a driver, the House Manager and the Qualified Mental Retardation Professional (QMRP) documented having attended a March 12, 2008 training related to client safety during transportation. However, the failure to properly secure clients with seat belts on the morning of May 8, 2008 indicated that said training had not been effective. 2. Cross-refer to W159.4. There was no evidence that all staff who were employed at the time of a March 7, 2008 incident involving Client #2 received additional training on the facility's incident management policies, as per the recommendations included in a March 26, 2008 investigation report that substantiated staff neglect. 3. Cross-refer to W249.1. Facility staff failed to	W 189	Cross reference and adopted with w-104.1. Cross reference and adopted with w-159.4.	6/10/08 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETION DATE
W 189	Continued From page 13 provide Client #1 with verbal prompts, or reminders, to wipe his mouth and chin while eating a meal, as reportedly instructed by the QMRP.	W 189	**Cross referenced and adopted with w-159.2.**	**6/11/08 and ongoing**
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, staff interviews and record review, the facility failed to ensure that clients were provided the opportunities for continuous active treatment in accordance with the individual program plans (IPPs) and demonstrated needs, for two of the three clients in the sample. (Clients #1 and #2) The findings include: 1. Facility staff failed to implement Client #1's informal training 'program' (verbal reminders) to address mealtime hygiene and the use of table napkins, as follows: On May 8, 2008, beginning at 6:52 AM, Client #1 was observed eating breakfast. While he ate waffles and syrup, food and syrup dribbled out of his mouth and onto his chin. At approximately 6:57 AM, staff observed his chin and asked him to wipe his mouth. He immediately did so, in	W 249	**Cross reference and adopted with w-159 #2.**	**6/11/08 and ongoing**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETION DATE
W 249	Continued From page 14 response to the reminder. Minutes later, however, he began eating a bowl of cold cereal with a spoon. He ate quickly. Throughout the process, milk dripped from his mouth, down his chin and neck and eventually went underneath his shirt. Staff walked in and out of the dining room; however, no one intervened. At approximately 7:01 AM, he picked up the bowl and began drinking from it. For the next minute or two, a significant amount of milk spilled down his neck, chin and underneath his shirt. At 7:04 AM, he was observed eating canned peaches. Milk remained visible on his chin and neck. Staff did not intervene and at 8:18 AM, Client #1 was observed leaving the facility for day program wearing the same shirt he had worn through the breakfast meal. Similar observations were made later that day at dinner, beginning at approximately 6:00 PM. At 6:15 PM, Client #1 was observed drooling continuously as he ate a burger and french fries. For at least 5 minutes, there were no staff present in the dining room. The client was not observed initiating the use of his napkin. Food and drool remained on his chin, without staff intervention. On May 12, 2008, at approximately 9:25 AM, the Qualified Mental Retardation Professional (QMRP) stated she was "not sure" whether his training needs in that area had been assessed. She did, however, say she had instructed staff to "provide napkins for all individuals" and provide a "verbal prompt with physical gesture" to Client #1. Observations at two meals on May 8, 2008, however, revealed that staff did not consistently provide him the needed verbal prompt. 2. Facility nurses failed to implement Client #2's informal 'program' to participate in applying	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETIO DATE
W 249	Continued From page 15 topical creams/ lotions, as follows: During the May 8, 2008 morning medication pass, at 7:57 AM, the nurse poured a glass of water and then stirred thickener into it. She then removed Client #2's medications from blister packs. At 8:04 AM, the nurse handed him the cup with medications and he placed them in his mouth. She then handed him the cup of water and he drank. That was the extent to which he was involved in the process. On May 12, 2008, at 9:15 AM, interview with the QMRP revealed that Client #2 was without a self-medication training program. Later that day, at 4:38 PM, review of Client #2's self-medication assessment, dated August 5, 2007, revealed that he "responds correctly to simple questions." There were no other skills or abilities indicated. The nurse who completed the assessment indicated that he was not approved for a training program "due to cognitive impairment." The nurse did, however, recommend that he take the cup from the nurse (which he was observed doing), "swallow water with one prompt" (which he did without any prompts), and "participate in application of topicals." Interviews with the LPN and QMRP revealed no evidence that Client #2 participated in applying topicals.	W 249		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide preventive and general	W 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	06/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETIO DATE
W 322	Continued From page 16 medical care for one of the three clients in the sample. (Client #2) The findings include: 1. Nursing staff failed to ensure that the medical team developed and implemented a post-operative plan of care to ensure the integrity of Client #2's surgical wound for proper healing. On May 9, 2008, review of Client #2's Nurse Progress Notes revealed that he returned home from the hospital on March 22, 2008 after having foreign bodies surgically removed from his digestive tract. The progress notes indicated thaton March 24, 2008, he showed signs/ symptoms of pain as well as an elevated body temperature. After notifying his physicians, the facility took him back to the hospital on that day. Continued review of Nurse Progress Notes revealed that on April 7, 2008, Client #2 was diagnosed with cellulitis, for which he was prescribed Keflex (antibiotic) 500 mg by mouth every 6 hours for 7 days. Client #2's primary care physician documented having assessed him on March 27, 2008. At the time, the client was reported as "stable" and the doctor recommended "continue present treatment." However, interviews with the Qualified Mental Retardation Professional and the LPN on May 12, 2008, at approximately 10:40 AM, revealed that the client had been observed scratching the wound site after his return from the hospital. He then developed cellulitis (infection) at the wound site. They reported that the client had been physically restrained while in hospital (padded wrist restraints initially, then mittens) to prevent him from scratching the would site and/or	W 322	DON and Nurses will continue to as discharge plan of care in conjunction with hospital to ensure the integrity of wounds and surgical sites. In cases where mits and any restraints are deemed necessary HRC will convene prior to discharge to ensure continuity of care.	6/30/08 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	06/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETIO DATE
W 322	Continued From page 17 removing tubes. Review of the client's records earlier had not indicated a post-operative plan of care (to include preventing infection of wounds). Further interview with the LPN and QMRP confirmed that there had been no post-operative plan of care developed by the medical team to ensure the integrity of Client #2's surgical wound for proper healing. 2. The medical team failed to ensure that Client #2 received medications as prescribed, following his March 22, 2008 return home from the hospital, as indicated by the following: a. Cross-refer to W331.1.a. On March 22, 2008, Client #2 was prescribed Tylenol #3 with codeine. The telephone order was written as follows: "Tylenol #3 one or two tabs by mouth every 4 hours/pain." He had been released from the hospital that day, after having undergone surgery to remove foreign objects lodged in his digestive tract. At 10:25 AM, when asked about the Tylenol #3 order, the facility's LPN stated: "He never got that... he was never in that much pain... it was PRN for pain." She presented the blister pack of Tylenol #3 and all 30 tabs remained intact. However, review of his Nurse Progress Notes revealed that Client #2 did experience pain after the surgery. On March 24, 2008, at 9:00 AM, a nurse indicated that she had administered a medication (Tylenol, 500 mg) that did not correspond with that ordered by the primary care physician (Tylenol #3 with codeine) on March 22, 2008. b. Client #2's March 22, 2008 order for Tylenol #3 was not filled timely. The prescription was filled on March 24, 2008, 2 days after his return	W 322	**Nurses have been re-inserviced on medication protocol and medication administration DON and Charge LPN will ensure that all medication as given as per physician's order.** **DON and Charge Nurse will ensure as medication policy that all medications received from hospitalization or acute medical issues be filled immediately upon discharge from hospital/ acute care clinic to ensure timely receipt of medication prescribed.**	**6/13/08 and ongoing**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	06/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETION DATE
W 322	Continued From page 18 home from the hospital. c. Cross-refer to W331.2. Nursing staff failed to monitor Client #2 at the frequency prescribed by the primary care physician. Nurse Progress Notes indicated that Client #2's status was monitored by a nurse twice daily (at 7AM and 6PM) on March 22, 2008 and March 23, 2008, instead of every 4 hours as ordered. d. Cross-refer to W331.6. Nursing staff failed to follow Client #2's standing physician's orders for treatment of elevated body temperatures. A Nurse Progress Note dated March 26, 2008, indicated that a nurse administered"Tylenol 500 mg given as ordered" for an elevated body temperature (99.2 degrees). Client #2 had a pre-existing, ongoing order for Tylenol, 2 tabs at 325 mg each (650 mg dose) as needed for pain or elevated body temperature. 3. There was no evidence that a Registered Nurse (RN) was directly involved in the monitoring and oversight immediately following Client #2's return home from the hospital on March 22, 2008. There was no evidence that the deficient practices cited above (and in W331) had been identified by the facility's medical team prior to this survey.	W 322	**DON has circulated reminder memo to all RN and LPN that all individuals discharged from hospital must be seen by RN within 48 hours of discharge from hospital and orders are to be taken off the discharge and transcribed to the MAR and POF within the first 24 hours to ensure continuity of care and to ensure an example of this deficiency does not reoccur.**	6/13/08 and ongoing
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide nursing services in accordance with the clients' needs, for one of the three clients	W 331		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETIO DATE
W 331	Continued From page 19 In the sample. (Client #2) The findings include: 1. Nursing staff failed to ensure that Client #2 received post-operative pain relief medication in accordance with physician's orders, as follows: Cross-refer to W368.4. During the May 8, 2008 medication pass verification process, it was observed that Client #2 had been prescribed Tylenol #3 with codeine on March 22, 2008. The telephone order was written as follows: "Tylenol #3 one or two tabs by mouth every 4 hours/pain." The client had been released from the hospital that day, after having undergone surgery to remove foreign objects lodged in his digestive tract. At 10:25 AM, when asked about the Tylenol #3 order, the facility's LPN stated: "He never got that... he was never in that much pain... it was PRN for pain." She presented the blister pack of Tylenol #3 and all 30 tabs remained intact. a. However, at approximately 10:35 AM, review of Nurse Progress Notes revealed that Client #2 had experienced pain after the surgery. On March 24, 2008, at 9:00 AM, a nurse wrote: "Tylenol 500 mg given to <client's name> for pain as ordered." The medication indicated in the progress note (Tylenol) did not correspond with that ordered by the primary care physician (Tylenol #3) on March 22, 2008. b. Client #2's March 22, 2008 order for Tylenol #3 was not filled timely. The prescription was filled on March 24, 2008, 2 days after his return home from the hospital. c. Interviews and review of nursing and	W 331	**Cross reference and adopted with w-322.2a.** **Cross reference and adopted with w-322.2b.**	6/13/08 and ongoing 6/13/08 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETIO DATE
W 331	Continued From page 20 medication records revealed no evidence that Client #2 received Tylenol #3 with codeine every 4 hours in accordance with the handwritten telephone order dated March 22, 2008. 2. The facility failed to document having monitored Client #2 at the frequency indicated by the primary care physician, following his return home from hospital, as follows: As noted above, Client #2 had been prescribed Tylenol #3 with codeine on March 22, 2008. The telephone order was written as follows: "Tylenol #3 one or two tabs by mouth every 4 hours/pain." On May 9, 2008, at approximately 10:35 AM, review of Client #2's Nurse Progress Notes revealed that his status was monitored by a nurse twice daily (at 7AM and 6PM). No other documentation was evidenced to show that his condition was monitored every 4 hours as ordered.	W 331	Cross referenced and adopted with w-322.	6/30/08 and ongoing
	3. Cross-refer to W322. Nursing staff failed to ensure that the medical team developed and implemented a post-operative plan of care to ensure the integrity of Client #2's surgical wound for proper healing.		Cross referenced and adopted with w-322.	6/30/08 and ongoing
	4. Nursing staff failed to clarify a telephone order, as follows: a. On May 8, 2008, at approximately 9:29 AM, a handwritten telephone order was observed in Client #2's chart, as follows: "Tylenol #3 one or two tabs by mouth every 4 hours/pain." Interview with the LPN later that morning, at 10:25 AM, revealed that she thought the Tylenol #3 was to be administered only if needed:"He never got that... he was never in that much pain... it was		Cross referenced and adopted with w-322.	6/30/08 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETIO DATE
W 331	Continued From page 21 PRN for pain." The handwritten telephone order did not, however, state directly that it was to be as needed for pain. b. On May 9, 2008, at approximately 5:35 PM, review of Client #2's MARs revealed that the Tylenol #3 was added to his March 2008 MAR on March 24, 2008. The client's April 2008 MAR, however, did not reflect the Tylenol #3 (either handwritten or typed by the pharmacy). His May 2008 MAR did reflect Tylenol #3. 5. Nursing staff failed to document administrations of medications on client Medication Administration Records (MARs), in accordance with facility policies and standard nursing practices, as follows: Cross-refer to W368.4. On May 9, 2008, beginning at 8:15 AM, review of Client #2's Nurse Progress Notes revealed two instances (March 24, 2008 and March 26, 2008) when a medication nurse documented having administered Tylenol 500 mg but failed to record it on the client's Medication Administration Record (MAR), in accordance with facility policies and standard nursing practices. 6. Nursing staff failed to follow Client #2's standing physician's orders for treatment of elevated body temperatures, as follows: On May 9, 2008, at approximately 10:35 AM, review of Nurse Progress Notes revealed that on March 24, 2008, at 9:00 AM, a nurse wrote: "Tylenol 500 mg given to <client's name> for pain as ordered." At 4PM later that day, a nurse documented an elevated body temperature, for which he was ordered to return to the hospital.	W 331	**Medication Tylenol #3 was ordered post operatively im a timeframe therefore it will not be reflected on MAR outside stated period.** **Nurses were re-inserviced on Medication Administration Policy.** **DON, RN and Charge Nurse will monitor for compliance**	**6/13/08 and ongoing**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETIO DATE
W 331	Continued From page 22 Two days later, on March 26, 2008, at 7 AM, a medication nurse documented in a progress note: "Tylenol 500 mg given as ordered" for an elevated body temperature (99.2 degrees). Client #2 had a pre-existing, ongoing order for Tylenol, 2 tabs at 325 mg each (650 mg dose) as needed for pain or elevated body temperature. He did not, however, have an order for 500 mg Tylenol.	W 331	**Nurses have been inserviced on the importance of accurate documentation as it relates to Nursing Notes and Medication Administration.** **Cross referenced and adopted with w-331.6.**	**6/13/08 and ongoing**
W 365	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. This STANDARD is not met as evidenced by: Based on interview and record review, facility nursing staff failed to properly document the administration of medication for pain and/or elevated body temperatures, for one of the three clients in the sample. (Client #2) The findings include: Cross-refer to W331.6. Client #2's Nurse Progress Notes included entries dated March 24, 2008 and March 26, 2008 indicating:"Tylenol 500 mg given to <client's name> for..." either pain or an elevated body temperature. Subsequent review of his March 2008 Medication Administration Record (MAR), however, revealed that the nurse(s) who administered Tylenol on those dates failed to document it on the client's MAR .	W 365		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.	W 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETIO DATE
W 368	Continued From page 23 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that all medications were administered in accordance with physician's orders, for four of the five clients residing in the facility. (Clients #1, #2, #3 and #5) The findings include: The morning medication administration pass was observed on May 8, 2008, beginning at 7:18 AM. The following systemic deficiencies were identified: 1. Cross–refer to W369.1. Client #1 did not receive Beconase nasal spray in accordance with physician's orders, as follows: a. Client #1 did not receive nasal spray that morning. At 8:51 am, review of Client #1's current physician's orders (dated March 1, 2008) revealed that since August 18, 2003, the client had an order for Beconase AQ Nasal Spray 0.042%, 2 sprays in each nostril twice daily for allergies. b. At 10:15 AM, the facility's LPN retrieved a bottle of Beconase Nasal Spray from the medication cabinet. The label showed that it was for Client #1. The bottle, however, remained full, even though the prescription had been filled on October 15, 2007, over 6 months earlier. 2. Cross-refer to W369.2. Client #3 did not receive Nasonex nasal spray in accordance with his physician's orders. 3. Cross-refer to W369.3. Client #5 did not	W 368	**All nurses have been inserviced on 6/13/08 on medication administration protocol especially in the area of check - checking the MAR and ensuring that each medication involving ointments, drops, etc. are present and is given as per doctors' orders. DON, Charge Nurse will complete a weekly medication cabinet check to ensure all medications are signed off for is present and are accounted for and given as per regulations.**	6/30/08 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETION DATE
W 368	Continued From page 24 receive Mineral Oil ear drops in accordance with his physician's orders. 4. Cross-refer to W331.6. Nursing staff failed to follow Client #2's standing physician's orders for treatment of pain and/or elevated body temperatures.	W 368	**Cross referenced and adopted with w-331.6**	**3/30/08 and ongoing**
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that medications were administered as prescribed, for three of the five clients residing in the facility. (Clients #1, #3 and #5) The findings include: The morning medication administration pass was observed on May 8, 2008, beginning at 7:18 AM. The following errors were observed: 1. Client #1 did not receive Beconase nasal spray in accordance with physician's orders, as follows: Client #1 was administered his medications between 7:32 - 7:37 AM. At 7:38 AM, the medication nurse brought a bottle of mineral oil but upon further review of the client's Medication Administration Records (MARs), she announced that the mineral oil (ear drops) were not scheduled for that morning. A quick glance at the MAR revealed that Beconase nasal spray was	W 369	**Cross referenced and adopted with w-369.**	**3/30/08 and ongoing**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETION DATE
W 369	Continued From page 25 listed as a 6AM medication. The client did not receive nasal spray during this pass and the nurse went on to assist the next client. At 8:51 am, review of Client #1's current physician's orders (dated March 1, 2008) confirmed that since August 18, 2003, the client had an order for Beconase AQ Nasal Spray 0/042%, 2 sprays in each nostril twice daily for allergies. 2. Client #3 did not receive Nasonex nasal spray in accordance with his physician's orders, as follows: a. Client #3 was administered his medications between 8:10 - 8:12 AM. At 8:12 AM, the medication nurse squeezed 1 spray of Nasonex 50 mcg nasal spray into his left and right nostrils. The client, however, did not take in a breath at the appropriate moments when the nurse squeezed the nasal spray bottle. The nurse did not offer the client any instructions during this process. The spray liquid immediately dripped out of the client's nose and down to his upper lip. The nurse grabbed a paper towel and wiped the medication from his upper lip area. The nurse was not observed using effective means to ensure that Client #3 received his prescribed nasal spray. b. At approximately 9:32 AM, review of Client #3's current POs (dated March 1, 2008) revealed that he was to receive 2 sprays of Nasonex 50 mcg spray into each nostril every day for allergy symptoms. The nurse, however, had been observed administering only 1 spray into each nostril that morning. 3. Client #5 did not receive Mineral Oil ear drops in accordance with his physician's orders, as	W 369	Cross referenced and adopted with w-368. Cross referenced and adopted with w-368.	3/30/08 and ongoing 3/30/08 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETION DATE
W 369	Continued From page 26 follows: At 7:38 AM, the medication nurse presented a bottle of mineral oil while she was administering Client #1's medications. However, upon review of the client's Medication Administration Records (MARs), she announced that the mineral oil (ear drops) were not scheduled for that morning. The nurse then administered Clients #2, #3 and #5s' medications. After the entire medication pass had been completed, the nurse stated that the mineral oil presented earlier had not been for Client #1 after all. She stated that the bottle had been in his medication basket by error, and that the mineral oil was prescribed for Client #5's use "before ENT" appointments. At 9:37 AM, review of Client #5's current POs (dated March 1, 2008) revealed that beginning January 24, 2008, he was ordered "5 drops mineral oil each ear daily for cerumen removal." The Qualified Mental Retardation Professional (QMRP) was present at the time. She and this surveyor reviewed the client's POs, nursing monthly reviews and other medical records and could find no evidence that the mineral oil drops had been discontinued, or limited to "before ENT" appointments (as stated earlier by the medication nurse). At 10:09 AM, the facility's LPN was asked about the mineral oil. She reviewed the MARs for Clients #1 and #5 and did not find a current listing for the ear drops on either MAR. She did, however, confirm that mineral oil drops were listed on Client #5's current POs. She further indicated that she would seek clarification from the primary care physician regarding whether the oil should be administered daily or only during	W 369	**Cross referenced and adopted with w-368.**	**3/30/08 and ongoing**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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) COMPLETION DATE
W 369	Continued From page 27 days preceding an ENT appointment (as stated earlier by the medication nurse).	W 369		
W 393	483.460(n)(1) LABORATORY SERVICES If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure it met the requirements for performing glucose monitoring testing, for the one individual (out of five clients that reside in the facility) whose blood glucose was being tested by facility staff. (Client #1) The finding includes: During the May 8, 2008 medication pass verification process, it was observed that Client #1's March 1, 2008 physician's orders ("for 120 days") included an order for "fingerstick weekly before breakfast." At 8:58 AM, the Qualified Mental Retardation Professional (QMRP) confirmed that the client's blood sugar was tested in the facility weekly. When asked whether the facility had a current Clinical Laboratory Improvement Act (CLIA) certificate of waiver, the QMRP stated no; however, their Director of Nursing was "in the process of securing" one. On May 9, 2008, at approximately 4:45 PM, the QMRP presented a photocopy of a CLIA waiver application form, dated May 1, 2008. She then confirmed that to date, the facility remained without a certificate of waiver.	W 393	**Application for CLIA Licensure has been submitted awaiting approval certificate.**	7/30/08

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 05/12/2008
NAME OF PROVIDER OR SUPPLIER SYMBRAL	STREET ADDRESS, CITY, STATE, ZIP CODE 4422 20TH STREET, NE WASHINGTON, DC 20011		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	INITIAL COMMENTS A licensure survey was conducted from May 7, 2008 through May 12, 2008. A random sample of three residents was selected from a resident population of five men with various degrees of disabilities. In addition, a focused review was conducted of a fourth resident's behavior support plan and psychotropic medications. The findings of this survey were based on observations at the group home and at two day programs, interviews with one parent, day program and residential staff as well as the review of clinical and administrative records, including incident reports.	I 000		
I 002	3500.2 GENERAL PROVISIONS Each GHMRP licensee and residence director shall demonstrate that he or she understands that the provisions of D.C. Law 2-137, D.C. Code, Title 6, Chapter 19 govern the care and rights of mentally retarded persons in addition to this chapter. This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP licensee and residence director failed to demonstrate that he or she understood that the provisions of Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) govern the care and rights of mentally retarded persons. The findings include: 1. The facility failed to demonstrate protection of residents' rights to receive habilitation, care or both in accordance with their Individual Support Plans (ISPs) [Title 7, Chapter 13, § 7-1305.04(c),	I 002		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH STREET, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 002	Continued From page 1 formerly § 6-1964(c)], as follows: a. Cross-refer to I422.1. GHMRP staff failed to concistently provide Resident #1 verbal prompts or reminders to wipe his mouth and chin with a napkin during meals. b. Cross-refer to I422.2. GHMRP nursing staff failed to administer medications for treating pain and/or elevated body temperature in accordance with Resident #2's physician's orders c. Cross-refer to I422.3 and I422.4. GHMRP nursing staff failed to administer nasal sprays in acordance with Residents #1 and #3s' physician's orders. 3. The facility failed to demonstrate protection of Resident #2's rights by failing to inform his parents who petitioned for the commitment of an allegation of neglect and/or that their internal investigation substantiated that neglect had indeed occured [Title 7, Chapter 13, § 7-1305.10(e) and (f), formerly § 6-1970(e) and (f)], as follows: Cross-refer to I374. Resident #2 sustained an injury to his face after a fall to the floor in the facility on Friday, March 7, 2008. He was subsequently taken to a hospital emergency room. The exact cause of the fall was not indicated at that time and there was no mention of staff neglect. The facility documented having notified Resident #2's parents by telephone on the following day, Saturday, March 8, 2008, at 9:02 AM. The Qualified Mental Retardation Professional (QMRP) initiated an investigation on March 10, 2008. Later that evening, she reportedly informed her administrators that staff on duty at the time of the incident had left	I 002	Cross reference and adopted with w-159.2. Cross reference and adopted with w-322 #2a. Cross reference and adopted with w-368.	6/11/08 and ongoing 6/13/08 and ongoing 6/30/08 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH STREET, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 002	Continued From page 2 Resident #2 alone and unsupervised, even though he had been sedated earlier that day for a medical procedure, and she recommended further investigation. On March 26, 2008, the agency issued a final investigation report, based on the administrative investigation. That report concluded that staff had indeed been neglectful and recommended the termination of the 3 staff involved. Susbequent interview with Resident #2's mother by telephone, followed by additional interview with the QMRP revealed that to date: a. the facility had not informed his parents that on March 10, 2008 an allegation of staff neglect was made, with additional investigation recommended; and, b. the facility had not informed Resident #2's parents that their investigation had determined staff neglect, with recommendations to terminate the employment for the three staff on duty at the time that their son sustained his injuries. 4. The facility failed to demonstrate protection of residents' rights to have their personal records kept complete and current [Title 7, Chapter 13, § 7-1305.12, formerly § 6-1972], as follows: a. Cross-refer to I474. Based on interview and record review, facility nursing staff failed to properly document the administration of Resident #2's medication for pain and/or elevated body temperatures. b. Cross-refer to I379.2. Resident #2's day program nurse documented the following on an Inter-Agency Communication (IAC) form, dated January 11, 2008, that was sent to the residence: "12:30 PM... Called to men's bathroom... showed me <resident's name> undershorts.	I 002	A& B. QMRP in a telephone on 5/20/08 to parents of individual #2 communicated findings of neglect and implemented recommendation for termination of staff involved in incident on 3/7/08. Call has been documented in individuals POR book as dated above. A follow up letter was also faxed to this effect. QMRP, IMC and House Manager will ensure that parent /guardian is notified in a timely manner of are incidents involving individuals. Cross referenced and adopted with w-322, w-331 and I-474. Cross referenced and adopted with w-153 and I-379.2.	6/30/08 and ongoing 6/13/08 and ongoing 6/30/08 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH STREET, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 002	Continued From page 3 Approximately 2 inches by 1 1/2 inch area of blood noted on seat of underwear. Material not heavily saturated. Called group home, spoke with Nurse <LPN name>. Home will monitor for further episodes..." The residential nurse, however failed to document in the resident's record the telephone call received that day from the day program, and the IAC was not found in the resident's record during the survey.	I 002	Cross referenced and adopted with w-153.	6/12/08 and ongoing
I 062	3502.20 MEAL SERVICE / DINING AREAS Dishes and eating utensils shall be cleaned after each meal and stored to maintain their sanitary condition. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to store dishes in a manner that maintains proper sanitation. The findings include: On May 12, 2008, at approximately 3:00 PM, inspection of the kitchen cabinets revealed stacks of plastic drinking bowls and beverage tumblers. The Qualified Mental Retardation Professional, who was present at the time, indicated that the stacked bowls and cups were clean and ready for future use by the residents. Further inspection, however, revealed water that was trapped between the stacked bowls. In addition, beverage tumblers had been stored turned upside down, with water trapped inside and no air flow to allow for drying.	I 062	Staff has been re-inserviced on house-keeping with specific instructions relating to cleaning and storage of kitchen utensils, pots, pans, plates, glasses and bowls. QMRP, QA, House Manager will monitor for compliance.	6/13/08 and ongoing
I 082	3503.10 BEDROOMS AND BATHROOMS	I 082		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH STREET, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 082	Continued From page 4 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. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure that bathrooms were equipped with paper cup dispensers. The finding includes: On May 12, 2008, at approximately 2:45 PM, there was no paper cup dispenser (and no paper cups) observed in the bathroom located in Resident #3's bedroom.	I 082	Maintenance request was circulated to the maintenance department highlighting deficiencies as outlined on 6/7/08. A cup dispenser was placed in the bathroom located in individuals #3 bedroom on 6/11/08.	6/14/08
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to maintain the interior of the facility in a clean, orderly, and attractive manner. The finding includes: On May 12, 2008, beginning at 2:35 PM, inspection of the facility revealed that the caulking around the inner shower stall was either missing or cracked in the bathroom located nearest to the kitchen.	I 090	Caulking around the inner shower stall has been replaced on 6/11/08. Symbral will ensure as per Maintenance Repair Policy that all repairs are identified, reported and affected in a timely manner.	6/11/08 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH STREET, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 186	Continued From page 5	I 186		
I 186	3508.5(c) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following: (c) The categories and numbers of supportive and direct care staff; and... This Statute is not met as evidenced by: Based on review of the policy and procedures manual, the GHMRP failed to establish an organizational chart depicting the numbers of supportive and direct care staff. The finding includes: On May 12, 2008, at 2:31 PM, review of the organizational chart that was presented revealed that it did not indicate the number of supportive and direct care staff employed at this facility.	I 186	Symbral's organization chart were updated to reflect the number of direct care staffs employed at each of its facility.	6/13/08 and ongoing
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on review of personnel records that were made available, the GHMRP failed to document having discussed the contents of job descriptions with every employee at least annually. The findings include: On May 12, 2007, beginning at 12:08 PM, review of personnel records revealed no evidence of annual job description reviews for the following:	I 203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH STREET, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 203	Continued From page 6 1. House Manager; 2. 5 of the 14 direct support staff (S2, S5, S7, S12 and S13); and 3. There was no job description presented for direct support staff S11.	I 203	**Job description have been discussed with and signed off on by all staff.** **QMRP, QA as per employment policy will ensure that job description for all staffs are reviewed annually.**	**6/13/08 and ongoing**
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that all staff obtained annual health certificates/ inventories. The findings include: Review of the personnel records on May 12, 2008, beginning at 12:08 PM, revealed the following: 1. The health certificates/ inventories on file for 2 of the 14 direct support staff (S3 and S14) had expired in April 2008 and January 2008, respectively. 2. There were no health certificates/ inventories made available for review for 3 additional direct support staff (S11, S12 and S13).	I 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH STREET, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 206	Continued From page 7 3. The health certificate/ inventory on file for the consulting RN had expired in March 2008. 4. There was no personnel record (and therefore no health certificate) made available for review for the consulting podiatrist. This is a repeat deficiency. See licensure deficiency report dated June 26, 2007.	I 206	3 &4 Symbral has updated its consultant files to include the specified for documents for all consultants. QMRP and QA will monitor to ensure compliance as per personnel policy.	6/13/08 and ongoing
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on interview and review of personnel records made available, the GHMRP failed to ensure that all staff had received training in first aid and/or certification in Cardiopulmonary resuscitation (CPR), in accordance with agency policies. The findings include: On May 12, 2008, beginning at 12:08 PM, review of personnel files and staff in-service training records revealed the following: 1. There was no documented evidence of first aid training within the previous 3 years for 6 of the 14 direct support staff (S1, S3, S9, S11, S12 and S14). 2. There was no documented evidence of CPR certification for the House manager; and, 3. No documented evidence of CPR certification	I 227	1, 2 &3- A reminder memo was circulated to all staff that as per staff training policy a ninety-day, probationary period upon employment is the time frame in which all trainings are to be completed. Failure to comply will result in disciplinary action by employer. QMRP, QA will monitor for compliance to prevent another repeat deficiency.	6/11/08 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH STREET, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 227	Continued From page 8 for 9 of the 14 direct support staff (S1, S2, S4, S5, S6, S9, S11, S12 and S14). This is a repeat deficiency. See licensure deficiency report dated June 26, 2007.	I 227		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to document effective training on specialty areas related to resident safety and appropriate mealtime assistance. The findings include: 1. A driver, the House Manager and the Qualified Mental Retardation Professional (QMRP) documented having attended a March 12, 2008 training related to resident safety during transportation. However, the failure to properly secure residents with seat belts on the morning of May 8, 2008 indicated that said training had not been effective. [See Federal Deficiency Report - Citation W104.1] 2. There was no evidence that all staff who were employed at the time of a March 7, 2008 incident involving Resident #2 received additional training on the facility's incident management policies, as per the recommendations included in a March 26,	I 229	Cross referenced and adopted with w-104. Staff involved in incident on 3/7/08 involving individual #2 were issued termination letters on 4/5/08 as such were no longer employed at time of survey. All other staff has been inserviced on Symbral's Incident Management Policy.	6/10/08 and ongoing 6/10/08 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH STREET, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 229	Continued From page 9 2008 investigation report that substantiated staff neglect. [See Federal Deficiency Report - Citation W159.4] 3. Cross-refer to I422. Facility staff failed to provide Resident #1 with verbal prompts, or reminders, to wipe his mouth and chin while eating a meal, as reportedly instructed by the QMRP.	I 229	3. Cross referenced and adopted with w-159.2.	5/11/08 and ongoing
I 271	3513.1(b) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (b) Personnel records for all staff including job descriptions either at the GHMRP or in a central office and made available upon request; This Statute is not met as evidenced by: Based on record review, the GHMRP failed to provide evidence of personnel records for all staff. The finding includes: Review of the GHMRP's personnel files on May 12, 2008, beginning at 12:08 PM, revealed no evidence of a personnel record being maintained for one direct support staff person (S11).	I 271	Records for direct care staff were misfiled at the main office, as such were not available at the time of survey for review. Records have been filed appropriately, have been photocopied and are included as attachment. Secretary, QA will ensure that a repeat does not occur.	6/7/08 and ongoing
I 374	3519.5 EMERGENCIES After medical services have been secured, each GHMRP shall promptly notify the resident ' s guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident ' s status as	I 374		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH STREET, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 374	Continued From page 10 soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident. This Statute is not met as evidenced by: Based on interview and review of incident reports and resident records, the facility failed to ensure that all allegations of neglect were reported promptly to the resident's parents, followed by written documentation, for one of the three residents in the sample. (Resident #2) The finding includes: According to an incident report dated March 10, 2008, Resident #2 sustained an injury to his face after a fall to the floor in the facility on Friday, March 7, 2008. He was subsequently taken to a hospital emergency room. The exact cause of the fall was not indicated at that time and there was no mention of staff neglect. The facility documented having notified Resident #2's parents by telephone on the following day, Saturday, March 8, 2008, at 9:02 AM. On May 7, 2008, at 5:19 PM, interview with the Qualified Mental Retardation Professional (QMRP) revealed that she had initiated an investigation on March 10, 2008. She then met with the administrator and Incident Management Coordinator later that evening at their corporate office. She reportedly informed her administrators that staff on duty at the time of the incident had left Resident #2 alone and unsupervised, even though he had been sedated earlier that day for a medical procedure. The House Manager reportedly had given instructions to provide close supervision to the resident that afternoon. The QMRP further stated that she was "very upset" by her preliminary findings and	I 374		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH STREET, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 374	Continued From page 11 recommended the suspension of 3 staff, pending the outcome of a more thorough investigation. The QMRP documented her preliminary findings and recommendations in an Internal Investigation Summary, dated March 11, 2008. On March 26, 2008, the agency issued a final investigation report, based on the administrative investigation. That report concluded that staff had indeed been neglectful and recommended the termination of the 3 staff involved. Resident #2's mother was interviewed by telephone on May 9, 2008, beginning at 9:30 AM. She confirmed having received a telephone call on March 8, 2008. The person who called had informed her that he "fell out of bed." When asked if the circumstances of the fall had been investigated, she replied "They claimed that he fell out of bed... was taken to the ER... he had a bruise. I don't know anything else... he has never fallen out of his bed before." The mother indicated that she and Resident #2's father had not received any additional information, either by telephone or in writing, since the March 8, 2008 telephone call. When interviewed on May 12, 2008, at 11:00 AM, the QMRP acknowledged that to date, the facility: 1. had not sent written notification to the parents; and, 2. had not shared the investigative findings and recommendations with the parents.	I 374	Cross referenced and adopted with I-002.	6/30/08 and ongoing
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other	I 379		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH STREET, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 379	Continued From page 12 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 incident reports and resident records, the facility failed to ensure that all injuries of unknown origin and/or allegations of neglect were reported immediately to the Department of Health (DOH) in accordance with District law (22 DCMR, Chapter 35, Section 3519.10), for two of the three residents in the sample. (Residents #1 and #2) The findings include: 1. The facility failed to notify the Department of Health (DOH) immediately of an allegation of neglect, as follows: Incident records in the facility and at DOH consistently documented that on Monday, March 10, 2008, at approximately 1:31 PM, the facility notified DOH by telephone that on Friday, March 7, 2008, Resident #2 had sustained an injury to his face after a fall to the floor in the facility. He was subsequently taken to a hospital emergency room. The exact cause of the fall and injury was not stated over the telephone and there was no mention of staff neglect. An incident report was to follow. The March 7, 2008 incident report was submitted to the DOH on March 25, 2008. On May 7, 2008, at 5:19 PM, interview with the	I 379	Cross referenced and adopted with w-153.a.	6/8/08 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH STREET, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 379	Continued From page 13 Qualified Mental Retardation Professional (QMRP) revealed that she had initiated an investigation on March 10, 2008. She then met with the administrator and Incident Management Coordinator later that evening at their corporate office. She reportedly informed them that staff on duty at the time of the incident had left Resident #2 alone and unsupervised, even though he had been sedated earlier that day for a medical procedure. The House Manager reportedly had given instructions to provide close supervision to the resident that afternoon. The QMRP further stated that she was "very upset" by her preliminary findings and recommended the suspension of 3 staff, pending the outcome of a more thorough investigation. The facility did not, however, report the QMRP's March 10, 2008 allegation of neglect to the DOH. 2. The facility failed to notify the DOH of two recent incidents that posed a risk to resident health and safety, as follows: On May 7, 2008, at approximately 4:00 PM, interview with the Qualified Mental Retardation Professional (QMRP) revealed there had been no injuries of unknown origin reported within the past twelve months. Subsequent review of incident reports confirmed that neither of the two incidents that were reported (emergency room visits) were related to injuries of unknown origin. At 5:00 PM, the QMRP stated that according to their policies, every injury of unknown origin must be reported immediately to their administrator and investigated. a. Resident #2's day program quarterly report, dated February 11, 2008, indicated that staff had discovered blood in Resident #2's underwear. The day program nurse documented the following	I 379	Cross referenced and adopted with w-153.	6/30/08 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH STREET, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 379	Continued From page 14 on an Inter-Agency Communication (IAC) form, dated January 11, 2008: "12:30 PM... Called to men's bathroom... showed me <resident's name> undershorts. Approximately 2 inches by 1 1/2 inch area of blood noted on seat of underwear. Material not heavily saturated. Called group home, spoke with Nurse <LPN name>. Home will monitor for further episodes..." The cause of the bleeding was not noted on either the IAC or the quarterly report. There was no corresponding incident report. In addition, there was no evidence of the January 11, 2008 IAC in the resident's chart. It should be noted that on May 9, 2008, at approximately 7:10 AM, the facility's LPN stated that she recalled Resident #2 having blood in his underpants in January and said the appropriate documentation would be found in his medical records. However, on May 12, 2008, the LPN and QMRP both alleged that there had been feces, not blood, in the client's underpants. They further alleged that the day program nurse had reported what staff had described, without having made a direct visual observation. Client #2's record failed to show evidence that the client and/or his underpants were assessed in his residence on January 11, 2008 or that the QMRP had addressed this alleged discrepancy with the day program. b. On May 9, 2008, at approximately 7:58 AM, review of Resident #2's residential Nurse Progress Notes revealed a note dated December 26, 2007 in which the LPN documented having received a call from the House Manager (HM). The HM reported that the resident "was sent from the day program with a swollen nose." The LPN further documented "assessed this evening... nose remains swollen... ice pack applied..." The	I 379	**Serious Reportable Incidents occurring at Day Programs are to be reported by the Day Program. As such there was an oversight by the Provider.** **IMC has restated to QMRP that an internal investigation (within 5 days) as well as nurses preliminary summary (within 24 hours) re-reports of injuries of known and unknown origin must be completed in a documented format as per protocol.** **For incidents occurring a the Day Program, QMRP will document day program on form and follow up investigation at Day Program within 24 hours to 48 hours of occurrence. A copy of the Day Program report is to be secured by QMRP as soon as possible.** **If the Day Program investigation is not forwarded within ten days (10) days to the provider a case conference will be called by the residential provider.** **IMC, QMRP and QA will ensure that all such incidents occurring at Day Programs are reported toDOH, DCRA and DDS Case Manager within 24 hours of notification by Day Program.**	**6/30/08 and ongoing**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH STREET, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 379	Continued From page 15 cause of the swollen nose was not indicated. There was no evidence of a corresponding incident report and no evidence that this or the unexplained blood in the underpants were reported immediately to the Department of Health. This is a repeat deficiency. See licensure deficiency report dated June 26, 2007.	I 379		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to provide supports and services in accordance with residents' plans, for four of the five residents of the facility. (Residents #1, #2, #3 and #5). The findings include: 1. Facility staff failed to implement Resident #1's informal training 'program' (verbal reminders) to address mealtime hygiene and the use of table napkins, as follows: On May 8, 2008, beginning at 6:52 AM, Resident #1 was observed eating breakfast. While he ate waffles and syrup, food and syrup dribbled out of his mouth and onto his chin. At approximately 6:57 AM, staff observed his chin and asked him to wipe his mouth. He immediately did so, in response to the reminder. Minutes later, however, he began eating a bowl of cold cereal with a spoon. He ate quickly. Throughout the process, milk dripped from his mouth, down his	I 422	Cross reference and adopted with w-159.2.	6/11/08 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH STREET, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 422	Continued From page 16 chin and neck and eventually went underneath his shirt. Staff walked in and out of the dining room; however, no one intervened. At approximately 7:01 AM, he picked up the bowl and began drinking from it. For the next minute or two, a significant amount of milk spilled down his neck, chin and underneath his shirt. At 7:04 AM, he was observed eating canned peaches. Milk remained visible on his chin and neck. Staff did not intervene and at 8:18 AM, Resident #1 was observed leaving the facility for day program wearing the same shirt he had worn through the breakfast meal. Similar observations were made later that day at dinner, beginning at approximately 6:00 PM. At 6:15 PM, Resident #1 was observed drooling continuously as he ate a burger and french fries. For at least 5 minutes, there were no staff present in the dining room. The resident was not observed initiating the use of his napkin. Food and drool remained on his chin, without staff intervention. On May 12, 2008, at approximately 9:25 AM, the Qualified Mental Retardation Professional (QMRP) stated she was "not sure" whether his training needs in that area had been assessed. She did, however, say she had instructed staff to "provide napkins for all individuals" and provide a "verbal prompt with physical gesture" to Resident #1. Observations at two meals on May 8, 2008, however, revealed that staff did not consistently provide him the needed verbal prompt. 2. Nursing staff failed to follow Resident #2's standing physician's orders for treatment of pain and/or elevated body temperatures, as follows: On May 9, 2008, at approximately 10:35 AM, review of Nurse Progress Notes revealed that on March 24, 2008, at 9:00 AM, a nurse wrote:	I 422		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH STREET, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 422	Continued From page 17 "Tylenol 500 mg given to <resident's name> for pain as ordered." At 4PM later that day, a nurse documented an elevated body temperature, for which he was ordered to return to the hospital. Two days later, on March 26, 2008, at 7 AM, a medication nurse documented in a progress note: "Tylenol 500 mg given as ordered" for an elevated body temperature (99.2 degrees). Resident #2 had a pre-existing, ongoing order for Tylenol, 2 tabs at 325 mg each (650 mg dose) as needed for pain or elevated body temperature. He did not, however, have an order for 500 mg Tylenol. 3. Resident #1 did not receive Beconase nasal spray in accordance with physician's orders, as follows: Resident #1 was administered his medications between 7:32 - 7:37 AM. At 7:38 AM, the medication nurse brought a bottle of mineral oil but upon further review of the resident's Medication Administration Records (MARs), she announced that the mineral oil (ear drops) were not scheduled for that morning. A quick glance at the MAR revealed that Beconase nasal spray was listed as a 6AM medication. The resident did not, however, receive nasal spray during this pass and the nurse went on to assist the next resident. At 8:51 am, review of Resident #1's current physician's orders (dated March 1, 2008) confirmed that since August 18, 2003, the resident had an order for Beconase AQ Nasal Spray 0/042%, 2 sprays in each nostril twice daily for allergies. 4. Resident #3 did not receive Nasonex nasal spray in accordance with his physician's orders, as follows:	I 422	Cross reference and adopted with w-331.6.	6/13/08 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH STREET, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 422	Continued From page 18 a. Resident #3 was administered his medications between 8:10 - 8:12 AM. At 8:12 AM, the medication nurse squeezed 1 spray of Nasonex 50 mcg nasal spray into his left and right nostrils. The resident, however, did not take in a breath at the appropriate moments when the nurse squeezed the nasal spray bottle. The nurse did not offer the resident any instructions during this process. The spray liquid immediately dripped out of the resident's nose and down to his upper lip. The nurse grabbed a paper towel and wiped the medication from his upper lip area. The nurse was not observed using effective means to ensure that Resident #3 received his prescribed nasal spray. b. At approximately 9:32 AM, review of Resident #3's current POs (dated March 1, 2008) revealed that he was to receive 2 sprays of Nasonex 50 mcg spray into each nostril every day for allergy symptoms. The nurse, however, had been observed administering only 1 spray into each nostril that morning. 5. Facility nurses failed to implement Resident #2's informal 'program' to participate in applying topical creams/ lotions, as follows: During the May 8, 2008 morning medication pass, at 7:57 AM, the nurse poured a glass of water and then stirred thickener into it. She then removed Resident #2's medications from blister packs. At 8:04 AM, the nurse handed him the cup with medications and he placed them in his mouth. She then handed him the cup of water and he drank. That was the extent to which he was involved in the process. On May 12, 2008, at 9:15 AM, interview with the QMRP revealed that Resident #2 was without a	I 422	I-422 A and B. Cross reference and adopted with w-369.	3/30/08 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH STREET, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 422	Continued From page 19 self-medication training program. Later that day, at 4:38 PM, review of Resident #2's self-medication assessment, dated August 5, 2007, revealed that he "responds correctly to simple questions." There were no other skills or abilities indicated. The nurse who completed the assessment indicated that he was not approved for a training program "due to cognitive impairment." The nurse did, however, recommend that he take the cup from the nurse (which he was observed doing), "swallow water with one prompt" (which he did without any prompts), and "participate in application of topicals." Interviews with the LPN and QMRP, however, revealed no evidence that Resident #2 participated in applying topicals.	I 422	Individual has no topical. See POF as such there is no programming.	6/12/08
I 474	3522.5 MEDICATIONS Each GHMRP shall maintain an individual medication administration record for each resident. This Statute is not met as evidenced by: Based on interview and record review, facility nursing staff failed to properly document the administration of medication for pain and/or elevated body temperatures, for one of the three residents in the sample. (Resident #2) The findings include: On May 9, 2008, at approximately 10:35 AM, review of Resident #2's Nurse Progress Notes revealed that on March 24, 2008, at 9:00 AM, a nurse wrote: "Tylenol 500 mg given to <resident's name> for pain as ordered." At 4PM later that day, a nurse documented an elevated body temperature, for which he was ordered to return to the hospital. Two days later, on March 26,	I 474		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH STREET, NE WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 474	Continued From page 20 2008, at 7 AM, a medication nurse documented in a progress note: "Tylenol 500 mg given as ordered" for an elevated body temperature (99.2 degrees). Subsequent review of his March 2008 Medication Administration Record (MAR), however, revealed that the nurse(s) who administered Tylenol on those dates failed to document it on the resident's MAR . It should be noted that Resident #2 had a pre-existing, ongoing order for Tylenol, 2 tabs at 325 mg each (650 mg dose) as needed for pain or elevated body temperature, not 500 mg. There was no evidence that the facility's medical team had identified the discrepancy prior to this survey.	I 474	Cross referenced and adopted with w-322 and w-331.	6/13/08 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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
R 000	INITIAL COMMENTS A licensure survey was conducted from May 7, 2008 through May 12, 2008. A random sample of three residents was selected from a resident population of five men with various degrees of disabilities. In addition, a focused review was conducted of a fourth resident's behavior support plan and psychotropic medications. The findings of this survey were based on observations at the group home and at two day programs, interviews with one parent, day program and residential staff as well as the review of clinical and administrative records, including incident reports.	R 000		
R 122	4701.2 BACKGROUND CHECK REQUIREMENT Except as provided in section 4701.6, each facility shall obtain a criminal background check, and shall either obtain or conduct a check of the District of Columbia Nurse Aide Abuse Registry, before employing or using the contract services of an unlicensed person. This Statute is not met as evidenced by: Based on the review of personnel records, the GHMRP failed to ensure or obtain criminal background checks prior to employing unlicensed persons. The findings include: Review of the personnel files on May 12, 2008, beginning at 12:08 PM, revealed no evidence of any criminal background checks for 3 of the 14 direct support staff (S8, S10 and S11).	R 122	Symbral will ensure that personnel files are updated and kept in reference in Criminal Background Checks. House Manager will ensure that within 5 business days of receiving a new staff that all required documents are on file. House Manager will inform QA of new staff admission to residential site. QA will audit files quarterly and provide QMRP and administration copies of audit for corrective action within 10 days.	6/30/08
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or	R 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	05/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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
R 125	Continued From page 1 contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of personnel records, the GHMRP failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions in which the employees had worked or resided within the seven (7) years prior to the check. The findings include: Review of the personnel files on May 12, 2008, beginning at 12:08 PM, revealed no evidence of comprehensive criminal background checks for the recently-hired Qualified Mental Retardation Professional (QMRP) and 7 of the 14 direct support staff, as follows: QMRP - A DC check was documented; however, she lived in Maryland. S1 - A DC check was documented; however, he lived in Maryland. S5 - A MD check was documented; however, she worked in DC from September 2004 until her January 2007 application with Symbral. S7 - A DC check was documented; however, he lived in Maryland. S8 - There was no evidence of a criminal background check. S9 - A MD check was documented; however, she	R 125	Cross reference and adopted with R-122.	6/30/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G174	A. BUILDING _____ B. WING _____	06/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	4422 20TH 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
R 125	Continued From page 2 worked in Ohio from June 2007 until January 2008. S10 - A February 28, 2008 application for a DC check was documented; the results, however, were not indicated. In addition, his March 4, 2008 application indicated that he lived and had worked in Maryland. There was no evidence, however, of a background check for Maryland S11 - There was no personnel record made available for review for this employee; therefore, there was no documented evidence of a criminal background check. This is a repeat deficiency. See licensure deficiency report dated June 26, 2007.	R 125		