

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

PRINTED: 12/29/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/08/2009
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NAME OF PROVIDER OR SUPPLIER SYMBRAL FOUNDATION	STREET ADDRESS, CITY, STATE, ZIP CODE 4422 20TH STREET, NE WASHINGTON, DC 20011
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W 000	<p>INITIAL COMMENTS</p> <p>On November 9, 2009, the provider notified the State Agency (SA) of an allegation of neglect based on an October 31, 2009 "monitoring visit" by a nurse consultant with the Universal Legal Services (ULS). Individuals' lunches that were served in the facility that day (Saturday) reportedly had not been served in the form and texture prescribed in their mealtime protocols. In addition to the allegation, the facility submitted four client-specific memoranda dated November 6, 2009 in which they outlined corrective measures taken to address the allegations, including immediate in-service training of all staff, as well as "QA monitoring at mealtimes at least three times per week or as needed for the next 90 days."</p> <p>On November 24, 2009, the SA received a copy of the ULS nurse consultant's report (dated November 4, 2009) via e-mail from Department on Disability Services (DDS). In the report, the nurse alleged having observed the following significant deficiencies:</p> <ul style="list-style-type: none"> (1) Clients' mealtime protocols were not being implemented as ordered. (2) Staff were not adequately familiar with clients' significant health risks. (3) Documentation in the clients' medical records did not adequately address clinical issues. (4) Staff were not familiar with and/or implementing clients' behavior support plans. (5) Staff had minimal meaningful interactions with clients during the 4-hour observation period. 	W 000	<p>Symbtral's governing body will implement corrective and preventative strategies to remedy observations 1-6 by the University Legal Services Monitor 10/31/09 and items a-f cited by Department of Health on 12/8/09.</p> <p>Proactive measures will be developed and staff re-training implemented and monitored by QMRP, DON and QA to ensure compliance.</p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p> <p><i>Received 1/12/10</i></p>	1/14/2010 and ongoing
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>[Signature]</i>	DATE 1/13/10
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 000	<p>Continued From page 1</p> <p>(6) Clients were not receiving needed dental treatment.</p> <p>The SA initiated an onsite investigation on December 7, 2009. The findings of the investigation were based on observations in the group home, interviews with the facility staff, and review of facility's records, including unusual incident reports, clinical, and administrative records. Five of the six allegations were substantiated and the remaining allegation was partially substantiated, as follows:</p> <p>(a) The facility failed to ensure that staff demonstrated competency in implementing Client #1's mealtime protocol (beverages not thickened to a honey consistency).</p> <p>(b) The facility documented having provided staff in-service training regarding clients' health management care plans on November 3, 2009, which was 3 days after the nurse consultant's visit.</p> <p>(c) Facility nurses failed to establish a Fall Precautions protocol or guidelines to address Client #3's osteopenia, and the primary care physician failed to address Client #1's most recent cardiovascular medical consultation findings (uncontrolled hypertension).</p> <p>(d) Facility staff failed to demonstrate the skills and techniques necessary to implement Client #1's and Client #4's behavior support plans.</p> <p>(e) Staff failed to implement proactive behavior support strategies to ensure that Clients #1 and #4 received continuous active treatment.</p>	W 000	<p>JAN 1 2 2010</p> <p>Staff received training on Meal Time Protocol Diet Texture for all individuals on the following dates: 1/10/08, 10/5/09, 11/3/09, 11/4/09, 11/19/09, 12/31/09.</p> <p>Additional training (staff training on diet texture was implemented by LaSandra, SLP from DCHRP on 1/11/10.</p> <p>Walking Protocol was established by physical therapist on 12/29/09 visit of individual #3 in addition to walking protocol implemented by PT on 12/29/09, Nursing and QMRP have establish other guidelines to ensure prevention of fall. All staff were trained on the same.</p> <p>Symbal's QMRP, DON, Speech and Language Therapist, LPN Case Manager and House Manager will ensure that scheduled training on diet texture / meal time protocols are done quarterly and as needed.</p>	<p>1/14/10</p> <p>1/14/10 and ongoing</p>
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W 000	Continued From page 2 (f) The facility failed to ensure timely comprehensive dental services for Clients #1 and #3.	W 000		
W 100	<p>Based on the findings, the facility was found not to be in compliance with the Condition of Participation in Active Treatment.</p> <p>440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS</p> <p>"Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if:</p> <p>(1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions;</p> <p>(2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and</p> <p>(3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to meet the Condition of Participation in Active Treatment for two of the five clients residing in the facility.</p> <p>The finding includes:</p> <p>The facility failed to ensure that Clients #1 and Client #4 received continuous, aggressive active treatment programming and services. [See</p>	W 100	Crossed referenced and adopted with W195, W196 and W249.	1/14/10 and ongoing

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W 100	Continued From page 3 W195, W196 and W249]	W 100		
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.	W 114	A letter was forwarded to PCP concerning proper documentation and dating of the records reviewed and orders given. The Nursing staff received training on medical record documentation on 1/05/2010. Additional training is scheduled for 1/20/10 to be given by Kim Chavis, RN from DCHRP. DON will perform quarterly and random monitoring to ensure compliance.	1/20/10
	<p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all entries in clients' records were signed and/or dated, for two of the five clients in the sample. (Clients #1 and #3)</p> <p>The findings include:</p> <p>1. On December 7, 2009 beginning at 11:25 a.m., review of Client #1's medical records revealed the client had several telephone orders that had been signed but not dated by the facility's Primary Care Physician (PCP) as documented below:</p> <p>On June 25, 2009, the PCP ordered via telephone Xanax 1 mg for audiological appointment scheduled for June 30, 2009, one hour prior to appointment;</p> <p>On June 25, 2009, the PCP ordered via telephone Xanax 1 mg by mouth one time dose for dental appointment scheduled for July 14, 2009;</p> <p>On May 4, 2009, the PCP ordered via telephone Debrox drops, five drops to each ear once a day for seven days, beginning of each month;</p> <p>On May 13, 2009, the PCP ordered via telephone to discontinue previous order of Cogentin 2 mg, twice a day and begin Cogentin 2 mg once daily (every morning);</p>		<p>Random monitoring of individual records will be performed by the QA team. Symbal has included additional nursing personnel to the QA team to conduct deficiency monitor and provide remedying interventions.</p>	

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W 114	<p>Continued From page 4</p> <p>On April 30, 2009, the PCP ordered via telephone Xanax 1 mg one dose for ENT appointment scheduled for May 4, 2009; and</p> <p>On April 30, 2009, the PCP ordered via telephone Xanax 1 mg one dose for dental appointment scheduled for May 13, 2009.</p> <p>Interview with the facility's nurse (LPN #1) on December 7, 2009, at approximately 12:10 p.m. failed to provide an explanation as to why the physician had not dated the orders.</p> <p>2. On December 7, 2009, at 11:09 a.m., review of Client #3's medical chart revealed that a medication nurse (LPN #2) who administered Lorazepam 2 mg for sedation prior to a June 16, 2009 dental appointment failed to place her signature on the Controlled Medication Utilization Record (CMUR) form. The name of the medication, date, time and dosage had all been documented; only the signature was missing. [Note: LPN #2's initials were on the client's June 2009 Medication Administration Record (MAR), documenting administration of the Lorazepam at 8:30 a.m.]</p> <p>3. On December 7, 2009 at approximately 10:45 a.m., review of a consent form in Client #3's record revealed that the date had been changed from May 7, 2009 to May 20, 2009. Instead of drawing a line through the date (a strike-through), someone had written 20 over the 7. Whoever changed the document failed to provide their initials/signature or note the date on which they made the alteration. Similarly, at 11:07 a.m., review of a CMUR form dated May 20, 2009 revealed that whoever changed the 7:30 a.m.</p>	W 114	<p>A letter was forwarded to PCP on 1/09/2010 concerning proper documentation and dating of the records reviewed and orders given. The Nursing staff received training on medical record documentation on 1/05/2010. Additional training is scheduled for 1/20/10 to be given by Kim Chavis, RN from DCHRP. DON will perform quarterly and random monitoring to ensure compliance.</p> <p>Random monitoring of individual records will be performed by the QA team. Symbal has included additional nursing personnel to the QA team to conduct deficiency monitor and provide remedying interventions.</p>	1/20/10 and on-going
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W 114	<p>Continued From page 5</p> <p>administration time (Lorazepam 1 mg for sedation) to 9:30 a.m. for Client #3 had not initialed/signed or dated this alteration.</p> <p>4. At approximately 11:35 a.m., further review of Client #3's Medication Administration Record (MAR) for May 2009 revealed that the medication nurse (LPN#2) who administered the Lorazepam 1 mg on May 20, 2009 did not document the time that she administered it. On the back of the same form, however, there was handwriting using a different style and with a different pen that had documented the 9:30 a.m. administration of Lorazepam on May 20, 2009.</p> <p>5. At approximately 12:00 p.m., the facility nurse (LPN #1) was interviewed regarding the MARs and CMURs. She stated that she, not LPN #2, had written the information on the June 16, 2009 CMUR. Upon review of the blank signature space, she acknowledged that LPN #2 should have signed it after administering the 2 mg Lorazepam that day. She acknowledged that she, not LPN #2, had written the 9:30 a.m. documentation on the back of Client #3's May 2009 MAR. She did not, however, volunteer the name of whoever had changed the administration time (7:30 a.m. became 9:30 a.m.) on his May 20, 2009 CMUR.</p> <p>6. Review of Client #1's medical record on December 7, 2009 at approximately 11:45 a.m., revealed a Health Management Care Plan dated August 7, 2009. Further review of the HMCP revealed no signature of who had developed/completed the HMCP.</p>	W 114	<p>HMCP for individual #1 was redeveloped with updates by current RN on 12/14/09. (Copy attached)</p>	1/20/10
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and	W 193		

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W 193	<p>Continued From page 6</p> <p>techniques necessary to administer interventions to manage the inappropriate behavior of clients.</p> <p>This STANDARD is not met as evidenced by: Based on observations, staff interview and record verification, the facility's staff failed to demonstrate the skills and techniques necessary to implement each client's behavior support plan (BSP), for two of the five clients in the sample. (Clients #1 and #4)</p> <p>The findings include:</p> <p>1. Cross-refer to W196.1. During evening observations on December 7, 2009, from 5:20 p.m. until 5:55 p.m., and from 6:15 p.m. until 6:40 p.m., Client #1 was observed pacing throughout the facility. Although his 1:1 support staff was observed within close proximity of the client at all times, the staff failed to implement the proactive treatment strategies that were outlined in the client's BSP.</p> <p>Review of the staff training records on December 8, 2009, at approximately 10:30 a.m., revealed that all staff had received training for Client #1's BSP on November 5, 2009. Observations on December 7, 2009, however, indicated that the training had not been effective.</p> <p>2. Cross-refer to W196.2 and W252. Similarly, observations of the direct support staff working with Client #4 revealed that they had not received effective training regarding the proactive strategies outlined in his BSP, as follows:</p> <p>Observations on December 7, 2009, revealed Client #4 was not presented with a variable</p>	W 193	<p>All staff(s) were re-trained on 1/08/10 BSP implementation with focus on appropriate intervention strategies when a behavior occurs and the proper use of reinforcers using a variable interval schedule for individuals with BSP's.</p> <p>A BSP implementation / best practices guide was developed. This tool will be use as a quick reference for staff to intervene and re-direct the individuals challenging behaviors. (see attached)</p>	1/08/10 and ongoing

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W 193	Continued From page 7 schedule of structured activities between the time he finished breakfast (7:25 a.m.) and when he prepared to leave for day program (8:43 a.m.). The BSP called for there to be a variable schedule, to keep him actively engaged. Staff did not stay close to Client #4 to prevent maladaptive behaviors such as pica and touching his private parts. Contrary to the BSP instructions, staff told Client #4 to stop doing a maladaptive behavior (touching himself) without subsequent instruction to place his hands in his lap or by his sides. Staff did not ask or instruct him to perform any tasks or otherwise engage him in meaningful activities. While seated, the client repeatedly put his left hand down his pants and kept it there while fondling his private parts when staff were not present. When staff did observe him touching his privates, they sometimes failed to ask him to move his hands to an appropriate activity. Later, review of his behavior data sheets revealed that staff failed to document the maladaptive behaviors they had observed, as required in the BSP.	W 193	Staff will use the BSP implementation / best practices guide to provide variable schedule as outlined in BSP during gaps in scheduled activities to help minimize frequency of target behaviors. Psychologist will do random monitoring at least once per month for the next 6 months, QMRP, QA and or House Manager will monitor daily for the next 30 days weekly for another 30 days and randomly and on going to ensure compliance.	1/14/10 and ongoing
W 194	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure staff demonstrated competency in implementing clients' mealtime protocols, for one of the five clients in the sample. (Client #1) The findings include:	W 194		

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W 194	<p>Continued From page 8</p> <p>During breakfast observations on December 7, 2009, at approximately 7:20 a.m., a direct care staff was observed adding two tablespoons of Thick & Easy thickener to Client #1's glass of orange juice. The staff stirred in the thickening powder and immediately handed the glass of juice to the client. He used the same procedure when adding thickener to Client #1's glass of milk. Neither beverage had begun to thicken before the client gulped it down quickly. Client #1's physician's orders dated September 1, 2009, and Individual Support Plan dated August 7, 2009, revealed that all beverages offered to him should have a nectar consistency.</p> <p>Later that day, at approximately 3:30 p.m., the facility nurse (LPN #1) and the house manager (HM) were interviewed in the kitchen. LPN #1 stated that staff should stir in the Thick & Easy and then wait at least 3 minutes before giving the beverage to the client. She further indicated that it might take a little longer than 3 minutes if beverage is cold. They acknowledged that Client #1 often drinks quickly. The HM said she found that combining a verbal directive for him to "slow down" while touching his hand and glass to physically slow his pace was effective for her. [Note: This was not reflected on his Mealtime Protocol dated November 18, 2008.]</p> <p>Subsequent review of the staff in-service training records, on December 8, 2009, at 2:00 p.m. revealed that the staff person observed that morning had received training on November 5, 2009. Observations, however, revealed that the training had not been effective.</p>	W 194	<p>Meal Time protocol was updated on 12/31/09 giving specific directions as to time span between mixing of thickener by staff and drinking of liquid by individual.</p> <p>Staff (s) were retrained on updated meal time protocol on 12/31/09.</p> <p>Speech and Language Therapist, QMRP, QA, LPN Case Manager and or House Manager will monitor for the next 90 days, 30 days daily and weekly and random monitoring for the next 60 days to ensure compliance. If any inconsistency is noted at any monitoring, instant re-training and or disciplinary action will be implemented.</p>	12/31/09 and ongoing
W 195	483.440 ACTIVE TREATMENT SERVICES	W 195		

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W 195	<p>Continued From page 9</p> <p>The facility must ensure that specific active treatment services requirements are met.</p> <p>This CONDITION is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to provide continuous and aggressive active treatment services, including 1:1 staff supervision and support, as prescribed to manage client behaviors [See W196]; failed to implement client training programs as recommended by their interdisciplinary teams [See W249]; failed to ensure that staff were adequately trained [See W193 and W194]; and failed to ensure accurate and consistent program data for each clients' formal programs [See W252].</p> <p>The effects of these systemic practices results in the failure of the facility to provide active treatment services.</p>	W 195	Crossed referenced and adopted with W196, W249, W193, W194 and W252.	1/14/10 and ongoing
W 196	<p>483.440(a)(1) ACTIVE TREATMENT</p> <p>Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward:</p> <p>(i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and</p> <p>(ii) The prevention or deceleration of regression or loss of current optimal functional status.</p> <p>This STANDARD is not met as evidenced by:</p>	W 196		

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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 C 12/08/2009
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NAME OF PROVIDER OR SUPPLIER SYMBRAL FOUNDATION	STREET ADDRESS, CITY, STATE, ZIP CODE 4422 20TH STREET, NE WASHINGTON, DC 20011
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W 196	<p>Continued From page 10</p> <p>Based on observation, interview and record review, facility staff failed to implement clients' behavior support plans (BSPs) as written, to include proactive strategies, thereby failing to provide continuous active treatment, for two of the five clients in the facility. (Clients #1 and #4)</p> <p>The findings include:</p> <p>1. During evening observations on December 7, 2009, from 5:20 p.m. until 5:55 p.m., Client #1 was observed pacing from the living room, through the kitchen and into the dining room, repeatedly. At 5:58 p.m., the client was observed eating dinner. After the client completed his dinner at 6:15 p.m., he continued to pace throughout the facility for the next 25 minutes. The one to one support staff was observed within close proximity of the client at all times.</p> <p>Interview with the 1:1 staff on December 7, 2009, at approximately 6:25 p.m. revealed that Client #1 had a BSP to address his pacing behaviors. Record review on December 8, 2009, at approximately 9:30 a.m., revealed Client #1's BSP dated May 19, 2009. The BSP recommended the following proactive treatment strategies:</p> <ul style="list-style-type: none"> - Provide a variable interval schedule of reinforcement of target behaviors (following directions, sensitivity to others around him; appropriate task performance and good posture); - Provide specific praise every 15 minutes; - Provide the client with regular scheduled structured activities; and 	W 196	<p>Staff (s) were re-trained on 1/8/10 BSP implementation and using the BSP Implementation Guide.</p> <p>Psychologist will monitor monthly, QMRP, House Manager and QA Team will monitor daily for the next 30 days, weekly and randomly for the next 60 days to provide oversight.</p>	1/08/10 and ongoing
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W 196	<p>Continued From page 11</p> <p>- Engage the client in a minimum of one activity every 15 minutes.</p> <p>The aforementioned interventions were not implemented when Client #1 was observed repeatedly pacing throughout the facility from 5:20 p.m. until 5:55 p.m and from 6:15 p.m. until 6:40 p.m.</p> <p>2. Client #4 was observed in his home on December 7, 2009 between 7:18 a.m. - 8:45 a.m. He finished his breakfast at approximately 7:25 a.m., walked into the living room and sat on the love seat. Client #4 sat on the love seat from 7:25 a.m. - 8:45 a.m. At 7:56 a.m., interview with two male direct support staff in the living room revealed that one of them was Client #4's designated 1:1 staff. He had been employed in the facility approximately 3 months. During this 85-minute observation period, facility staff failed to implement proactive/ preventive as well as intervention strategies as outlined in the client's behavior support plan (BSP), as follows:</p> <p>a. At approximately 7:35 a.m., Client #4 was observed smiling while he leaned against his designated 1:1 staff (both were seated on the love seat). The client's hand was down his pants and he was touching his private parts. The 1:1 staff, however, did not intervene.</p> <p>b. Later on, at approximately 8:00 a.m., Client #4's 1:1 left the living room for approximately one minute. When he returned, he sat down next to the client again. At that moment, the client removed his left hand from down his pants, began vocalizing and bit down onto his right hand. He asked the client to stop and he complied. The staff, however, did not make any other requests</p>	W 196	<p>(A-N) Symbal has been providing unfunded additional staffing support to individual #4. Symbal has made submission to MAA to approve funding QMRP and DDS Service Coordinator are working to update MAA with additional information to obtain funding approval for an assigned one on one staffing.</p> <p>However in light of the unsuccessful effort to utilize shared staffing support Symbal will implement an assigned one on one staffing for individual #4 pending approval</p> <p>Symbal will ensure that one on one staff receive training in program implementation and intervention.</p> <p>A protocol will be developed that will direct the one on one staff to have BSP data collection sheet and enter data within five minutes after intervention (see attached)</p>	1/14/10 and ongoing
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W 196	<p>Continued From page 12</p> <p>or suggest a meaningful activity involving his hands. For the 36 minutes between 7:25 a.m. and 8:01 a.m., the client remained seated on the love seat with no scheduled activity.</p> <p>c. At approximately 8:05 a.m., Client #4's 1:1 staff left the living room. The client immediately left his seat, walked quickly to the dining room, reached under the table and then returned to the love seat while chewing on something briefly. It had appeared as if he had picked up something white from the floor underneath the table where Client #3 had been eating his breakfast earlier. Within less than a minute, the client stopped chewing and then swallowed before any staff returned to the room. Client #5 and this surveyor were the only persons in the area to witness the behavior. [Note: Later that day, Client #5 was observed with a balled-up white paper napkin at his place setting at dinner.]</p> <p>d. The 1:1 returned to the living room at approximately 8:10 a.m.. Client #4 had his hands down his pants stimulating himself while seated on the love seat. The 1:1, however, left the living room again without intervening.</p> <p>e. During this same period, the second male staff person was seated at the dining room table, approximately 15 feet away from Client #4. He had been employed for approximately 2 years. At 8:15 a.m., he observed the client fondling himself. He instructed him to remove his hands from his pants, and the client complied. The staff, however said nothing more to him. The staff then informed this surveyor that Client #4 "always puts his hands" down his pants. Immediately, Client #4 made a squealing vocalization and bit down on his right hand. The staff person called the client's</p>	W 196			

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W 196	<p>Continued From page 13</p> <p>first name, said nothing else and then left the area.</p> <p>f. At the same time that the other staff left the area, Client #4's 1:1 staff returned to the living room and saw him fondling himself. He asked him to remove his hand and he did. The staff adjusted the client's shirt and as the staff stood up, the client put his left hand back down his pants. The 1:1 staff again told him to stop, and then walked to the far end of the dining room table. He began entering data in Client #4's book. Meanwhile, Client #4, who was now out of view, was squealing and biting on his right hand. The 1:1 called out to him, telling him to stop. The client continued making the squealing sound and began slapping the back of his head 4 or 5 times in succession. He stopped for a few seconds then resumed vocalizing and slapping the back of his head. There was no staff present in the living room and his behaviors went without intervention.</p> <p>g. The facility's house manager (HM) had arrived at about the same time that Client #4 was vocalizing and slapping the back of his head. During an introductory interview, the 1:1 staff left the living room. Client #4 remained seated on the love seat, fondling his private parts and not engaged in a meaningful activity. At approximately 8:22 a.m., the HM observed that he was touching himself and she called the client's name. She did not, however, suggest that he do anything else with his hands.</p> <p>h. At 8:27 a.m., the HM went to kitchen. Client #4 immediately put his left hand down his pants and resumed fondling himself. There was no staff present. The 1:1, who had not been with Client #4 for the past 4 -5 minutes, was observed</p>	W 196		

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W 196	<p>Continued From page 14</p> <p>carrying a blue mop bucket out of the kitchen and down the hall. Meanwhile, Client #2 and this surveyor were the only persons in the area to witness the fondling behavior.</p> <p>i. At 8:29 a.m., staff could be heard talking in the kitchen. There were no staff present in the living room. Meanwhile, Client #4 continued fondling himself on the love seat and Client #5 came into the living room and sat down.</p> <p>j. At 8:34 a.m., Client #4's 1:1 returned to the living room. This was 7 minutes after the client had been left alone. He observed the client's hand down his pants. The 1:1 touched the client gently on his arm. There was a brief, momentary interaction between the two, then the 1:1 staff left the living room. The client immediately resumed touching his private parts.</p> <p>k. At 8:36 a.m., a female staff person from the overnight shift entered the living room. She asked Client #4 to sit up. He sat up and stopped fondling himself. He also squealed loudly and bit his right hand. The staff person observed his behavior and left the living room without suggesting that he do anything else with his hands.</p> <p>l. At 8:38 a.m., the qualified mental retardation professional (QMRP) arrived in the facility. She greeted Client #4 and his peers, and instructed Client #4 to remove his hand from his pants. The client squealed and bit his right hand.</p> <p>m. At 8:41 a.m., Client #4 put his left hand back down his pants and a second later, the overnight female staff returned to the living room. She observed him fondling himself but she did not</p>	W 196		
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W 196	<p>Continued From page 15</p> <p>intervene. She shook her head slightly and then left the room.</p> <p>n. At approximately 8:43 a.m., a driver who had been in the facility since 7:00 a.m. assisting staff with the morning routine, walked into the living room. He took Client #4 by the left hand and asked him to come with him. The client stood up, began biting on his own right and squealing loudly as they left to retrieve the client's coat. They would soon be departing for day programs.</p> <p>Later that day, beginning at 3:58 p.m., review of Client #4's annual psychological assessment dated July 3, 2009 and his BSP dated August 10, 2008 confirmed that his targeted maladaptive behaviors included self-injurious behaviors (hand biting, skin picking), pica of cigarette butts and touching his private parts in public. In addition, he was assigned 1:1 staffing to address "elopement/absconding." Further review revealed "Proactive Procedures: provide a variable interval schedule for reinforcement... <client's name> will be provided with staff who will stay close enough to him to prevent possible pica behavior... a full schedule of structured activities which involves gross motor strength... appropriate hand position (i.e. no hands in pants), hands on task, at his side, on the table, etc.... <client's name> will be given specific praise every 10 - 20 minutes for engaging in appropriate behavior. Communicate to <client's name> in positive terms only. For instance, sign/gesture 'put your hands to your side' or 'sit back' rather than telling him to 'stop' undesired behaviors... If <client's name> attempts to... hand biting... touching private parts in public... verbal/gestural prompts to stop and... put his hands to his lap - extend your hand if necessary... Say thank you. Redirect him to the</p>	W 196		

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W 196	Continued From page 16 scheduled activity... A critical component to the success of the above response is to provide environmental enrichment approaches that provide appropriate engagement behaviors in the home environment."	W 196		
W 249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, facility staff failed to implement training programs as recommended by their interdisciplinary teams and failed to consistently implement client behavior support plans at the needed frequency, for two of the five clients in the sample. (Clients #1 and #4)</p> <p>The findings include:</p> <p>1. On December 7, 2009, at approximately 3:30 p.m., Client #1 arrived home from his day program. The client was observed greeting the surveyor and had bad breath odor. During dinner observations, on December 7, 2009, at 5:52 p.m., parsley was observed on Client #1's plate. Interview with the direct care staff during dinner preparations indicated that the client received parsley to help with his breathe odor.</p>	W 249	<p>Program was started but discontinued after 1 day due to staffing concern of heavy drooling which was addressed informally by some members of his ISP Team. ISP Team at a case conference convened on 1/11/10 readdressed the issue of individual getting his parsley from the refrigerator as indicated as a part of IPP recommended by said team on 8/7/09. Concerns were once again raised about heavy drooling and also that the staff was responsible for grounding parsley with meal given current food texture (Ground). Team recommended that ISP be amended to reflect a cancelation of said objective from his ISP (ISP was amended and forwarded to DDS on 1/11/10).</p> <p>It was further recommended that staff continue to obtain parsley from refrigerator and include as part of grounded diet texture which was don at the time of the survey.</p> <p>Recommendations are a part of minutes recorded at case conference convened and served as part of individual's records at his residence.</p> <p>QMRP, House Manager and Nurse will continue to monitor to ensure compliance.</p>	1/11/10 and ongoing

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W 249	Continued From page 17 Review of Client #1's medical record on December 7, 2009 at 2:31 p.m., revealed a dental consultation dated July 14, 2009. The client received a full mouth examination and moderate calculus deposits were noted. It was recommended that the client receive fresh parsley to control his halitosis. Review of the client's data sheet, dated August 7, 2009, revealed a program objective which stated "[the client] will get his parsley from the refrigerator one out of two times for three consecutive months." Review of the data sheets reflected no IPP for the aforementioned program. Further review of the qualified mental retardation professional's (QMRP) quarterly review revealed no program status. When interviewed on December 8, 2009, at approximately 10:30 a.m., the QMRP acknowledged that the program had not started.	W 249	Staff (s) were re-trained on BSP Implementation by Symbra's Psychologist on 1/8/10. Behavior Support Plan Implementation Guide was developed, implemented and staff training effected. This tool will be used in collaboration with BSP to ensure quick reference for staff in providing and adhering to strategies outlined in BSP. Psychologist, QMRP, House Manager and newly developed QA Team will continue to monitor to ensure compliance.	1/8/10 and ongoing
W 252	2. Cross-refer to W196.1. Facility staff failed to consistently implement Client #1's BSP. 3. Cross-refer to W196.2. Facility staff failed to consistently implement Client #4's BSP. 483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation and record review, facility staff failed to document all behavior data in accordance with the behavior support plan (BSP), for one of the five clients in the sample. (Client	W 252	Crossed referenced and adopted with W196.2, W193.1 and W193.2.	1/14/10 and ongoing

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W 252	<p>Continued From page 18 #2)</p> <p>The findings include:</p> <p>Cross-refer to W249.2. On December 7, 2009, Client #4 was observed repeatedly engaged in two of his targeted maladaptive behaviors during an 85-minute period, between 7:25 a.m. - 8:43 a.m. Staff were not always present to witness the behaviors. At times, however, there was a staff with him who observed his behaviors, as follows:</p> <p>The client's designated 1:1 staff observed him touching his private parts and/or biting on his hand (targeted maladaptive behaviors) at 8:01 a.m., 8:10 a.m., 8:17 a.m. and 8:34 a.m.</p> <p>Other staff observed him fondling himself in public and/or biting his hand at 8:15 a.m., 8:36 a.m. and 8:41 a.m.; as did the house manager at 8:22 a.m. and a driver/ support staff at 8:43 a.m.</p> <p>Later that day, beginning at 3:58 p.m., review of Client #4's BSP dated August 10, 2009, and Psychological Assessment dated July 3, 2009, confirmed that touching his private parts in public were among the list of targeted maladaptive behaviors being addressed. Staff were instructed to document each incident of a maladaptive behavior on the designated data collection sheets. "Time block data" would also be collected every 30 minutes.</p> <p>At 4:29 p.m., review of Client #4's behavioral data sheets revealed inconsistent data collection. The sheet for December 2009 showed no data recorded for December 1, 2009 (left blank) for self-injurious behaviors and touching his privates in public. Staff were to write "0" if there were no</p>	W 252	<p>Crossed reference and adopted with W249.2 and W196.2. In addition staff will be trained on 30 minutes block time from first occurrence of behavior as opposed to time block data collected every 30 minutes, and 0 if behavior does not occur as per psychologist recommendation for data collection procedures which will be updated in individuals' BIP and the necessary amendment made to ISP upon receipt.</p>	1/14/10 and ongoing
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W 322	<p>behaviors observed. Review of the December 7, 2009 data revealed that the qualified mental retardation professional was the only staff that documented a behavioral episode that morning (the only episode that she had observed, at 8:38 a.m.). None of the 9 incidents referenced above had been documented by the other staff before they completed their shift, as required.</p> <p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>This STANDARD is not met as evidenced by: Based on record review, the facility's primary care physician (PCP) failed to ensure medical oversight, for two of the five clients in the sample. (Clients #1 and #3)</p> <p>The findings include:</p> <ol style="list-style-type: none"> The facility's PCP failed to address Client #1's uncontrolled hypertension, as follows: <p>Review of Client #1's medical record on December 7, 2009 at 11:30 a.m., revealed a diagnosis of uncontrolled hypertension. Further record review revealed a cardiology consult dated October 13, 2009. The cardiology consult revealed that the client's blood pressure read, "137/80, continue present medications and return in six months." Further review of the consult sheet as well as the PCP's progress notes failed to show evidence that the PCP was aware of the findings.</p> <ol style="list-style-type: none"> Record review of Client #1 medical records on 	W 322	<p>PCPs quarterly note on 12/4/08 and 3/31/09 shows documentation increased blood pressure and follow up by Cardiologist. Further documentation on 11/9/09 revealed note from PCP "pt stable seen by Cardiologist". (Copy attached)</p> <p>Cardiology consults and BP finding will be reported to PCP, Nursing will immediately ensure that PCP is informed of specialty consult findings. Ongoing monitoring will be performed by facility's DON.</p>	1/14/10 and ongoing

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W 322	<p>Continued From page 20</p> <p>December 7, 2009, at approximately 10:00 a.m., revealed a diagnosis of onychomycosis. The client had been seen by a podiatrist on August 18, 2009. It was recommended that the client return in three months. There was no evidence that the facility had scheduled a podiatry follow up appointment, to date. Interview with the licensed practical nurse on the same day confirmed that the client had not been seen by the podiatrist nor had an appointment been scheduled.</p> <p>3. Facility nurses and/or the PCP failed to establish a Fall Precautions protocol or guidelines to address Client #3's osteopenia, as follows:</p> <p>On December 8, 2009, at approximately 2:30 p.m., review of Client #3's orthopedic evaluation, dated October 9, 2009, revealed that he was at risk of fragility fractures due to osteopenia if he were to pursue general exercise. Instead, the orthopedic recommended limiting the client to "general walking" for safety. The qualified mental retardation professional (QMRP) stated that she had since instructed staff to limit him to walking or tossing a toy basketball through a hoop in the facility basement. Review of the client's exercise programs data sheet for November 2009, confirmed the limitation had been implemented.</p> <p>However, review of Client #3's health management care plan (HMCP), dated September 9, 2009, revealed that Fall Precautions was an intervention prescribed to address his osteopenia. At approximately 2:53 p.m., interview with the facility nurse revealed that she was unaware of any training to staff on fall precautions. She was unaware of any fall protocol or guidelines and she then directed this surveyor to the QMRP. When asked about fall</p>	W 322	<p>Individual #1's medical record reveals that he was seen by Podiatrist on 11/18/09. Follow up with Onychomycosis and received treatment of debridement of nails. (copy of documentation attached)</p> <p>Physical Therapist has evaluated and established fall precaution protocol on individual #3 on 12/29/09 and DON and QMRP have developed other monitoring guidelines to address potential for falls given diagnosis of Osteopenia. Copy attached. DON/QMRP/Nurse will do oversight monitoring. Staff trainings on fall precaution and monitoring guidelines were done on 1/11/10.</p>	<p>1/11/10 and ongoing</p> <p>1/11/10 and ongoing</p>
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W 322	Continued From page 21 precautions or protocols, the QMRP deferred back to the nurse. Further review of the HMCP revealed that staff training was "required" and that the nurse, PCP, and QMRP were all to provide quarterly oversight. The client's record, however, showed no evidence that the nurse, PCP and/or the QMRP had established fall precautions guidelines (or protocol), provided instruction to staff regarding fall precautions, or provided quarterly oversight, in accordance with the HMCP.	W 322	QMRP will monitor quarterly as a part of Quarterly reports done which referenced monitoring of HCMP.	1/14/10	
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 observation, staff interview and record review, the facility failed to ensure all nursing services as needed to meet client needs, for one of the five clients in the sample. (Client #1) The findings include: The facility's registered nurse failed to review and/or clarify Client #1's Health Management Care Plan (HMCP), related to intervention to address his diagnosis of gastritis. Observation during breakfast on December 7, 2009, at 7:20 a.m., revealed Client #1 drinking a cup of milk and orange juice. Observations during dinner at 5:52 p.m., revealed the client receiving milk and tomato based pot roast. Review of the client's Health Management Care Plan (HMCP), dated August 7, 2009, and updated on November 9, 2009, revealed a diagnosis of	W 331	Individual #1's diet restrictions in reference to Gastritis will be clarified by GI doctor on scheduled hospitalization on 1/10/10 and HMCP will be re-developed and corrected base on GI recommendation.	1/14/10	

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W 331	Continued From page 22 gastritis. Further review revealed the client's diet should limit acid producing foods (i.e., tomatoes and milk) in his diet. Interview with the licensed practical nurse (LPN) and qualified mental retardation professional (QMRP) on December 8, 2009, at approximately 10:00 a.m., indicated "no knowledge of such limitations," and confirmed that the client received milk, orange juice and tomato based products.	W 331		
W 336	<p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility's registered nurse (RN) failed to ensure direct physical examinations were conducted quarterly or on a more frequent basis, for two of the five clients residing in the facility. (Clients #4 and #5)</p> <p>The findings include:</p> <p>1. On December 7, 2009, at 2:09 p.m., review of Client #4's medical chart revealed that the most recent quarterly nursing assessment had been documented on July 23, 2009. The next assessment had been due in October 2009. According to the qualified mental retardation professional (who was present at that moment), the facility's director of nursing had served as the RN from July 2009 until a new RN was hired, effective October 2009.</p>	W 336	<p>Current RN was hired on October 15, 2009 and has been on orientation process during month of October, However current RN has performed direct physical initial assessment on 11/10/09 as documented.</p> <p>Quarterly assessment form was completed as requested on DOH monitoring visit. Current RN will strive to perform quarterly assessment on timely manner.</p>	1/14/10

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W 336	Continued From page 23 2. On December 8, 2009, at 11:15 a.m., review of Client #5's medical chart revealed that an RN had documented performing an annual nursing assessment on February 6, 2009. There was no evidence, however, that an RN had performed a quarterly assessment in the 10 months that had since passed. According to the assessment form, quarterlies had been projected for May 2009, August 2009 and November 2009.	W 336	Due to QA monitoring findings of poor performance by previous RN, Symbal has taken appropriate disciplinary action and the previous RN was replaced by the current RN. The current RN has performed direct physical assessment on 11/10/09. Quarterly assessment has been completed and corrected as requested on DOH monitoring visit. Current RN will strive to perform physical assessments quarterly on timely manner.	1/14/10 and ongoing
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely comprehensive treatment services for the maintenance of dental health, for two of the five clients in the sample. (Clients #1 and #3) The findings include: 1. Review of Client #1's medical record on December 7, 2009, at 2:31 p.m., revealed a dental consultation dated February 25, 2009. The dentist noted that the client had moderate calculus deposits and needed scaling. Further review revealed additional dental consultation forms dated July 14, 2009 and October 7, 2009. Both consultation forms revealed moderate calculus deposits and recommended scaling on the next visits. Interview with the Licensed Practical Nurse (LPN) on December 8, 2009, at	W 356		

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W 356	<p>Continued From page 24</p> <p>approximately 10:00 a.m., revealed that the client needed preauthorization prior to returning to the dentist office for scaling. At the time of the survey, the facility failed to ensure Client #1 received timely dental services (scaling).</p> <p>2. Similarly, the facility failed to ensure that Client #3 received timely dental treatment (scaling), as follows:</p> <p>On December 7, 2009, beginning at 10:34 a.m., review of Client #3's dental records revealed that on February 23, 2009, the dentist recommended scaling. The client subsequently refused treatment on April 27, 2009 and May 20, 2009. After the client again refused treatment on June 16, 2009, even though he had received Lorazepam 2 mg two hours prior to the appointment, the dentist recommended deep conscious sedation. The dentist wrote that he/she would submit a preauthorization form to Medicaid.</p> <p>At 12:07 p.m., review of nurse progress notes in Client #3's dental record revealed no evidence of communications with the dentist's office for approximately 10 weeks after the June 16, 2009 visit. According to a September 3, 2009 progress note, LPN #1 telephoned the dentist, who stated that they would resubmit another preauthorization form to Medicaid. Interview with LPN #1 revealed that it normally took between 4-6 weeks for preauthorization approval. The next documented communication was when LPN #1 telephoned the dentist more than 11 weeks later, on November 24, 2009. The dentist reportedly referred the nurse to a local hospital's dental clinic. A progress note dated November 30, 2009, indicated that the dental clinic referred LPN #1 to</p>	W 356	<p>Symbal's Nursing department will act on finding another Dentist for individual #1 to ensure that individual is receiving timely dental services.</p> <p>Nursing has scheduled on appointment for Individual #3 on 1/15/10 with the new dental clinic. (Copy of appointment attached)</p> <p>Nursing ensure that individual is receiving medical and dental treatments in timely manner. Ongoing monitoring will be performed by DON and QA team.</p> <p>DCHRP and DDS have been contacted to assist in identifying and developing additional resources that will be able to provide timely dental care to the individual.</p>	<p>1/15/10 and ongoing</p> <p>1/15/10 and ongoing</p>
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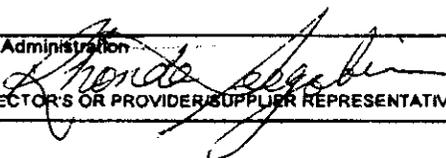
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W 356	<p>Continued From page 25</p> <p>their affiliated dental school, which would reopen December 4, 2009. There was no evidence that anything had been scheduled yet with the dental school. Interview with the qualified mental retardation professional and LPN #1 indicated that they would contact Client #3's sister to obtain written consent for deep conscious sedation after a date was scheduled. To date, there had not been an appointment scheduled.</p> <p>On December 8, 2009, at 4:08 p.m., LPN #1 presented another progress note dated December 3, 2009 indicating that she had telephoned the school however, they had not yet reopened. As of December 8, 2009, Client #3 had not received treatment that was recommended on February 23, 2009.</p>	W 356		

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1 000	<p>INITIAL COMMENTS</p> <p>On November 9, 2009, the provider notified the Department of Health, Health Regulation and Licensing Administration (HRLA) of an allegation of neglect based on an October 31, 2009 "monitoring visit" by a nurse consultant with the Universal Legal Services (ULS). Residents' lunches that were served in the facility that day (Saturday) reportedly had not been served in the form and texture prescribed in their mealtime protocols. In addition to the allegation, the facility submitted four resident-specific memoranda dated November 6, 2009 in which they outlined corrective measures taken to address the allegations, including immediate in-service training of all staff, as well as "QA monitoring at mealtimes at least three times per week or as needed for the next 90 days."</p> <p>On November 24, 2009, the HRLA received a copy of the ULS nurse consultant's report (dated November 4, 2009) via e-mail from Department on Disability Services (DDS). In the report, the nurse alleged having observed the following significant deficiencies:</p> <p>(1) Residents' mealtime protocols were not being implemented as ordered.</p> <p>(2) Staff were not adequately familiar with residents' significant health risks.</p> <p>(3) Documentation in the residents' medical records did not adequately address clinical issues.</p> <p>(4) Staff were not familiar with and/or implementing residents' behavior support plans (BSPs).</p>	1 000	<p>Symbra's governing body will implement corrective and preventative strategies to remedy observations 1-6 by the University Legal Services Monitor 10/31/09 and items a-f cited by Department of Health on 12/8/09. Proactive measures will be developed and staff re-training implemented and monitored by QMRP, DON and QA to ensure compliance.</p>	1/14/2010 and ongoing

Health Regulation Administration



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

TITLE
CEO

(X6) DATE

1/13/10

STATE FORM

6899

T99G11

If continuation sheet 1 of 29

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1 000	<p>Continued From page 1</p> <p>(5) Staff had minimal meaningful interactions with residents during the 4-hour observation period.</p> <p>(6) Residents were not receiving needed dental treatment.</p> <p>The HRLA initiated an onsite investigation on December 7, 2009. The findings of the investigation were based on observations in the group home, interviews with the facility staff, and review of facility's records, including unusual incident reports, clinical, and administrative records. Five of the six allegations were substantiated and the remaining allegation was partially substantiated, as follows:</p> <p>(a) The facility failed to ensure that staff demonstrated competency in implementing Resident #1's mealtime protocol (beverages not thickened to a honey consistency).</p> <p>(b) The facility documented having provided staff in-service training regarding residents' health management care plans on November 3, 2009, which was 3 days after the nurse consultant's visit.</p> <p>(c) Facility nurses failed to establish a Fall Precautions protocol or guidelines to address Resident #3's osteopenia, and the primary care physician failed to address Resident #1's most recent cardiovascular medical consultation findings (uncontrolled hypertension).</p> <p>(d) Facility staff failed to demonstrate the skills and techniques necessary to implement Resident #1's and Resident #4's BSPs.</p> <p>(e) Staff failed to implement proactive behavior support strategies to ensure that Residents #1</p>	1 000	<p>Symbal's governing body have established a QA Team previously a Quality Assurance Personnel who will conduct weekly monitoring to ensure diagnostic, preventative and curative measures to maintain compliance relating to observations a-f as documented.</p> <p>QA team is representational of Program Implementation and documentation, Recreational, Nursing, HR and maintenance body of administration.</p>	1/14/10 and ongoing

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1 000	Continued From page 2 and #4 received continuous active treatment. (f) The facility failed to ensure timely comprehensive dental services for Residents #1 and #3.	1 000		
1 229	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: I. Based on observation, staff interview and record verification, the facility failed to ensure staff demonstrated competency in implementing residents feeding protocol, for one of the five residents in the sample. (Resident #1) The findings include: During breakfast observations on December 7, 2009 at approximately 7:20 a.m., a direct care staff was observed adding two tablespoons of Thick & Easy thickener to Resident #1's glass of orange juice. The staff stirred in the thickening powder and immediately handed the glass of juice to the resident. He used the same procedure when adding thickener to Resident #1's glass of milk. Neither beverage had begun to thicken before the resident gulped it down quickly. Resident #1's physician's orders dated September 1, 2009 and Individual Support Plan dated August 7, 2009 revealed that all beverages offered to him should have a nectar consistency.	1 229	Immediate training of Direct Care Staff on diet texture and Aspiration precaution will be implemented by LaSandra, SLP from DCHRP on 1/11/10. Ongoing training and monitoring will be done by QMRP and QA team. 1. Meal Time protocol and One on One job description were updated for individual #1 on 12/31/09. Those updates gave specific instructions relating to usage of thickener and included ensuring adherence to and implementation of meal time protocol as a part of one on one job duties. All staff were trained on amended tools on 12/31/09. In addition a memo issued to one on direct care staff indicated that all staff working per shift are responsible to ensure that proper implementation of meal time protocol are adhered to or face disciplinary actions. (see attached)	12/31/09 and on-going

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I 229	<p>Continued From page 3</p> <p>Later that day, at approximately 3:30 p.m., the facility nurse (LPN #1) and the house manager (HM) were interviewed in the kitchen. LPN #1 stated that staff should stir in the Thick & Easy and then wait at least three minutes before giving the beverage to the resident. She further indicated that it might take a little longer than three minutes if beverage is cold. They acknowledged that Resident #1 often drinks quickly. The HM said she found that combining a verbal directive for him to "slow down" while touching his hand and glass to physically slow his pace was effective for her. [Note: This was not reflected on his Mealtime Protocol dated November 18, 2008.]</p> <p>Subsequent review of the staff in-service training records, on December 8, 2009, at 2:00 p.m. revealed that the staff person observed that morning had received training on November 5, 2009. Observations, however, revealed that the training had not been effective.</p> <p>II. Based on observations, interviews and record review, the facility's staff failed to demonstrate the skills and techniques necessary to implement each resident's Behavior Support Plan (BSP), for two of the five residents in the sample. (Residents #1 and #4)</p> <p>The findings include:</p> <p>A. During evening observations on December 7, 2009, from 5:20 p.m. until 5:55 p.m., Resident #1 was observed pacing from the living room, through the kitchen and into the dining room, repeatedly. At 5:58 p.m., the resident was observed eating dinner. After the resident completed his dinner at 6:15 p.m., he continued</p>	I 229	<p>Consequently, all staff were re-trained on meal time protocols for all individuals. Speech Therapist, QMRP, QA Team, DON, LPN, House Manager and or DDS Service Coordinator have extended previous, 90 days weekly 3 times monitoring to include and other 90 days to ensure compliance.</p>	12/31/09 and on-going

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I 229	<p>Continued From page 4</p> <p>to pace throughout the facility for the next 25 minutes. The one to one support staff was observed within close proximity of the resident at all times.</p> <p>Interview with the 1:1 staff on December 7, 2009, at approximately 6:25 p.m. revealed that Resident #1 had a BSP to address his pacing behaviors. Record review on December 8, 2009, at approximately 9:30 a.m., revealed Resident #1's BSP dated May 19, 2009. The BSP recommended the following proactive treatment strategies:</p> <ul style="list-style-type: none"> - Provide a variable interval schedule of reinforcement of target behaviors (following directions, sensitivity to others around him; appropriate task performance and good posture); - Provide specific praise every 15 minutes; - Provide the resident with regular scheduled structured activities; and - Engage the resident in a minimum of one activity every 15 minutes. <p>The aforementioned interventions were not implemented when Resident #1 was observed repeatedly pacing throughout the facility from 5:20 p.m. until 5:55 p.m and from 6:15 p.m. until 6:40 p.m.</p> <p>Review of the staff training records on December 8, 2009, at approximately 10:30 a.m., revealed that all staff had received training for Resident #1's BSP on November 5, 2009. Observations on December 7, 2009, however, indicated that the training had not been effective.</p>	I 229	<p>Staff will be re-trained on variable interval schedule, positive reinforcement (providing specific praise) as well as implementation of scheduled activities as per BSP. One such activity will be the inclusion of individuals #1 special program as a part of activities of daily living, recreational and leisure, QMRP provided training to this effect on 1/11/09.</p>	1/11/10 and ongoing

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I 229	Continued From page 5 B. Similarly, observations of the direct support staff working with Resident #4 revealed that they had not received effective training regarding the proactive strategies outlined in his BSP, as follows: Observations on December 7, 2009, revealed Resident #4 was not presented with a variable schedule of structured activities between the time he finished breakfast (7:25 a.m.) and when he prepared to leave for day program (8:43 a.m.). The BSP called for there to be a variable schedule, to keep him actively engaged. Staff did not stay close to Resident #4 to prevent maladaptive behaviors such as pica and touching his private parts. Contrary to the BSP instructions, staff told Resident #4 to stop doing a maladaptive behavior (touching himself) without subsequent instruction to place his hands in his lap or by his sides. Staff did not ask or instruct him to perform any tasks or otherwise engage him in meaningful activities. While seated, the resident repeatedly put his left hand down his pants and kept it there while fondling his private parts when staff were not present. When staff did observe him touching his privates, they sometimes failed to ask him to move his hands to an appropriate activity. Later, review of his behavior data sheets revealed that staff failed to document the maladaptive behaviors they had observed, as required in the BSP.	I 229		
I 260	3512.1 RECORDKEEPING: GENERAL PROVISIONS Each Residence Director shall maintain current and accurate records and reports as required by this section. This Statute is not met as evidenced by:	I 260		

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1260	<p>Continued From page 6</p> <p>Based on interview and record review, the group home for the mentally retarded person (GHMRP) failed to ensure the resident's habilitation and treatment records were current and accurate in the manner required by this section for three of five residents residing in the facility. (Residents #1, #3 and #5)</p> <p>The findings include:, for one of the five residents in the sample. (Resident #3)</p> <p>The finding includes:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure that consent forms provided a clear, accurate record of the medication and/or dosage proposed for Resident #3. <p>The facility's nurse failed to specify on a consent form the name and dosage of a sedative prescribed for Resident #3. Review of the resident's dental records on December 7, 2009 at 10:34 a.m. revealed that his sister had signed a consent form on June 15, 2009. The form indicated that he had a dental appointment scheduled for the next day at 10:30 a.m. Further review of the form revealed that while it stated that "the purpose of this medication and the side effects have been explained to me fully..." the form did not specify what medication he would receive or how many milligrams would be administered. When interviewed later that day, the nurse stated that she had been responsible for preparing the consent form (document).</p> <ol style="list-style-type: none"> 2. The facility's nurses failed to ensure physician orders were correctly transcribed, as follows: <p>Review of Resident #1's medical record on December 7, 2009, beginning at 11:25 am.,</p>	1260	<p>The DON has completed additional training on 1/05/2010 to all Nurses on "obtaining and transcribing orders, medical records documentation, and obtaining consent" On 1/20/10 by Kim Chavis, RN from DCHRP will provide follow-on training on these and other topic. Ongoing training and monitoring will be done by DON.</p>	1/20/2010 And ongoing

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I 260	Continued From page 7 revealed physician orders that read: Loxapine 100 mg by mouth twice (po) a day monthly, Depakote Sprinkle 375 mg po twice a day monthly, Clonazepam 1 mg po in the evening, monthly and Cogentin 2 mg po once a day, monthly. The aforementioned physician orders were dated November 6, 2009, October 2, 2009, September 3, 2009, and August 6, 2009, and were signed by the LPN. Further review of the physician orders could not determine how the orders were transcribed (by telephone, in person, etc.). Interview with LPN on December 7, 2009, at approximately 1:00 p.m., revealed that the psychiatrist conducted his monthly psychiatric consult and issued verbal orders. There was no evidence that the LPN transcribed the verbal orders correctly. 3. The facility's nursing services failed to monitor Resident #5's dental flossing, in accordance with his HMCP, as follows: a. On December 7, 2009, beginning at 1:43 p.m., the facility nurse (LPN #1) indicated that none of the five residents flossed their teeth. She stated that the dentist "never recommends" flossing for these men. However, on December 8, 2009 beginning at approximately 9:00 a.m., review of Resident #5's dental records revealed that on April 21, 2009, his dentist had recommended brushing and flossing. The dentist again recommended brushing and flossing on October 7, 2009. The dentist had documented gingivitis and 2 teeth with caries on June 22, 2009. During a December 8, 2009, interview at 10:02 a.m., LPN #1 repeated what she had stated the previous day, that none of the clients flossed and the dentist had not recommended flossing.	I 260	Immediate Training was given on 1/5/10 to nurse on obtaining and transcribing physician orders and importance of providing medical treatment according to physician's order and in accordance to HMCP. Ongoing monitoring will be done by DON and QA team.	1/5/10 and ongoing

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I 260	Continued From page 8 b. On December 8, 2009 beginning at approximately 9:30 a.m., review of Resident #5's HMCP dated February 6, 2009 revealed that it identified "potential for poor oral/dental hygiene" as a concern. Direct support staff and nurses were assigned "daily" monitoring of the resident's "ability to perform oral care" and to monitor for "bleeding gums, complaints of oral pain or decrease in appetite." [Note: The HMCP did not define the term "oral care."] The HMCP further indicated that training for staff was required and that the RN, dentist and QMRP would provide quarterly "oversight." At 11:15 a.m., review of Resident #5's medical chart revealed that an RN had performed an annual nursing assessment on February 6, 2009. There was no evidence, however, that an RN had provided quarterly oversight of his oral care, as required by the HMCP, in the past 10 months.	I 260	LPN will perform monthly dental assessment and RN will perform quarterly dental assessment.	1/14/10
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all entries in residents' records were signed and/or dated, for two of the five residents in the sample. (Residents #1 and #3) The findings include: 1. On December 7, 2009 beginning at 11:25 a.m., review of Resident #1's medical records revealed the resident had several telephone orders that had been signed but not dated by the facility's Primary Care Physician (PCP) as documented	I 291	A letter was forwarded to PCP on 1/09/2010 concerning proper documentation and dating of the records reviewed and orders given. The Nursing staff received training on medical record documentation on 1/05/2010. Additional training is scheduled for 1/20/10 to be given by Kim Chavis, RN from DCHRP. DON will perform quarterly and random monitoring to ensure compliance. Random monitoring of individual records will be performed by the QA team. Symbal has included additional nursing personnel to the QA team to conduct deficiency monitor and provide remedying interventions	1/20/2010 and ongoing

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I 291	<p>Continued From page 9</p> <p>below:</p> <p>On June 25, 2009, the PCP ordered via telephone Xanax 1 mg for audiological appointment scheduled for June 30, 2009, one hour prior to appointment;</p> <p>On June 25, 2009, the PCP ordered via telephone Xanax 1 mg by mouth one time dose for dental appointment scheduled for July 14, 2009;</p> <p>On May 4, 2009, the PCP ordered via telephone Debrox drops, five drops to each ear once a day for seven days, beginning of each month;</p> <p>On May 13, 2009, the PCP ordered via telephone to discontinue previous order of Cogentin 2 mg, twice a day and begin Cogentin 2 mg once daily (every morning);</p> <p>On April 30, 2009, the PCP ordered via telephone Xanax 1 mg one dose for ENT appointment scheduled for May 4, 2009; and</p> <p>On April 30, 2009, the PCP ordered via telephone Xanax 1 mg one dose for dental appointment scheduled for May 13, 2009.</p> <p>Interview with the facility's nurse (LPN #1) on December 7, 2009, at approximately 12:10 p.m. failed to provide an explanation as to why the physician had not dated the orders.</p> <p>2. On December 7, 2009, at 11:09 a.m., review of Resident #3's medical chart revealed that a medication nurse (LPN #2) who administered Lorazepam 2 mg for sedation prior to a June 16, 2009 dental appointment failed to place her signature on the Controlled Medication Utilization</p>	I 291	<p>A letter was forwarded to PCP on 1/09/2010 concerning proper documentation and dating of the records reviewed and orders given. The Nursing staff received training on medical record documentation on 1/05/2010. Additional training is scheduled for 1/20/10 to be given by Kim Chavis, RN from DCHRP.</p> <p>DON will perform quarterly and random monitoring to ensure compliance.</p> <p>Random monitoring of individual records will be performed by the QA team. Symbal has included additional nursing personnel to the QA team to conduct deficiency monitor and provide remedying interventions.</p>	1/20/2010 and ongoing

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I 291	<p>Continued From page 10</p> <p>Record (CMUR) form. The name of the medication, date, time and dosage had all been documented; only the signature was missing. [Note: LPN #2's initials were on the resident's June 2009 Medication Administration Record (MAR), documenting administration of the Lorazepam at 8:30 a.m.]</p> <p>3. On December 7, 2009 at approximately 10:45 a.m., review of a consent form in Resident #3's record revealed that the date had been changed from May 7, 2009 to May 20, 2009. Instead of drawing a line through the date (a strike-through), someone had written 20 over the 7. Whoever changed the document failed to provide their initials/signature or note the date on which they made the alteration. Similarly, at 11:07 a.m., review of a CMUR form dated May 20, 2009 revealed that whoever changed the 7:30 a.m. administration time (Lorazepam 1 mg for sedation) to 9:30 a.m. for Resident #3 had not initialed/signed or dated this alteration.</p> <p>4. At approximately 11:35 a.m., further review of Resident #3's Medication Administration Record (MAR) for May 2009 revealed that the medication nurse (LPN#2) who administered the Lorazepam 1 mg on May 20, 2009 did not document the time that she administered it. On the back of the same form, however, there was handwriting using a different style and with a different pen that had documented the 9:30 a.m. administration of Lorazepam on May 20, 2009.</p> <p>5. At approximately 12:00 p.m., the facility nurse (LPN #1) was interviewed regarding the MARs and CMURs. She stated that she, not LPN #2, had written the information on the June 16, 2009 CMUR. Upon review of the blank signature space, she acknowledged that LPN #2 should</p>	I 291	<p>A letter was forwarded to PCP on 1/09/2010 concerning proper documentation and dating of the records reviewed and orders given. The Nursing staff received training on medical record documentation on 1/05/2010. Additional training is scheduled for 1/20/10 to be given by Kim Chavis, RN from DCHRP. DON will perform quarterly and random monitoring to ensure compliance.</p> <p>Random monitoring of individual records will be performed by the QA team. Symbal has included additional nursing personnel to the QA team to conduct deficiency monitor and provide remedying interventions.</p>	1/20/2010 and ongoing

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I 291	Continued From page 11 have signed it after administering the 2 mg Lorazepam that day. She acknowledged that she, not LPN #2, had written the 9:30 a.m. documentation on the back of Resident #3's May 2009 MAR. She did not, however, volunteer the name of whoever had changed the administration time (7:30 a.m. became 9:30 a.m.) on his May 20, 2009 CMUR. 6. Review of nurse progress notes on December 8, 2009 revealed numerous progress notes in which LPN #1 indicated that a dentist or doctor's office had placed a call to the facility. For instance, a progress note dated September 3, 2009 indicated "<dentist's name> called... authorization hasn't been returned from Medicaid... will resubmit..." However, interview with LPN #1 at 4:09 p.m. revealed that she had intended to document her telephone call to the dentist. She then acknowledged that this and other (similar) progress notes did not accurately reflect the circumstances of her contact with the medical professional/outside provider. 7. Review of Resident #1's medical record on December 7, 2009 at approximately 11:45 a.m., revealed a Health Management Care Plan dated August 7, 2009. Further review of the HMCP revealed no signature of who had developed/ completed the HMCP.	I 291	A letter was forwarded to PCP on 1/09/2010 concerning proper documentation and dating of the records reviewed and orders given. The Nursing staff received training on medical record documentation on 1/05/2010. Additional training is scheduled for 1/20/10 to be given by Kim Chavis, RN from DCHRP. DON will perform quarterly and random monitoring to ensure compliance. Random monitoring of individual records will be performed by the QA team. Symbal has included additional nursing personnel to the QA team to conduct deficiency monitor and provide remedying interventions. HMCP for individual #1 was redeveloped and corrected by current RN on 12/14/09.	1/20/2010 and on-going
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.	I 401		

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I 401	<p>Continued From page 12</p> <p>This Statute is not met as evidenced by:</p> <p>I. Based on observation and record review, the facility's primary care physician (PCP) failed to ensure medical oversight, for two of the five residents in the sample. (Residents #1 and #3)</p> <p>The findings include:</p> <p>A. The facility's PCP failed to address Resident #1's uncontrolled hypertension, as follows:</p> <p>Review of Resident #1's medical record on December 7, 2009 at 11:30 a.m., revealed a diagnosis of uncontrolled hypertension. Further record review revealed a cardiology consult dated October 13, 2009. The cardiology consult revealed that the resident's blood pressure read, "137/80, continue present medications and return in six months." Further review of the consult sheet as well as the PCP's progress notes failed to show evidence that the PCP had provided oversight.</p> <p>B. The facility's medical team (nurses and PCP) failed to establish a Fall Precautions protocol or guidelines to address Resident #3's osteopenia, as follows:</p> <p>On December 8, 2009, at approximately 2:30 p.m., review of Resident #3's orthopedic evaluation, dated October 9, 2009, revealed that he was at risk of fragility fractures due to osteopenia if he were to pursue general exercise. Instead, the orthopedic recommended limiting the resident to "general walking" for safety. The qualified mental retardation professional (QMRP) stated that she had since instructed staff to limit him to walking or tossing a toy basketball through a hoop in the facility basement. Review of the</p>	I 401	<p>Walking Protocol was established by physical therapist on 12/29/09 visit of individual #3 in addition to walking protocol implemented by PT on 12/29/09, Nursing and QMRP have establish other guidelines to ensure prevention of fall.</p>	1/14/2010 and Ongoing

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I 401	<p>Continued From page 13</p> <p>resident's exercise programs data sheet for November 2009, confirmed the limitation had been implemented.</p> <p>However, review of Resident #3's health management care plan (HMCP), dated September 9, 2009, revealed that Fall Precautions was an intervention prescribed to address his osteopenia. At approximately 2:53 p.m., interview with the facility nurse revealed that she was unaware of any training to staff on fall precautions. She was unaware of any fall protocol or guidelines and she then directed this surveyor to the QMRP. When asked about fall precautions or protocols, the QMRP deferred back to the nurse.</p> <p>Further review of the HMCP revealed that staff training was "required" and that the nurse, PCP, and QMRP were all to provide quarterly oversight. The resident's record, however, showed no evidence that the nurse, PCP and/or the QMRP had established fall precautions guidelines (or protocol), provided instruction to staff regarding fall precautions, or provided quarterly oversight, in accordance with the HMCP.</p> <p>II. The facility failed to provide nursing services to meet the residents' needs, as follows:</p> <p>A. Resident #1 was not referred to a podiatrist at the prescribed frequency, as follows:</p> <p>Record review of Resident #1 medical records on December 7, 2009, at approximately 10:00 a.m., revealed a diagnosis of onychomycosis. The resident had been seen by a podiatrist on August 18, 2009. It was recommended that the resident return in three months. There was no evidence that the facility had scheduled a podiatry follow up</p>	I 401	<p>Walking Protocol was established by physical therapist on 12/29/09 visit of individual #3 in addition to walking protocol implemented by PT on 12/29/09, Nursing and QMRP have establish other guidelines to ensure prevention of fall.</p> <p>Individual #1's medical record reveals that he was seen by Podiatrist on 11/18/09. Follow up with Onychomycosis and received treatment of debridement of nails. (copy of documentation attached)</p>	<p>1/14/10 and ongoing</p> <p>1/14/10 and ongoing</p>

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I 401	<p>Continued From page 14</p> <p>appointment, to date. Interview with the licensed practical nurse on the same day confirmed that the resident had not been seen by the podiatrist as recommended.</p> <p>B. The facility's registered nurse failed to ensure clear procedures for Resident #1's diagnosis of gastritis.</p> <p>Observation during breakfast on December 7, 2009, at 7:20 a.m., revealed Resident #1 drinking a cup of milk and orange juice. Observations during dinner at 5:52 p.m., revealed the resident receiving milk and tomato based pot roast. Review of the resident's Health Management Care Plan (HMCP), dated August 7, 2009, and updated on November 9, 2009, revealed a diagnosis of gastritis. Further review revealed the resident's diet should limit acid producing foods (i.e., tomatoes and milk) in his diet. Interview with the licensed practical nurse (LPN) and qualified mental retardation professional (QMRP) on December 8, 2009, at approximately 10:00 a.m., indicated "no knowledge of such limitations," and confirmed that the resident received milk, orange juice and tomato based products.</p> <p>C. The facility's nurses failed to ensure physician orders were correctly transcribed, as follows:</p> <p>Review of Resident #1's medical record on December 7, 2009, beginning at 11:25 am., revealed physician orders that read: Loxapine 100 mg by mouth twice (po) a day monthly, Depakote Sprinkle 375 mg po twice a day monthly, Clonazepam 1 mg po in the evening, monthly and Cogentin 2 mg po once a day, monthly. The aforementioned physician orders were dated November 6, 2009, October 2, 2009,</p>	I 401	<p>GI doctor will be requested to clarify diet restriction for Gastritis while in hospital (hospitalization scheduled for 1/10/10), HMCP will be updated based on clarification of diet by GI doctor.</p> <p>Crossed referenced and adopted with I260 (2).</p>	<p>1/14/10 and ongoing</p> <p>1/14/10 and ongoing</p>

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I 401	<p>Continued From page 15</p> <p>September 3, 2009, and August 6, 2009, and were signed by the LPN. Further review of the physician orders could not determine how the orders were transcribed (by telephone, in person, etc.).</p> <p>Interview with LPN on December 7, 2009, at approximately 1:00 p.m., revealed that the psychiatrist conducted his monthly psychiatric consult and issued verbal orders. There was no evidence that the LPN transcribed the verbal orders correctly.</p> <p>D. The facility's nursing services failed to monitor Resident #5's dental flossing, in accordance with his HMCP, as follows:</p> <p>1. On December 7, 2009, beginning at 1:43 p.m., the facility nurse (LPN #1) indicated that none of the five residents flossed their teeth. She stated that the dentist "never recommends" flossing for these men. However, on December 8, 2009 beginning at approximately 9:00 a.m., review of Resident #5's dental records revealed that on April 21, 2009, his dentist had recommended brushing and flossing. The dentist again recommended brushing and flossing on October 7, 2009. The dentist had documented gingivitis and 2 teeth with caries on June 22, 2009. During a December 8, 2009, interview at 10:02 a.m., LPN #1 repeated what she had stated the previous day, that none of the residents flossed and the dentist had not recommended flossing.</p> <p>2. On December 8, 2009 beginning at approximately 9:30 a.m., review of Resident #5's HMCP dated February 6, 2009 revealed that it identified "potential for poor oral/dental hygiene" as a concern. Direct support staff and nurses were assigned "daily" monitoring of the resident's</p>	I 401	Crossed referenced and adopted with I260 (b).	1/14/10 and ongoing

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I 401	<p>Continued From page 16</p> <p>"ability to perform oral care" and to monitor for "bleeding gums, complaints of oral pain or decrease in appetite." [Note: The HMCP did not define the term "oral care."] The HMCP further indicated that training for staff was required and that the RN, dentist and QMRP would provide quarterly "oversight." At 11:15 a.m., review of Resident #5's medical chart revealed that an RN had performed an annual nursing assessment on February 6, 2009. There was no evidence, however, that an RN had provided quarterly oversight of his oral care, as required by the HMCP, in the past 10 months.</p> <p>E. The facility's registered nurse (RN) failed to ensure direct physical examinations were conducted quarterly or on a more frequent basis, as follows:</p> <p>1. On December 7, 2009, at 2:09 p.m., review of Resident #4's medical chart revealed that the most recent quarterly nursing assessment had been documented on July 23, 2009. The next assessment had been due in October 2009. According to the qualified mental retardation professional (who was present at that moment), the facility's director of nursing had served as the RN from July 2009 until a new RN was hired, effective October 2009.</p> <p>2. On December 8, 2009, at 11:15 a.m., review of Resident #5's medical chart revealed that an RN had documented performing an annual nursing assessment on February 6, 2009. There was no evidence, however, that an RN had performed a quarterly assessment in the 10 months that had since passed. According to the assessment form, quarterlies had been projected for May 2009, August 2009 and November 2009.</p>	I 401	<p>Crossed referenced and adopted with I260 (b).</p> <p>Current RN was hired on October 15, 2009 and has been on orientation process during month of October, However current RN has performed direct physical initial assessment on 11/10/09 as documented.</p> <p>Quarterly assessment form was completed as requested on DOH monitoring visit. Current RN will strive to perform quarterly assessment on timely manner</p> <p>Due to QA monitoring findings of poor performance by previous RN, Symbal has taken appropriate disciplinary action and the previous RN was replaced by the current RN. The current RN has performed direct physical assessment on 11/10/09. Quarterly assessment has been completed and corrected as requested on DOH monitoring visit. Current RN will strive to perform physical assessments quarterly on timely manner.</p>	<p>1/14/10 and ongoing</p> <p>1/14/10 and ongoing</p> <p>1/14/10 and ongoing</p>	

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I 401	<p>Continued From page 17</p> <p>III. Based on interview and record review, the facility failed to ensure timely comprehensive treatment services for the maintenance of dental health, for two of the five residents in the sample. (Residents #1 and #3)</p> <p>The findings include:</p> <p>1. Review of Resident #1's medical record on December 7, 2009, at 2:31 p.m., revealed a dental consultation dated February 25, 2009. The dentist noted that the resident had moderate calculus deposits and needed scaling. Further review revealed additional dental consultation forms dated July 14, 2009 and October 7, 2009. Both consultation forms revealed moderate calculus deposits and recommended scaling on the next visits. Interview with the Licensed Practical Nurse (LPN) on December 8, 2009, at approximately 10:00 a.m., revealed that the resident needed preauthorization prior to returning to the dentist office for scaling. At the time of the survey, the facility failed to ensure Resident #1 received timely dental services (scaling).</p> <p>2. Similarly, the facility failed to ensure that Resident #3 received timely dental treatment (scaling), as follows:</p> <p>On December 7, 2009, beginning at 10:34 a.m., review of Resident #3's dental records revealed that on February 23, 2009, the dentist recommended scaling. The resident subsequently refused treatment on April 27, 2009 and May 20, 2009. After the resident again refused treatment on June 16, 2009, even though he had received Lorazepam 2 mg two hours prior to the appointment, the dentist recommended deep conscious sedation. The dentist wrote that</p>	I 401	<p>Symbra's Nursing department will act on finding another Dentist for individual #1 to ensure that individual is receiving timely dental services.</p> <p>Nursing has scheduled on appointment for Individual #3 on 1/15/10 with the dental clinic. Copy of appointment attached. Nursing will put more effort to follow up and make sure that individual is receiving medical and dental treatments on timely manner. Ongoing monitoring will be performed by DON and QA team.</p>	<p>1/30/10</p> <p>1/30/10</p>

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I 401	Continued From page 18 he/she would submit a preauthorization form to Medicaid. At 12:07 p.m., review of nurse progress notes in Resident #3's dental record revealed no evidence of communications with the dentist's office for approximately 10 weeks after the June 16, 2009 visit. According to a September 3, 2009 progress note, LPN #1 telephoned the dentist, who stated that they would resubmit another preauthorization form to Medicaid. Interview with LPN #1 revealed that it normally took between 4-6 weeks for preauthorization approval. The next documented communication was when LPN #1 telephoned the dentist more than 11 weeks later, on November 24, 2009. The dentist reportedly referred the nurse to a local hospital's dental clinic. A progress note dated November 30, 2009, indicated that the dental clinic referred LPN #1 to their affiliated dental school, which would reopen December 4, 2009. There was no evidence that anything had been scheduled yet with the dental school. Interview with the qualified mental retardation professional and LPN #1 indicated that they would contact Resident #3's sister to obtain written consent for deep conscious sedation after a date was scheduled. To date, there had not been an appointment scheduled. On December 8, 2009, at 4:08 p.m., LPN #1 presented another progress note dated December 3, 2009 indicating that she had telephoned the school however, they had not yet reopened. As of December 8, 2009, Resident #3 had not received treatment that was recommended on February 23, 2009.	I 401	Nursing has scheduled on appointment for Individual #3 on 1/15/10 with the dental clinic. Copy of appointment attached. Nursing will put more effort to follow up and make sure that individual is receiving medical and dental treatments on timely manner. Ongoing monitoring will be performed by DON and QA team.	1/15/10 and ongoing
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training	I 422		

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I 422	Continued From page 19 and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: I. Based on observation, interview and record review, facility staff failed to implement residents' behavior support plans (BSPs) as written, to include proactive strategies, thereby failing to provide habilitation, training and assistance, for two of the five residents in the facility. (Residents #1 and #4) The findings include: A. During evening observations on December 7, 2009, from 5:20 p.m. until 5:55 p.m., Resident #1 was observed pacing from the living room, through the kitchen and into the dining room, repeatedly. At 5:58 p.m., the resident was observed eating dinner. After the resident completed his dinner at 6:15 p.m., he continued to pace throughout the facility for the next 25 minutes. The one to one support staff was observed within close proximity of the resident at all times. Interview with the 1:1 staff on December 7, 2009, at approximately 6:25 p.m. revealed that Resident #1 had a BSP to address his pacing behaviors. Record review on December 8, 2009, at approximately 9:30 a.m., revealed Resident #1's BSP dated May 19, 2009. The BSP recommended the following proactive treatment strategies: - Provide a variable interval schedule of reinforcement of target behaviors (following directions, sensitivity to others around him; appropriate task performance and good posture);	I 422	Crossed referenced and adopted with I229.2A.	1/14/10 and ongoing

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I 422	<p>Continued From page 20</p> <ul style="list-style-type: none"> - Provide specific praise every 15 minutes; - Provide the resident with regular scheduled structured activities; and - Engage the resident in a minimum of one activity every 15 minutes. <p>The aforementioned interventions were not implemented when Resident #1 was observed repeatedly pacing throughout the facility from 5:20 p.m. until 5:55 p.m and from 6:15 p.m. until 6:40 p.m.</p> <p>B. Resident #4 was observed in his home on December 7, 2009 between 7:18 a.m. - 8:45 a.m. He finished his breakfast at approximately 7:25 a.m., walked into the living room and sat on the love seat. Resident #4 sat on the love seat from 7:25 a.m. - 8:45 a.m. At 7:56 a.m., interview with two male direct support staff in the living room revealed that one of them was Resident #4's designated 1:1 staff. He had been employed in the facility approximately 3 months. During this 85-minute observation period, facility staff failed to implement proactive/ preventive as well as intervention strategies as outlined in the resident's behavior support plan (BSP), as follows:</p> <ol style="list-style-type: none"> 1. At approximately 7:35 a.m., Resident #4 was observed smiling while he leaned against his designated 1:1 staff (both were seated on the love seat). The resident's hand was down his pants and he was touching his private parts. The 1:1 staff, however, did not intervene. 2. Later on, at approximately 8:00 a.m., Resident #4's 1:1 left the living room for approximately one minute. When he returned, he sat down next to 	I 422	(1-14) Crossed referenced and adopted with I229.2B.	1/14/10 and ongoing

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I 422	<p>Continued From page 21</p> <p>the resident again. At that moment, the resident removed his left hand from down his pants, began vocalizing and bit down onto his right hand. He asked the resident to stop and he complied. The staff, however, did not make any other requests or suggest a meaningful activity involving his hands. For the 36 minute period between 7:25 a.m. and 8:01 a.m., the resident remained seated on the love seat with no scheduled activity.</p> <p>3. At approximately 8:05 a.m., Resident #4's 1:1 staff left the living room. The resident immediately left his seat, walked quickly to the dining room, reached under the table and then returned to the love seat while chewing on something briefly. It had appeared as if he had picked up something white from the floor underneath the table where Resident #3 had been eating his breakfast earlier. Within less than a minute, the resident stopped chewing and then swallowed before any staff returned to the room. Resident #5 and this surveyor were the only persons in the area to witness the behavior. [Note: Later that day, Resident #5 was observed with a balled-up white paper napkin at his place setting at dinner.]</p> <p>4. The 1:1 returned to the living room at approximately 8:10 a.m.. Resident #4 had his hands down his pants stimulating himself while seated on the love seat. The 1:1, however, left the living room again without intervening.</p> <p>5. During this same period, the second male staff person was seated at the dining room table, approximately 15 feet away from Resident #4. He had been employed for approximately 2 years. At 8:15 a.m., he observed the resident fondling himself. He instructed him to remove his</p>	I 422		

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I 422	<p>Continued From page 22</p> <p>hands from his pants, and the resident complied. The staff, however said nothing more to him. The staff then informed this surveyor that Resident #4 "always puts his hands" down his pants. Immediately, Resident #4 made a squealing vocalization and bit down on his right hand. The staff person called the resident's first name, said nothing else and then left the area.</p> <p>6. At the same time that the other staff left the area, Resident #4's 1:1 staff returned to the living room and saw him fondling himself. He asked him to remove his hand and he did. The staff adjusted the resident's shirt and as the staff stood up, the resident put his left hand back down his pants. The 1:1 staff again told him to stop, and then walked to the far end of the dining room table. He began entering data in Resident #4's book. Meanwhile, Resident #4, who was now out of view, was squealing and biting on his right hand. The 1:1 called out to him, telling him to stop. The resident continued making the squealing sound and began slapping the back of his head 4 or 5 times in succession. He stopped for a few seconds then resumed vocalizing and slapping the back of his head. There was no staff present in the living room and his behaviors went without intervention.</p> <p>7. The facility's house manager (HM) had arrived at about the same time that Resident #4 was vocalizing and slapping the back of his head. During an introductory interview, the 1:1 staff left the living room. Resident #4 remained seated on the love seat, fondling his private parts and not engaged in a meaningful activity. At approximately 8:22 a.m., the HM observed that he was touching himself and she called the resident's name. She did not, however, suggest that he do anything else with his hands.</p>	I 422		

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I 422	Continued From page 23 8. At 8:27 a.m., the HM went to kitchen. Resident #4 immediately put his left hand down his pants and resumed fondling himself. There was no staff present. The 1:1, who had not been with Resident #4 for the past 4 -5 minutes, was observed carrying a blue mop bucket out of the kitchen and down the hall. Meanwhile, Resident #2 and this surveyor were the only persons in the area to witness the fondling behavior. 9. At 8:29 a.m., staff could be heard talking in the kitchen. There were no staff present in the living room. Meanwhile, Resident #4 continued fondling himself on the love seat and Resident #5 came into the living room and sat down. 10. At 8:34 a.m., Resident #4's 1:1 returned to the living room. This was 7 minutes after the resident had been left alone. He observed the resident's hand down his pants. The 1:1 touched the resident gently on his arm. There was a brief, momentary interaction between the two, then the 1:1 staff left the living room. The resident immediately resumed touching his private parts. 11. At 8:36 a.m., a female staff person from the overnight shift entered the living room. She asked Resident #4 to sit up. He sat up and stopped fondling himself. He also squealed loudly and bit his right hand. The staff person observed his behavior and left the living room without suggesting that he do anything else with his hands. 12. At 8:38 a.m., the qualified mental retardation professional (QMRP) arrived in the facility. She greeted Resident #4 and his peers, and instructed Resident #4 to remove his hand from his pants. The resident squealed and bit his right	I 422		

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1422	<p>Continued From page 24</p> <p>hand.</p> <p>13. At 8:41 a.m., Resident #4 put his left hand back down his pants and a second later, the overnight female staff returned to the living room. She observed him fondling himself but she did not intervene. She shook her head slightly and then left the room.</p> <p>14. At approximately 8:43 a.m., a driver who had been in the facility since 7:00 a.m. assisting staff with the morning routine, walked into the living room. He took Resident #4 by the left hand and asked him to come with him. The resident stood up, began biting on his own right and squealing loudly as they left to retrieve the resident's coat. They would soon be departing for day programs.</p> <p>Later that day, beginning at 3:58 p.m., review of Resident #4's annual psychological assessment dated July 3, 2009 and his BSP dated August 10, 2008 confirmed that his targeted maladaptive behaviors included self-injurious behaviors (hand biting, skin picking), pica of cigarette butts and touching his private parts in public. In addition, he was assigned 1:1 staffing to address "elopement/absconding." Further review revealed "Proactive Procedures: provide a variable interval schedule for reinforcement... <resident's name> will be provided with staff who will stay close enough to him to prevent possible pica behavior... a full schedule of structured activities which involves gross motor strength... appropriate hand position (i.e. no hands in pants), hands on task, at his side, on the table, etc.... <resident's name> will be given specific praise every 10 - 20 minutes for engaging in appropriate behavior. Communicate to <resident's name> in positive terms only. For instance, sign/gesture 'put your hands to your side' or 'sit back' rather</p>	1422		

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I 422	<p>Continued From page 25</p> <p>than telling him to 'stop' undesired behaviors... If <resident's name> attempts to... hand biting... touching private parts in public... verbal/gestural prompts to stop and... put his hands to his lap - extend your hand if necessary... Say thank you. Redirect him to the scheduled activity... A critical component to the success of the above response is to provide environmental enrichment approaches that provide appropriate engagement behaviors in the home environment."</p> <p>II. Based on observation, interview and record review, facility staff failed to implement training programs as recommended by Resident #1's interdisciplinary team.</p> <p>The finding includes:</p> <p>On December 7, 2009, at approximately 3:30 p.m., Resident #1 arrived home from his day program. The resident was observed greeting the surveyor and had bad breath odor. During dinner observations, on December 7, 2009, at 5:52 p.m., parsley was observed on Resident #1's plate. Interview with the direct care staff during dinner preparations indicated that the resident received parsley to help with his breathe odor.</p> <p>Review of Resident #1's medical record on December 7, 2009 at 2:31 p.m., revealed a dental consultation dated July 14, 2009. The resident received a full mouth examination and moderate calculus deposits were noted. It was recommended that the resident receive fresh parsley to control his halitosis. Review of the resident's data sheet, dated August 7, 2009, revealed a program objective which stated "[the resident] will get his parsley from the refrigerator one out of two times for three consecutive</p>	I 422	<p>Program was started but discontinued after 1 day due to staffing concern of heavy drooling which was addressed informally by some members of his ISP Team. ISP Team at a case conference convened on 1/11/10 readdressed the issue of individual getting his parsley from the refrigerator as indicated as a part of IPP recommended by said team on 8/7/09. Concerns were once again raised about heavy drooling and also that the staff was responsible for grounding parsley with meal given current food texture (Ground). Team recommended that ISP be amended to reflect a cancelation of said objective from his IPP.</p>	1/14/10 and ongoing

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I 422	Continued From page 26 months." Review of the data sheets reflected no IPP for the aforementioned program. Further review of the qualified mental retardation professional's (QMRP) quarterly review revealed no program status. When interviewed on December 8, 2009, at approximately 10:30 a.m., the QMRP acknowledged that the program had not started.	I 422		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District and federal laws that govern the care and rights of persons with mental retardation, for five of the six residents of the facility. (Residents #1, #2, #3, #4 and #6) The findings include: 1. Based on interview and record review, the facility's nurses and primary care physician failed to establish a Fall Precautions protocol or guidelines to address Resident #3's osteopenia, as follows: Cross-refer to I401.(I.B.) Resident #3's health management care plan (HMCP), dated	I 500		

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1500	<p>Continued From page 27</p> <p>September 9, 2009, revealed that Fall Precautions was an intervention prescribed to address his osteopenia. The facility nurse was unaware of any training to staff on fall precautions. She was unaware of any fall protocol or guidelines and she then directed this surveyor to the QMRP. When asked about fall precautions or protocols, the QMRP deferred back to the nurse.</p> <p>Further review of the HMCP revealed that staff training was "required" and that the nurse, PCP, and QMRP were all to provide quarterly oversight. The resident's record, however, showed no evidence that the nurse, PCP and/or the QMRP had established fall precautions guidelines (or protocol), provided instruction to staff regarding fall precautions, or provided quarterly oversight, in accordance with the HMCP.</p> <p>2. Based on interview and record review, the facility failed to ensure timely comprehensive treatment services for the maintenance of dental health, as follows:</p> <p>Cross-refer to 1401(III). The facility failed to ensure that Residents #1 and #3 received timely dental services (scaling).</p> <p>3. Based on observation, staff interview and record verification, the facility failed to ensure that Resident #1 only received beverages that were thickened to a nectar consistency, in accordance with his Individual Support Plan and Health Management Care Plan; as follows:</p> <p>Cross-refer to 1229(I). On December 7, 2009 at approximately 7:20 a.m., a direct care staff added two tablespoons of Thick & Easy thickener to Resident #1's glass of orange juice, stirred and</p>	1500	<p>Walking protocol was established by Physical Therapy on 12/29/09. In addition to walk protocol QMRP and Nursing have establish other guidelines to ensure prevention of fall. Training on fall precaution and other monitoring guidelines as established by DON and QMRP was done on 1/11/10, by QMRP.</p> <p>Symbal's Nursing department will act on finding another Dentist for individual #1 to ensure that individual is receiving timely dental services.</p> <p>Nursing has scheduled on appointment for individual #3 on 1/15/10 with the dental clinic. Copy of appointment attached. Nursing will put more effort to follow up and make sure that individual is receiving medical and dental treatments on timely manner. Ongoing monitoring will be performed by DON and QA team.</p> <p>Staff training on diet texture scheduled to be implemented by LaSandra, SLP from DCHRP on 1/11/10. Ongoing monitoring will be performed by QMRP and Nursing.</p>	<p>1/15/2010 and ongoing</p> <p>1/15/2010 and ongoing</p> <p>1/15/2010 and ongoing</p>

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0167	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/08/2009
NAME OF PROVIDER OR SUPPLIER SYMBRAL FOUNDATION		STREET ADDRESS, CITY, STATE, ZIP CODE 4422 20TH STREET, NE WASHINGTON, DC 20011		
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I 500	<p>Continued From page 28</p> <p>immediately handed the glass of juice to the resident. He used the same procedure when adding thickener to Resident #1's glass of milk. Neither beverage had begun to thicken before the resident gulped it down quickly. Resident #1's physician's orders dated September 1, 2009 and Individual Support Plan dated August 7, 2009 revealed that all beverages offered to him should have a nectar consistency.</p> <p>4. Based on observation, interview and record review, facility staff failed to implement Resident #1's and #4's behavior support plans (BSPs) as written, to include proactive strategies, thereby failing to provide habilitation, training and assistance in accordance with their Individual Support Plans, as follows:</p> <p>Cross-refer to I229(II) and I422. During evening observations on December 7, 2009, from 5:20 p.m. until 5:55 p.m., and from 6:15 p.m. until 6:40 p.m., Resident #1 was observed pacing throughout the facility. Although his 1:1 support staff was observed within close proximity of the resident at all times, the staff failed to implement the proactive treatment strategies that were outlined in the resident's BSP. Similarly, observations of the direct support staff working with Resident #4 revealed that they had not received effective training regarding the proactive strategies outlined in his BSP.</p>	I 500		