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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	09G058		03/27/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000		
	A recertification survey was conducted from March 26, 2013 through March 27, 2013. A sample of two clients was selected from a population of four males with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process. The findings of the survey were based on observations in the home and two day programs, interviews with one client, direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]		Received 4/15/13 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client washed their hands prior to lunch, for one of the two in the sample. (Client #2) The finding includes: The day program staff failed to ensure Client #2 washed his hands prior to lunch time, as detailed below:	W 120	The Provider's Director of Nursing and the Nursing Team trained the day program Nursing team, staff and individual #2 on hand washing, infection control, universal precaution and systematic training. The Provider's Nursing Team will continue the training and monitoring as needed to ensure compliance.	4/9/2013 and ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE CEO (X6) DATE 4/12/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G058		03/27/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 120	Continued From page 1 Observations conducted at the day program on March 26, 2013, at 11:30 a.m., revealed Client #2 opened the door to the nurse station for his noon medications, took his medications and returned back to his classroom. At 11:45 a.m., the client was given applesauce by day program Staff #1 (DPS1). Client #2 inserted a small hole in the top the applesauce, stuck his finger inside the applesauce and licked the applesauce off his fingers. At no time was the client instructed to wash his hands by DPS1 who sat directly in front of him. At 11:59 a.m., the client stuck his fingers inside his mouth and rubbed the top of his hand. At approximately 12:10 p.m., Client #2 walked over to the window, picked up some trash off the floor and placed the trash in the trash can. Seconds later, the client stuck his hand inside the trash can, rearranged the trash inside the trash can and returned back to his seat. At 12:13 p.m., Client #2 was observed eating his lunch which consisted of peas, meat sauce and noodles. The client used his fingers to keep the peas from falling off the spoon. Interview with DPS1 on the same day at 12:27 p.m., acknowledged that her routine was a little different. She stated that she usually instructs the clients to wash their hands or provided hand sanitizer prior to lunch. DPS1 stated that her supplies (hand sanitizer) were packed away in her car. She further stated that she should have had Client #2 wash his hands because he [client] was always touching and picking up items. When asked, DPS1 stated that she has had training on infection control. Review of the day program's in-service training records on March 26, 2013, at approximately	W 120	Continue from page 1.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	09G058		03/27/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 120	Continued From page 2 12:40 p.m., confirmed that DPS1 received training on infection control on January 10, 2013. Observations on March 26, 2013, during lunch however, indicated the training had not been effective.	W 120	Continue from page 2.	
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of investigations to the administrator or designated representative within five working days for an incident of neglect, for one of the four clients residing in the facility. (Client #3) The finding includes: On March 26, 2013, beginning at 1:38 p.m., review of the facility's incident management records revealed an incident (allegation of neglect) report dated September 17, 2012. According to the incident, while on vacation, staff reported that Client #3 ingested Pine Sol. The poison control center was contacted and informed the staff to monitor the client for signs and symptoms of coughing and vomiting. Review of the corresponding investigative report revealed registered nurse #1 (RN1) completed the investigation on September 27, 2012. Further review revealed there was no documented evidence that the results of the investigation were	W 156	The Governing Body of the facility will report all results of investigations to the Administrator or designated representative within five (5) working days of all incidents of Neglect or any incidents. The Administrator will sign all investigation reports within five (5) days and as needed before filing.	4/8/2013 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	09G058		03/27/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 156	Continued From page 3 reported to the administrator within five working days. Interview with RN1 on March 27, 2013, at approximately 1:10 p.m., revealed that the results for the aforementioned incident was reviewed by the facility's administrator within five working days. RN1 however, could not produce any written evidence that the administrator had reviewed the results of the investigations within five working days.	W 156	Continue from page 3.	
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation and interview, the facility staff failed to ensure clients were afforded choice during dinner, for four of the four clients residing in the facility. (Clients #1, #2, #3 and #4) The finding includes: On March 26, 2013, beginning at 6:10 p.m., dinner observations revealed employment specialist #1 (ES1) placed ketchup on top of each client's baked fish. Client #2 was observed to immediately push his fish off of his plate onto Client #3's plate. Client #1 and Client #4 were observed to eat less than 15% of their baked fish. This was confirmed through interview with ES1 after dinner. Continued interview with ES1 on the same day at approximately 7:05 p.m., revealed that there were	W 247	Staff has been trained on individual #1, #2, #3 and #4 independence and choice making during meal preparation. The QIDP and the House Manager will continue to train and monitor staff as needed for compliance.	4/8/2013 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	09G058		03/27/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 247	Continued From page 4 several other condiments available to put on their baked fish. When asked, ES1 stated that all clients were more than capable of expressing their wants and needs. ES1 then acknowledged that he should have provided each client the opportunity for choice of condiments during dinner. At the time of the survey, the facility's staff failed to allow clients to exercise their independence and allow options of choice.	W 247	Continue from page 4.	
W 371	483.460(k)(4) DRUG ADMINISTRATION • The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to to ensure that each client participated in a self-medication training program as recommended, for two of the two clients in the sample. (Clients #1 and #2) The findings include: The facility failed to implement Clients #1 and #2 recommended self-medication training programs, as detailed below: a. On March 26, 2013, at 6:47 p.m., observations of the evening medication administration revealed licensed practical nurse #1 (LPN1) punched Client #1's medications into a medication cup and	W 371	The LPN Medication Nurses received training on self medication program for individuals #1 and #2 and all the other individuals leaving the home on 3/28/2013. The Director of Nursing will continue to train the LPN Medications Nurses every six (6) months and as needed on individuals proper participation of Self Medication Administration Program.	3/28/2013 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	09G058		03/27/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 371	Continued From page 5 handed the cup to the client. The client consumed his medications and drank his water. At no time did the LPN1 encourage Client #1 participate with his medication administration. b. On March 26, 2013, at 7:00 p.m., LPN1 punched Client #2's medications into a medication cup and handed the cup to the client during the medication administration. The client consumed his medications and drank his water. At no time did the LPN encourage Client #2 to participate with his medication administration. Interview with LPN1 on the same day at approximately 7:05 p.m., revealed that neither client had a self-medication program. On March 27, 2013, at 9:39 a.m. and 10:36 a.m., respectively, review of Clients #1 individual program plan (IPP) dated February 26, 2013, and review of Client #2's IPP dated September 7, 2013, revealed that both clients had self-medication training programs. The programs revealed that given verbal prompts, the clients will participate in the following targeted steps 50% of the time for three consecutive months. - Obtain medication cup; - Name each medication; - Remove medication from each blister pack into the medication cup; and - Replace the blister pack back in the medication cabinet. Review of the program documentation for Clients	W 371	Continue from page 5.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G058		03/27/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 371	Continued From page 6 #1 and #2 for March 26, 2013, on the same day at approximately 10:45 a.m., revealed there was no documented evidence that the clients programs had been implemented. On March 27, 2013, at approximately 10:50 a.m., registered nurse #1 (RN1) reviewed the clients program documentation in the presence of the surveyor. RN1 then confirmed that the Clients #1 and #2's self-medication programs were not implemented as recommended.	W 371	Continue from page 6.	
W 455	483.470(I)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure effective infection control procedures (hand washing) were implemented, for one of the two clients included in the sample. (Client #2) The finding includes: On March 26, 2013, at approximately 6:20 p.m., dinner observations revealed Client #2 was served double portions of baked fish with ketchup on top, flavored mashed potatoes, mixed vegetables and wheat bread with butter. At 6:23 p.m., the client got up from the dining table, went into the kitchen, removed the lid from the trash can, threw some food inside the trash can, and returned back to his seat. After returing to the tables, he was observed to use his hands to scoop his vegetables onto his spoon to eat them.	W 455	All staff and individual were trained on 4/8/2013 on Infection Control, Hand Washing and Universal Precaution at home and all the day program staff trained on 4/9/2013 by the Provider's Nursing Team. The training will continue every six (6) months and as needed.	4/8/2013 and ongoing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	09G058		03/27/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 455	Continued From page 7 This occurred two more times throughout dinner. Each time, employment specialist #1 (ES1) and the qualified intellectual disabilities professional #1 (QIDP #1) verbally prompted the client to stop throwing food inside the trash can. The client however, was not encouraged to wash his hands. Interview with ES1 on March 26, 2013, at approximately 7:10 p.m., revealed that he should have had Client #2 wash his hands each time the client touched the trash can. Further interview revealed that he has had training on universal precautions (hand washing) within the past year. Review of the in-service training records on March 27, 2013, at 1:14 p.m., revealed that all staff including ES1 received training on infection control procedures (hand washing) on August 15, 2012. Observations on March 26, 2013, however, revealed the training had not been effective.	W 455	Continue from page 7.	
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure clients received the appropriate amount of food during dinner as ordered by the physician, for one of the two sampled clients. (Client #2) The finding includes: The facility staff failed to ensure that Client #2	W 460	The Management Team will ensure and continue to make sure that the dietary orders by the PCP and Nutritionist will be implemented and monitored weekly weights and staff monitoring for proper diet recommendation. The Nursing team will notify the PCP if there is any weight loss or weight gain of 1 lb per week.	4/10/2013 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G058		03/27/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

W 460 Continued From page 8

received the appropriate amount of food during dinner time, as evidenced below:

On March 26, 2013, beginning at 6:10 p.m., dinner observations revealed employment specialist #1 (ES1) placed ketchup on top of each client's baked fish. Client #2 was observed to immediately push his fish off of his plate onto Client #3's plate. Client #2 ate 100% of his mashed potatoes, vegetables and wheat bread. The client however, was not offered any other meat as a substitution for the baked fish throughout the remainder of the dinner.

Interview with ES1 at approximately 7:05 p.m., revealed Client #2 did not like baked fish and chicken. When asked why Client #2 given baked fish knowing that he did not like baked fish, ES1 stated that he was following the dietician's menu. ES1 stated that there was a substitution list that the facility used when client's refused certain foods. ES1 went on to acknowledge that he should have offered another meat substitution to Client #2 from the dietician's list.

Review of Client #2's current physician's orders (POs) dated December 2012 on March 27, 2013, at 9:52 a.m., revealed the client was prescribed Ensure Plus three times a day, low fat, low cholesterol, no concentrated sweets double portion diet for breakfast and dinner. Review of a written PO dated January 10, 2013, revealed weight loss was added to the client's diagnosis. It should be noted that Client #2 was one pound under his desirable body weight.

W 460

Continue from page 8.

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	HFD03-0039		03/27/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	INITIAL COMMENTS A licensure survey was conducted from March 26, 2013 through March 27, 2013. A sample of two residents was selected from a population of four males with varying degrees of intellectual disabilities. The findings of the survey were based on observations in the home and two day programs, interviews with one resident, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	I 000		
			All staff were trained on individual #2 and the other individual's diet, meal time protocol and substitution list as ordered by the PCP and recommended by the Nutritionist on 4/8/2012. The training will continue every six (6) months and as needed.	4/8/2013 and ongoing
I 040	3502.1 MEAL SERVICE / DINING AREAS Each GHMRP shall provide each resident with a nourishing, well-balanced diet. This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for individuals with intellectual disabilites (GHIID) failed to ensure residents received their prescribed modified diets as ordered by the physician, for one of the two sampled residents. (Resident #2) The finding includes: The GHIID staff failed to ensure that Resident #2 received the appropriate amount of food during dinner time, as evidenced below: On March 26, 2013, beginning at 6:10 p.m., dinner observations revealed employment	I 040		
			The Management Team will ensure and continue to make sure that the dietary orders by the PCP and Nutritionist will be implemented and monitored weekly weights and staff monitoring for proper diet recommendation. The Nursing team will notify the PCP if there is any weight loss or weight gain of 1 lb per week.	4/10/2013 and ongoing

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 4/12/13

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	HFD03-0039		03/27/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 040	Continued From page 1 specialist #1 (ES1) placed ketchup on top of each resident's baked fish. Resident #2 was observed to immediately push his fish off of his plate onto Resident #3's plate. Resident #2 ate 100% of his mashed potatoes, vegetables and wheat bread. The resident however, was not offered any other meat as a substitution for the baked fish throughout the remainder of the dinner. Interview with ES1 at approximately 7:05 p.m., revealed Resident #2 did not like baked fish and chicken. When asked why Resident #2 given baked fish knowing that he did not like baked fish, ES1 stated that he was following the dietician's menu. ES1 stated that there was a substitution list that the GHIID used when resident's refused certain foods. ES1 went on to acknowledge that he should have offered another meat substitution to Resident #2 from the dietician's list. Review of Resident #2's current physician's orders (POs) dated December 2012 on March 27, 2013, at 9:52 a.m., revealed the resident was prescribed Ensure Plus three times a day, low fat, low cholesterol, no concentrated sweets double portion diet for breakfast and dinner. Review of a written PO dated January 10, 2013, revealed weight loss was added to the resident's diagnosis. It should be noted that Resident #2 was one pound under his desirable body weight.	I 040	Continued from page 1.	
I 226	3510.5(c) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by:	I 226	All staff and individual were trained on 4/8/2013 on Infection Control, Hand Washing and Universal Precaution at home and all the day program staff trained on 4/9/2013 by the Provider's Nursing Team. The training will continue every six (6) months and as needed.	4/8/2013 and ongoing

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	HFD03-0039		03/27/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 226	Continued From page 2 Based on observation, interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that all staff received effective training on infection control, for one out of eight employment specialist staff. (Employment Specialist staff #1) The findings include: 1. The day program staff failed to ensure Resident #2 washed his hands prior to lunch time, as detailed below: Observations conducted at the day program on March 26, 2013, at 11:30 a.m., revealed Resident #2 opened the door to the nurse station for his noon medications, took his medications and returned back to his classroom. At 11:45 a.m., the resident was given applesauce by day program Staff #1 (DPS1). Resident #2 inserted a small hole in the top the applesauce, stuck his finger inside the applesauce and licked the applesauce off his fingers. At no time was the resident instructed to wash his hands by DPS1 who sat directly in front of him. At 11:59 a.m., the resident stuck his fingers inside his mouth and rubbed the top of his hand. At approximately 12:10 p.m., Resident #2 walked over to the window, picked up some trash off the floor and placed the trash in the trash can. Seconds later, the resident stuck his hand inside the trash can, rearranged the trash inside the trash can and returned back to his seat. At 12:13 p.m., Resident #2 was observed eating his lunch which consisted of peas, meat sauce and noodles. The resident used his fingers to keep the peas from falling off the spoon. Interview with DPS1 on the same day at 12:27	I 226	Continue from page 2.	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	HFD03-0039		03/27/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 226	Continued From page 3 p.m., acknowledged that her routine was a little different. She stated that she usually instructs the residents to wash their hands or provided hand sanitizer prior to lunch. DPS1 stated that her supplies (hand sanitizer) were packed away in her car. She further stated that she should have had Resident #2 wash his hands because he [resident] was always touching and picking up items. When asked, DPS1 stated that she has had training on infection control. Review of the day program's in-service training records on March 26, 2013, at approximately 12:40 p.m., confirmed that DPS1 received training on infection control on January 10, 2013. Observations on March 26, 2013, during lunch however, indicated the training had not been effective. 2. On March 26, 2013, at approximately 6:20 p.m., dinner observations revealed Resident #2 was served double portions of baked fish with ketchup on top, flavored mashed potatoes, mixed vegetables and wheat bread with butter. At 6:23 p.m., the resident got up from the dining table, went into the kitchen, removed the lid from the trash can, threw some food inside the trash can, and returned back to his seat. After returing to the tables, he was observed to use his hands to scoop his vegetables onto his spoon to eat them. This occurred two more times throughout dinner. Each time, employment specialist #1 (ES1) and the qualified intellectual disabilities professional #1 (QIDP #1) verbally prompted the resident to stop throwing food inside the trash can. The resident however, was not encouraged to wash his hands. Interview with ES1 on March 26, 2013, at approximately 7:10 p.m., revealed that he should	I 226	Continue from page 3.	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	HFD03-0039		03/27/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 226	Continued From page 4	I 226		
	have had Resident #2 wash his hands each time the resident touched the trash can. Further interview revealed that he has had training on universal precautions (hand washing) within the past year. Review of the in-service training records on March 27, 2013, at 1:14 p.m., revealed that all staff including ES1 received training on infection control procedures (hand washing) on August 15, 2012. Observations on March 26, 2013, however, revealed the training had not been effective.		Continue from page 4.	
I 422	3521.3 HABILITATION AND TRAINING	I 422		
	Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHIID failed to implement an effective system to ensure that each resident participated in a self-medication training program as recommended by the interdisciplinary team, for two of the two residents in the sample. (Residents #1 and #2) The finding includes: The GHIID failed to implement Residents #1 and #2 recommended self-medication training programs, as detailed below: a. On March 26, 2013, at 6:47 p.m., observations of the evening medication administration revealed licensed practical nurse #1 (LPN1) punched Resident #1's medications into a medication cup and handed the cup to the resident. The resident consumed his medications and drank his water.		The LPN Medication Nurses received training on self medication program for individuals #1 and #2 and all the other individuals leaving the home on 3/28/2013. The Director of Nursing will continue to train the LPN Medications Nurses every six (6) months and as needed on individuals proper participation of Self Medication Administration Program.	3/28/2013 and ongoing

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	HFD03-0039		03/27/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 422	Continued From page 5 At no time did the LPN1 encourage Resident #1 participate with his medication administration. b. On March 26, 2013, at 7:00 p.m., LPN1 punched Resident #2's medications into a medication cup and handed the cup to the resident during the medication administration. The resident consumed his medications and drank his water. At no time did the LPN encourage Resident #2 to participate with his medication administration. Interview with LPN1 on the same day at approximately 7:05 p.m., revealed that neither resident had a self-medication program. On March 27, 2013, at 9:39 a.m. and 10:35 a.m., respectively, review of Residents #1 individual program plan (IPP) dated February 26, 2013, and review of Resident #2's IPP dated September 7, 2013, revealed that both residents had self-medication training programs. The programs revealed that given verbal prompts, the residents will participate in the following targeted steps 50% of the time for three consecutive months. - Obtain medication cup; - Name each medication; - Remove medication from each blister pack into the medication cup; and - Replace the blister pack back in the medication cabinet. Review of the program documentation for Residents #1 and #2 for March 26, 2013, on the same day at approximately 10:45 a.m., revealed there was no documented evidence that the	I 422	Continue from page 5.	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	HFD03-0039		03/27/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 422	Continued From page 6 residents programs had been implemented. On March 27, 2013, at approximately 10:50 a.m., registered nurse #1 (RN1) reviewed the residents program documentation in the presence of the surveyor. RN1 then confirmed that the Residents #1 and #2's self-medication programs were not implemented as recommended.	I 422	Continue from page 6.	