

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

PRINTED: 06/03/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G087</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/24/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SYMBRAL FOUNDATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>722 "L" STREET, NE WASHINGTON, DC 20002</b>
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(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
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W 000 INITIAL COMMENTS

A recertification survey was conducted from May 22, 2012, through May 24, 2012. A sample of two clients was selected from a population of two men with various degrees of intellectual disabilities. The survey was conducted utilizing the fundamental survey process

The findings of the survey were based on observations in the home and at two day programs, interviews with direct support staff, administrative staff and one client, 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.]

W 365 483.460(j)(4) DRUG REGIMEN REVIEW

An individual medication administration record must be maintained for each client.

This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure medication records were accurately maintained for two clients residing in the facility. (Client #1 and #2)

The findings include:

The facility failed to ensure each client's medication administration record (MAR) was accurately maintained, as evidenced below:

a. Observation of the medication administration on May 22, 2012, at 6:43 p.m., revealed Client #2

W 000

Symbtral's governing body will ensure that all required policies are implemented as required to safe-guard and provide habilitation to the individuals we serve.

6/5/12  
and  
ongoing

In addition, that these policies are aligned to present Health and Wellness Standards and other best practices guide Symbtral's governing body and QA Teams will monitor to ensure compliance.

Department of Health  
Health Regulation & Licensing Administration  
Intermediate Care Facilities Division  
809 North Capitol St., N.E.  
Washington, D.C. 20002  
*Received 6/13/12*

W 365

TAR - Treatment administration records will be placed in the treatment book of each individual, done at Symbtral Foundation. However, the treatment books will be signed by the person/staff administering the treatment.

6/10/12

For example: after the application of lotion/cream and by a TME per PCP's orders, her/she will sign the ongoing TAR, and if an LPN administers lotion or cream per PCP's orders, he/she will sign the TAR.

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their 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 365 Continued From page 1  
received Kepra, Thorazine and Trileptal from the evening licensed practical nurse (LPN).  
On May 22, 2012, at 7:11 p.m., record review of Client #2's medication administration record (MAR) revealed the evening LPN initialed that she administered Chlorhexidine Gluconate (mouthwash).  
b. Observation of the medication administration on May 22, 2012, at 6:54 p.m., revealed Client #1 received Klonopin, Chlorpromazine, Docusate Sodium and Revia from the evening licensed practical nurse (LPN).  
On May 22, 2012, at 7:13 p.m., record review of Client #1's medication administration record (MAR) revealed the evening LPN initialed that she applied Ammonium Lactate Lotion and Minerin Cream.  
Interview with the evening LPN on May 22, 2012, at 7:15 p.m., revealed she was instructed to always initial for the aforementioned orders. Further interview revealed that the direct support staff will administer the treatments to Client #1 and Client #2 later that evening.

W 365

For Medications given by the TME's, MAR-medication administration records will be signed by TMEs, those medications given by LPN, will be the only medication records section signed or documented by the LPN.

6/10/12  
and  
ongoing

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

W 371

See page 3.

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W 371 Continued From page 2  
does not specify otherwise.

W 371

This STANDARD is not met as evidenced by:  
Based on observations, interviews, and the review of records, the facility failed to properly assess to develop written self administration objectives, for two of two clients residing in the facility. (Clients #1 and #2)

The findings include:

The facility failed to assess and develop a self medication administration program for Client #1 and #2 , as evidenced below:

a. Observation of the medication administration on May 22, 2012, beginning at 6:36 p.m., revealed licensed practical nurse #1 (LPN) prepared Client #2's medications. The LPN measured and punched Client #2's medications into a medication cup. The LPN then handed the client his medications. At approximately 6:45 p.m., the surveyor asked the LPN what the medications were treating, however, Client #2 answered instead by stating the use of each of his medications. Interview with the LPN confirmed that the client was accurate.

Record review on May 23, 2012, beginning at 10:58 a.m., failed to reveal a self medication assessment for Client #2.

b. Observation of the medication administration on May 22, 2012, beginning at 6:50 p.m., revealed the evening LPN prepared Client #1's medications. The LPN punched Client #1's medications into a medication cup. The LPN

A & B: Self Medication Assessments have been done for both individuals in this sample to include active participation in self medication programs, as highlighted in attachment.

In addition, all individuals served will be provided self medication assessment to include implementation of a self medication program reflective by continued data collection and evaluation.

RN, LPN Case Manager, QIDP, House Manager and 1:1 care staff where applicable will continue to monitor to ensure compliance.

6/8/12  
and  
ongoing

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W 371 Continued From page 3  
handed the client his medications, then handed his water to him.

Record review on May 23, 2012, beginning at 3:00 p.m., failed to reveal a self medication assessment for Client #1.

Interview with the evening LPN and the licensed practical nurse coordinator on May 22, 2012, at approximately 7:15 p.m., revealed Client #1 and Client #2 were not assessed for a self medication program.

W 371  
Continued from page 3.

W 436 483.470(g)(2) SPACE AND EQUIPMENT

The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

This STANDARD is not met as evidenced by:  
Based on observation, staff interview and record review, the facility failed to ensure adaptive equipment was furnished, monitored and maintained as recommended, for one of two clients in the sample. (Client #1)

W 436

A second sippy cup was purchased for individual #1 making a total of two (2) cups. 6/8/12 and ongoing

QIDP re-inserviced all staff on consistent usage of all adaptive equipment with special emphasis on those used at meal-time.

QIDP, QA Team and House Manager will monitor 1/3 meal time for the next thirty (30) days and PRN for the next sixty (60) days to ensure compliance to best practice guide outlined by Health and Wellness Standards.

The finding includes:

The facility staff failed to ensure consistent use of Client #1's sippy cup as evidenced below:

Observation on May 22, 2012, at 6:12 p.m., revealed Client #1 eating his dinner. At 6:15 p.m., the client drank water from his sippy cup

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W 436 Continued From page 4  
independently. One minute later, the client drank milk from a cup without a top. As the client was drinking, milk was observed to spill on his clothes. At 6:22 p.m., the client spilled milk again. Therefore, the evening one to one staff assisted Client #1 as he drank his milk.  
  
Interview with the evening one to one staff on May 22, 2012, at 6:27 p.m., revealed that the top was not put on Client #1's sippy cup because the hole was too small and they did not have another cup.

W 436  
Continued from page 4.

Health Regulation & Licensing Administration

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1 000 INITIAL COMMENTS

1 000

A licensure survey was conducted from May 22, 2012, through May 24, 2012. A sample of two residents was selected from a population of two men with various degrees intellectual disabilities.

The findings of the survey were based on observations in the home and at two day programs, interviews with direct support staff, administrative staff and one client, 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.]

Symbtral's governing body will ensure that all required policies are implemented as required to safe-guard and provide habilitation to the individuals we serve.

6/5/12  
and  
ongoing

In addition, that these policies are aligned to present Health and Wellness Standards and other best practices guide Symbtral's governing body and QA Teams will monitor to ensure compliance.

*Reviewed 6/13/12*  
Department of Health  
Health Regulation & Licensing Administration  
Intermediate Care Facilities Division  
899 North Capitol St., N.E.  
Washington, D.C. 20002

1 206 3509.6 PERSONNEL POLICIES

1 206

Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties.

Staff #15 has furnished a copy of his health certificate which has been placed in his personnel file.

6/7/12  
and  
ongoing

This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that all employees had current health certificates, for one of seventeen staff. (Staff #15.)

QIDP sent memo to personnel office as a reminder that all staff and contractors including maintenance personnel that have contact with individual serve must maintain an active personnel file to include current physical and police clearance for all jurisdictions of having lived and or worked within that last seven (7) years.

The finding includes:

QA Team and House Manager will check records and issue alerts within ninety (90) days, sixty (60) days and thirty (30) days prior to expiration to ensure compliance in maintaining active files.

On May 23, 2012, beginning 12:45 p.m., review of the personnel records failed to show evidence of

QIDP, QA Team, Human Resource and House Manager will continue to monitor to ensure compliance.

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

TITLE  
*CFO*

(X6) DATE  
*6-12-12*

Health Regulation & Licensing Administration

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I 206 Continued From page 1  
a current physician's health certificate for Staff #15.  
  
At approximately 1:30 p.m., on the same day, interview with the administrative administrator (AA) and the training coordinator (TC) confirmed that there was no evidence of a health inventory performed by a physician for the aforementioned personnel.

I 206

Continued from page 1.

I 420 3521.1 HABILITATION AND TRAINING  
  
Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning.  
  
This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to provide habilitation and training to its residents that would enable them to acquire and maintain life skills needed to cope with their environments and achieve optimum level of physical, mental, and social functioning, for two of the two residents residing in the facility. (Resident #1 and #2)

I 420

A & B: Self Medication Assessments have been done for both individuals in this sample to include active participation in self medication programs, as highlighted in attachment.

6/8/12  
and  
ongoing

In addition, all individuals served will be provided self medication assessment to include implementation of a self medication program reflective by continued data collection and evaluation.

RN, LPN Case Manager, QIDP, House Manager and 1:1 care staff where applicable will continue to monitor to ensure compliance.

The findings include:

The facility failed to assess and develop a self medication administration program for Resident #1 and #2, as evidenced below:

a. Observation of the medication administration on May 22, 2012, beginning at 6:36 p.m., revealed licensed practical nurse #1 (LPN) prepared Resident #2's medications. The LPN

Health Regulation & Licensing Administration

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I 420	Continued From page 2  measured and punched Resident #2's medications into a medication cup. The LPN then handed the client his medications. At approximately 6:45 p.m., the surveyor asked the LPN what the medications were treating, however, Resident #2 answered instead by stating the use of each of his medications. Interview with the LPN confirmed that the client was accurate.  Record review on May 23, 2012, beginning at 10:58 a.m., failed to reveal a self medication assessment for Resident #2.  b. Observation of the medication administration on May 22, 2012, beginning at 6:50 p.m., revealed the evening licensed practical nurse LPN prepared Resident #1's medications. The LPN punched Resident #1's medications into a medication cup. The LPN handed the resident his medications, then handed his water to him.  Record review on May 23, 2012, beginning at 3:00 p.m., failed to reveal a self medication assessment for Resident #1.  Interview with the evening LPN and the licensed practical nurse coordinator on May 22, 2012, at approximately 7:15 p.m., revealed resident #1 and resident #2 was not assessed for a self medication program.	I 420	Continued from page 2.	

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R 125	4701.5 BACKGROUND CHECK REQUIREMENT	R 125		
	<p>The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check.</p> <p>This Statute is not met as evidenced by: Based on the interview and record review, at agency personnel office for persons with intellectual disabilities failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions where staff had worked or resided within the seven (7) years prior to the check, for one of the seventeen staff employed. (Staff #15)</p> <p>The finding includes:</p> <p>Review of the personnel files on May 23, 2012, beginning at 12:45 p.m., revealed the Agency failed to provide evidence of a criminal background check that disclosed a seven year history of all jurisdictions where staff #15 worked and/or resided at the time of the survey.</p> <p>At approximately 1:30 p.m., on May 23, 2012, the surveyor reviewed the aforementioned findings listed above with the training coordinator (TC) and the administrative assistant (AA). They verified that a criminal background checks was not conducted in all jurisdictions where staff lived within the past seven years.</p>		<p>Staff #15 has provided a copy of his criminal background check for all jurisdictions where he has lived and worked within the last seven (7) years.</p> <p>QIDP sent memo to personnel office as a reminder that all staff and contractors including maintenance personnel that have contact with the individuals we serve, Symbra's HR must maintain active personnel files to include current physicals and police clearances for all jurisdictions of having lived and or worked within that last seven (7) years.</p>	6/7/12 and ongoing

Health Regulation & Licensing Administration

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

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12.6.12