

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

HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002

PRINTED: 06/15/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

09G174

(X2) HEALTH REGULATION ADMINISTRATION
B. WING

(X3) DATE SURVEY
COMPLETED

06/15/2010

NAME OF PROVIDER OR SUPPLIER

SYMBRAL FOUNDATION

STREET ADDRESS, CITY, STATE, ZIP CODE

4422 20TH STREET, NE
WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS An recertification survey was conducted from June 14, 2010, through June 15, 2010, utilizing the full survey process. A random sample of two clients were selected from a population of four men with various levels of disabilities. The findings of the survey were based on observations at the group home and one day program, interviews with clients and staff, and the review of clinical and administrative records including incident reports.	W 000	Symbtral's governing body has received deficiency report and have established protocols, make amendments as well as executing other interventions to ensure compliance to regulatory codes as per monitoring agencies.	7/1/10 and ongoing
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and review of the client's records, the facility failed to ensure that all injuries of unknown origin were reported immediately to the administrator and to the State agency, for four of the four clients residing in the facility. (Clients #1, #2, #3 and #4) The findings include: 1. Review of the Client #3's nursing note dated May 27, 2010, on June 14, 2010, at approximately 11:00 a.m., revealed that Client #3 was observed with a bruise on his right thumb, a superficial abrasion about half an inch. First aid was applied.	W 153	Incident Management Coordinator re-inserviced QMRP, House Manager and all direct care staff working with individuals at this facility on reporting all injuries of unknown origin as per incident management protocol. CEO has reiterated as per Incident reporting form that all incidents must be reported to her. Failure to provide notification will result in disciplinary action.	7/7/10 and ongoing

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

Khonda M. [Signature] RN

TITLE

CEO

(X6) DATE

7/12/2010

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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 153	<p>Continued From page 1</p> <p>There was no evidence the facility reported the injury of unknown origin to the administrator or to the Department of Health (DOH).</p> <p>2. The facility failed to report a medication error to the administrator or to DOH, for three of the four clients residing in the facility. (Clients #1, #2 and #4)</p> <p>On June 14, 2010, at 7:30 a.m., the surveyor entered the facility. Interview with the direct care support at 7:38 a.m., revealed that the medication nurse had not arrived. At 8:24 p.m., a LPN was observed entering the facility. Interview with the LPN, at 8:32 a.m., revealed that she would be administering the client's morning medications. The LPN began administering Client #4's medication at 8:42 a.m., and ended with Client #1's medication administration at approximately 9:25 a.m.</p> <p>Review and reconciliation of the physician orders on June 14, 2010, at 10:00 a.m., revealed that Clients #1, #2 and #4 should have received their medications at 7:00 a.m. Interview with the LPN, after the medication administration, indicated that she was running late because she had other homes to pass medications. Inquiry was made to the qualified mental retardation professional (QMRP) on June 15, 2010, at approximately 10:00 a.m., of an incident report regarding the medication error that occurred on June 14, 2010. She had no knowledge of an incident report. Further inquiry was made to the LPN Coordinator at approximately 11:15 a.m., and she revealed that the LPN was asked to report to the facility's headquarters office and an incident report would be generated at that time. According to the</p>	W 153	<p>2. An updated incident report which included individuals #1, 2, 4 was faxed to DOH on 7/7/10. CEO was then notified as indicated on form.</p> <p>DON completed an in-service training with all the medication nurses on 7/5/10. Medication time frame schedule shall be maintained to accommodate the 1 hour before and after window.</p> <p>In cases of emergency the medication staff contact the DON to report any lateness. A late medication pass order shall be obtained from the PCP whenever occurrences are passed the allowed 1 hour window.</p> <p>DON will monitor time frame of medication pass as per telephone calls via checkiist for the next 30 days. Direct Care Staff and House Manager was given a memo by QMRP to provide notification of nurse's arrival 5 minutes before and 5 minutes past given the 1 hour window before and after for medication pass.</p> <p>QA Team, DON, QMRP, LPN Case Manager, House Manager and Direct Care Staff will continue to monitor to ensure compliance.</p>	7/5/10 and ongoing

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W 153	Continued From page 2 incident report, the LPN completed the incident report on June 15, 2010, at 3:35 p.m. Review of the incident report revealed that Client #3 was the only client mentioned in the report. However Clients #1, #2, and #4 should have been included in the report.	W 153	See 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 all investigations to the administrator, designated representative or to other officials in accordance with State Law within five working days of the incident, for two of four clients residing in the facility. (Clients #1 and #4) The findings include: Review of the facility's incident and investigative reports on June 14, 2010, beginning at 9:30 a.m., revealed the following incidents and investigative reports: a. On February 22, 2010, 911 was called due to Client #1's uncontrollable cough. According to the investigation, the client was diagnosed with asthma exacerbation.	W 156	(A,B,C) A checklist was developed which request that CEO attaches her signature to all investigative reports before they leave Provider Agency. This will substantiate the Findings of each investigation is known. CEO, Incident Management Coordinator, QA Team, QMRP, DON and House Manager will continue to monitor to ensure compliance.	7/6/10 and ongoing

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W 156	<p>Continued From page 3</p> <p>b. On February 24, 2010, Client #1 was taken to the emergency room for uncontrollable wheezing. According to the investigation report, Client #1 was discharged on March 3, 2010, with a diagnosis of acute asthma exacerbation.</p> <p>c. On March 2, 2010, Client #4 received a small superficial scratch while attending his day program. According to the investigation report, Client #1's classmate scratched him when he tried to take his cake.</p> <p>An interview was conducted with the qualified mental retardation professional (QMRP) on June 14, 2010, at approximately 4:30 p.m., to ascertain information regarding the facility's incident management system. According to the QMRP, all investigative results were completed by the Incident Management Coordinator and reported to the administrator.</p> <p>On June 14, 2010, at approximately 10:00 a.m., review of the investigative reports revealed that there was no documented evidence that the administrator had been notified of the results of the aforementioned investigations.</p> <p>At the time of the survey, the facility failed to provide documented evidence that verified the administrator was notified of the results of the investigative reports within five working days as required.</p>	W 156	See page 3.	
W 192	<p>483.430(e)(2) STAFF TRAINING PROGRAM</p> <p>For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p>	W 192	(A) Nutritionist re-inserviced all 1:1 staff and other direct care staff on implementation of dietary order as per menu and caloric restrictions / texture.	7/7/10 and ongoing

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W 192	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff demonstrated competency to address the needs of the clients, for one of two clients in the sample. (Client #1)</p> <p>The findings include:</p> <p>A. The facility failed to ensure staff was adequately trained to implement the calorie restricted and textured diet.</p> <p>On June 14, 2010, at 12:14 p.m., Client #2 was observed eating a jelly sandwich on wheat bread and vanilla pudding. Review of the spring/summer menu on June 15, 2010, at approximately 11:15 a.m., revealed Client #2's menu consisted of peanut butter and jelly, celery and jello. Moments later, interview with the QMRP revealed that the client was allergic to peanuts, however no substitution was provided.</p> <p>B. The facility staff failed to follow pureed diet as order.</p> <p>On June 14, 2010, at 12:07 p.m., Client #1 was observed eating pureed peanut butter and jelly, celery and jello. Review of the spring/summer menu on June 15, 2010, at approximately 11:15 a.m., revealed clients on a non-pureed diet should receive the aforementioned lunch. Clients on a pureed diet were required to receive a 1/2 cup of pureed tuna, two slices of soaked bread, 1/2 cup of pureed vegetables and plain jello.</p> <p>On June 15, 2010, at 11:30 a.m., interview with the license practical nurse revealed that the staff did not follow the menu as required.</p>	W 192	(B) Nutritionist, QA Team, DON, QMRP, LPN Case Manager and House Manager will continue to monitor to ensure compliance 1st 30 days x 3 weekly, 2nd 30 days x 1 weekly.	7/7/10 and ongoing

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W 192	Continued From page 5	W 192	See page 5.	
W 212	<p>Review of the facility's in-service training records on June 15, 2010, at approximately 10:40 a.m., revealed that all staff had received nutritional training on November 17, 2009. There was no evidence that training had been effective.</p> <p>483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to provide the necessary assessments, for one of two clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>During the entrance conference on June 14, 2010, at 10:10 a.m., the qualified mental retardation professional (QMRP) stated that Client #1 does not attend his day program due to medical reasons. The QMRP indicted that the client will go back to his day program once his wheezing is under control and his primary care physician (PCP) recommends him to attend his day program.</p> <p>On June 14, 2010, at 12:07 p.m., Client #1 was observed drinking milk from a provale cup independently. Minutes later, Client #1 was drinking water from a regular glass with assistance from his one to one direct support staff. Further observation on the same day at 5:49 p.m., revealed Client #1 drinking milk, water and prune juice from a regular glass.</p>	W 212	<p>A second provale cup was purchased for individual #1.</p> <p>All staff including individual #1 1:1 were re-inserviced on usage of prescribed adaptive equipment at all times.</p> <p>Speech and Language Therapist visited home on 6/16/10 and noted that adaptive equipment as specified was effective in satisfying individual #1 medical/nutritional needs.</p> <p>PCP noted dated 3/31/09 indicated that individual did not need O.T.</p> <p>However, given his decline in health and functional mobility an Occupation Therapist's Evaluation was done on 7/9/10. (see attached)</p> <p>PCP, Speech and Language Therapist, Occupational Therapist, QA Team, DON, QMRP, LPN Case Manager and House Manager will continue to monitor to ensure compliance.</p>	<p>6/16/10 and ongoing</p> <p>6/15/10</p> <p>7/9/10 and ongoing</p>

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W 212	<p>Continued From page 6</p> <p>Review of Client #1's medical records on June 14, 2010, at 12:23 p.m., revealed the client was hospitalized on February 25, 2010 for acute exacerbation of asthma. Interview with the QMRP on June, 15, 2010, at 10:52 a.m., indicated that the client's functional status had change after he was discharged on March 3, 2010.</p> <p>Further record review on June 15, 2010, at approximately 10:00 a.m., revealed Client #1 received a barium swallow test on April 19, 2010, at the hospital. As a result, the client's diet was changed from pureed with honey thickened liquids to pureed with nectar thickened liquids. The video fluoroscopic report also recommended a change from a regular glass to a proval cup. According to a PCP note dated March 2009, revealed that Client #1 was in need of an occupational therapy assessment. However, review of the client's Individual Support Plan (ISP) dated June 2, 2010 on June 15, 2010, at approximately 2:00 p.m., revealed an occupational assessment was not a part of his ISP.</p> <p>It should be noted that although the group home had modified the diet textures (pureed with nectar thickened liquids) and were utilizing the use of adaptive cup as recommended during the February 25, 2010, there was no evidence that speech and occupational therapy had assessed Client #1 to verify if these modifications were effectively meeting his needs.</p>	W 212	See page 6.	
W 227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs,</p>	W 227	See page 8.	

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W 227	<p>Continued From page 7</p> <p>as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that an objective was developed to address self medication training program needs as identified by the interdisciplinary team (IDT) in the comprehensive assessment, for one of the two clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>On June 14, 2010, at 9:05 a.m., the licensed practical nurse (LPN) was observed preparing the Client #2's medications, pouring a cup of water and giving the client the medication and a cup of water. The client consumed the medications and the water. Interview with the LPN, after the medication administration, indicated that the client usually punches his medications, but since the surveyor is here, "I did it." According to the self medication assessment dated February 6, 2009, on June 15, 2010, at approximately 11:00 a.m., the client was recommended to participate in a self-medication program, but the specific goal and corresponding program objective was not documented on the assessment. Interview with the qualified mental retardation professional (QMRP) and LPN Coordinator and further record review on June 15, 2010, at 11:10 a.m., revealed Client #2's IPP dated February 17, 2010. Review of the plan and discussion with the QMRP, the facility failed to provide evidence of an objective written to assist the client with acquiring skills in the domain of self-medication administration.</p>	W 227	<p>Informal Self Medication program was in-placed for individual #2. However, nurse failed to implement program. Nurse resigned on 6/15/10. New medication Nurse was in-serviced on self medication program for individual #2. Program has been made formal and progress being documented as per data sheet.</p> <p>QA Team, DON, QMRP, LPN Case Manager will continue to monitor to ensure compliance.</p>	6/17/10 and ongoing

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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, staff interview, and record verification, the facility failed to implement a client's Individual Support Plan (ISP), for one of the two clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>On June 14, 2010, at 8:15 a.m., the one to one support staff was observed handing Client #1 playing cards. At 8:38 a.m., the one to one staff began to play dominoes. At 11:50 a.m. the one to one support staff took the client into the kitchen then she began to prepare his lunch. At 12:38 p.m., the one to one support staff informed the license practical nurse (LPN) that the client was wheezing. The LPN listened to his chest and lungs, shortly after, the LPN told the one to one staff/trained medication employee to administer his treatment for wheezing.</p> <p>Review of Client #1's IPP dated June 2, 2010, on June 15, 2010, at 1:45 p.m., revealed an objective stated that the client will be provided the opportunity to engage in an activity of choice during ill health or when at home during routine day program hours. However, at no time during</p>	W 249	<p>All 1:1 staff were re-trained on 6/18/10 on implementation of IPP goals along with offering choices as per checklist of activities individual's interest.</p>	6/18/10 and ongoing

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W 249	Continued From page 9 the survey were any of the 1:1 staff observed giving the client the opportunity to decide what activity he wanted to engage in. Interview with the qualified mental retardation professional (QMRP) on June 15, 2010, at approximately 3:00 p.m., revealed Client #1 should be given a choice of activities depending on how he feels. There was no evidence that one to one direct support staff implemented Client #1's day program goal as recommended in the IPP.	W 249	See page 9.	
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop an alternative active treatment schedule that outlined the current active treatment programs, for one of two clients in the sample. (Client #1) The finding includes: During the entrance conference on June 14, 2010, at 10:10 a.m., the qualified mental retardation professional (QMRP) stated that Client #1 does not attend his day program due to medical reasons. The QMRP indicated that the client will go back to his day program once his wheezing is under control and his primary care physician recommends him to attend his day	W 250	An alternative schedule of activities was developed, staff training done and schedule was implemented.	6/16/10 and ongoing

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W 250	<p>Continued From page 10 program.</p> <p>On June 14, 2010, at 8:15 a.m., Client #1 was observed playing cards with his one to one direct support staff. At 8:38 a.m., Client #1 and his one to one staff began to play dominoes. At 11:50 a.m. the one to one support staff took the client into the kitchen then began to prepare his lunch. At 12:38 p.m., the one to one support staff informed the license practical nurse (LPN) that the client was wheezing. The LPN listened to his chest and lungs. shortly after, the LPN told the one to one staff/trained medication employee (TME) to administer his treatment for wheezing. At approximately 1:15 p.m., the TME stated the client was no longer wheezing.</p> <p>Review of the client's habilitation record on June 15, 2010, at 12:30 p.m., revealed a list of things to do with Client #1, however, there was no documented evidence of an alternative activity schedule.</p>	W 250	See page 10.	
W 252	<p>483.440(e)(1) PROGRAM DOCUMENTATION</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that data was collected in the form and required frequency, for two of the two clients in the sample. (Clients #1 and #2)</p> <p>The findings include:</p>	W 252	1. QMRP received disciplinary action from CEO for failure to implement data collection as per specified program as identified and accepted by IDT.	6/15/10

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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 252	<p>Continued From page 11</p> <p>1. On June 14, 2010, at 5:58 p.m., during dinner observations, Client #1 was observed holding a tray of dishes while being wheeled to the kitchen. Moments later, interview with the one to one direct support staff revealed the client has a goal to take his dishes to the kitchen with assistance.</p> <p>Review of the Client #1's Individual Program Plan (IPP) dated June 2, 2010, on June 15, 2010, at approximately 1:45 p.m., revealed a program objective which stated, "[the client] will clear his place at the table and carry his used utensils on a tray to the kitchen area and hand each utensil to staff to place in sink 100% of recorded times for three consecutive months." Continued review revealed documentation is required Monday - Friday. Review of the data sheet on June 15, 2010, at approximately 2:00 p.m., revealed no documentation from the previous date (June 14, 2010). Interview with the QMRP confirmed that the staff failed to document the program to clear his place setting.</p> <p>There was no evidence that data had been collected in accordance with Client #1's IPP</p> <p>2. On June 14, 2010, at 11:00 a.m., Client #2 was observed taking a shower. Interview with the staff indicated that he refused to take a shower last night and again earlier this morning.</p> <p>Interview with the qualified mental retardation professional (QMRP) on June 15, 2010, at 11:00 a.m., indicated that Client #2 has a Behavior Support Plan (BSP) to address his non-compliant behaviors. Further interview revealed that if the client refused to perform personal hygiene activities (bathing) in the evening then he should</p>	W 252	<p>1. In addition data collection sheet for identified program was developed. Staff trained and data sheet implemented on 6/16/10.</p> <p>CEO has requested that all program designed and accepted by Individual's IDT are put into effect within 3-10 days post ISP meeting. Copies of same with data collection sheet must be submitted to QA Team who will follow up accordingly 3-5 days upon receipt.</p> <p>CEO, QA Team, QWMRP and House Manager will monitor to ensure compliance to regulatory code.</p>	6/16/10 and ongoing

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W 252	<p>Continued From page 12 be offered it the following morning. If after the second request, the next morning, then that incident of non-compliance should be documented as a non-compliant behavior.</p> <p>Review of the Client #2's BSP dated March 6, 2010, on June 15, 2010, at approximately 11:15 a.m., revealed a program objective which stated, "[the client] will exhibit no more that ten incidents of non-compliance." Review of the data sheet on June 15, 2010, at approximately 11:30 a.m., revealed no documentation from the previous date (June 14, 2010). Interview with the QMRP confirmed that the staff failed to document the non-compliance behavior on June 14, 2010.</p> <p>There was no evidence that data had been collected in accordance with Client #2's IPP, which was necessary for a functional assessment of the client's progress.</p>	W 252	<p>2. QMRP, House Manager and all direct care staff were re-trained by Behavioral Specialist on the importance of documentation of targeted behaviors as per BSP.</p>	6/18/10
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 failed to ensure that the health status was reviewed by the Registered Nurse (RN) staff on a quarterly or more frequent basis, for one of the two clients included in the sample. (Client #1)</p> <p>The finding includes: Interview with the facility's Licensed Practical</p>	W 336	<p>The RN shall complete individualized Nursing Quarterly review on or latest by the end of the month scheduled.</p> <p>Individual #2 quarterly evaluation was completed as scheduled.</p> <p>Each assigned LPN Case Manager Shall notify the RN of each due quarterly evaluation 2 weeks prior scheduled dates.</p> <p>QA Team, QMRP, DON, LPN Case Manager and House Manager will monitor to ensure compliance.</p>	7/7/10

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W 336	Continued From page 13 Nurse (LPN) Coordinator on June 14, 2010, at 10:45 a.m., revealed that the Registered Nurse (RN) should complete quarterly nursing exams. Review of Client #2's medical record on June 14, 2010, at 10:50 a.m., revealed a nursing assessment dated February 5, 2010, with the next quarterly scheduled May 2010. The LPN Coordinator confirmed the missing nursing quarterly review for Client #2.	W 336	See page 13.	
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility's staff failed to follow client's physician orders (POS), for two of the four clients residing in the facility. (Clients #1 and #3) The findings include: 1. On June 14, 2010, at 7:30 a.m., the surveyor entered the facility. Interview with the direct care support at 7:38 a.m., revealed that Client #1 already had his breakfast and that the licensed practical nurse (LPN) had not arrived. At 8:24 p.m., the LPN was observed entering the facility. Interview with the LPN, at 8:32 a.m., revealed that she would be administering the morning medications, to the clients. At 9:25 a.m., the LPN was observed preparing Client #1's medications. The client consumed Tamsulosin HCL 0.4 mg tablet. Interview with the medication nurse indicated that the Tamsulosin HCL was used to treat his diagnosis of uncontrolled hypertension. Review and reconciliation of the physician orders	W 368	1. DRUG ADMINISTRATION: Nursing staff shall ensure adherence to diabetic monitoring and medication regimen and blood sugar testing as per orders. Medication Nurses were retrained on the 6 rights of medication administration. DON shall conduct evaluation of competencies as needed or annually for the LPN.	7/5/10

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W 368	<p>Continued From page 14</p> <p>on June 14, 2010, at 10:00 a.m., confirmed that Client #1 was prescribed Tamsulosin HCL 0.4 mg, once a day. The POS was further ordered that the pill should be administer 1/2 hour after the meal.</p> <p>Interview with the LPN Coordinator on June 15, 2010, at 10:45 a.m., confirmed that Client #1 should received Tamsulosin HCL, 30 minutes after his breakfast.</p> <p>2. On June 14, 2010, at 7:30 a.m., the surveyor entered the facility. Interview with the direct care support at 7:38 a.m., revealed that Client #3 had his breakfast at 7:00 a.m., and the medication nurse had not arrived. At 8:24 p.m., the licensed practical nurse (LPN) was observed entering the facility. Interview with the LPN, at 8:32 a.m., revealed that she would be administering the morning medications, to the clients. At 8:57 a.m., the LPN was observed obtaining blood sugar levels from Client #3, using a blood glucose meter. The client's reading was 170 mg. The LPN was observed administering the client's entire medication regime.</p> <p>Interview with the LPN, after the medication administration, indicated that Client #3's blood sugar should be monitored prior to the client having breakfast.</p> <p>Review of Client #3's POS dated June 2010, on June 14, 2010, at 9:50 a.m., indicated an order that read, "Fasting blood sugar every other day before breakfast, via finger stick." According to the medication administration records (MARs), a finger stick should have been conducted on every other day (Monday, June 14, 2010), prior to the client's breakfast. Further interview with the LPN</p>	W 368	<p>2 RN conducted Diabetic Management Training from the medication Nurses for individual #3.</p> <p>1) Training emphasized the 6 rights of medication administration.</p> <p>2) Completing a diabetic assessment for fasting blood glucose level via finger stick.</p> <p>3) Review and clarification of Medical Orders.</p>	7/5/10

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W 368	Continued From page 15 Coordinator on June 14, 2010, at approximately 11:00 a.m., confirmed that the client's blood sugar should be conducted every other day before breakfast via finger sticks.	W 368	See page 14.	
W 381	<p>483.460(I)(1) DRUG STORAGE AND RECORDKEEPING</p> <p>The facility must store drugs under proper conditions of security.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to store drugs under proper conditions of security, for one of two clients in the sample. (Client # 1)</p> <p>The finding includes:</p> <p>On June 14, 2010, at approximately 9:20 a.m., licensed practical nurse (LPN) was observed placing Client #1's medication on a tray and going upstairs. She laid the tray on the kitchen counter, containing the client's morning medications. At 9:22 a.m., she went downstairs to retrieve something from the medication cabinet. Client #1's medications were observed on the kitchen counter unattended. Further observation revealed the qualified mental retardation professional, the surveyors, the house manager and the LPN Coordinator were sitting at the dining room table and staff were going in and out of the kitchen.</p> <p>In an interview with LPN, after the medication</p>	W 381	The RN completed a training on medication administration as related to storage and handling (transport) during each medication pass.	7/5/10 and ongoing

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W 381	Continued From page 16 administration, confirmed that Client #1's medications were left unattended. Interview with the LPN Coordinator on June 14, 2010, at approximately 10:45 a.m., it was acknowledged that Client #1's medications were left unattended on the kitchen counter.	W 381	See page 16.	
W 436	<p>There was no evidence that all drugs were stored under proper conditions of security.</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure adaptive equipment were being furnished, monitored and maintained as recommended, for one of two clients in the sample. (Client #1)</p> <p>The findings include:</p> <p>1. Facility failed to provide an adequate supply of Client #1's provale cup, as follows:</p> <p>On June 14, 2010, at 12:07 p.m., Client #1 was observed drinking milk from a provale cup independently. Minutes later, Client #1 was drinking water from a drinking glass with assistance from his one to one direct support staff. There was spillage as the staff took the glass of water away from his mouth while the</p>	W 436	<p>1. An additional provale cup was purchased for individual #1. Staff were re-inserviced on consistency in usage of specified adaptive equipment.</p> <p>QA Team, QMRP, LPN Charge Nurse and House Manager will monitor to ensure compliance, as per observation checklist of meal time.</p>	6/16/10 and ongoing

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W 436	<p>Continued From page 17</p> <p>client was drinking. When asked about the provale cup and the drinking glass at 12:19 p.m., the one to one staff stated that the client only had one provale cup, therefore she gave him water in a regular glass. Further observation on the same day at 5:49 p.m., revealed Client #1 drinking milk, water and prune juice from a regular glass.</p> <p>On June 15, 2010, at approximately 11:00 a.m., review of Client #1's video fluoroscopic report, dated April 19, 2010, revealed a provale cup was recommended for Client #1. The provale cup was also reflected in his mealtime protocol, dated May 5, 2010.</p> <p>2. Facility staff failed to ensure consistent use of Client #1's eyeglasses.</p> <p>On June 14, 2010, at 12:47 p.m., review of Client #1's physician order, dated June 1, 2010, revealed the client had a diagnosis of early cataract. On June 15, 2010, at 9:00 a.m., review of the clients ophthalmology consult form, dated December 22, 2008, revealed the client was prescribed hyperopia glasses. However, during observation on June 14, 2010, the client was observed without the use of his glasses. When asked about Client #1's glasses on June 15, 2010, at 9:15 a.m., the one to one direct support staff stated he wears glasses. She then retrieved it from the china cabinet and placed it on his face.</p> <p>Interview with the qualified mental retardation professional on June 15, 2010, at approximately 2:00 p.m., revealed Client #1 had two sets of eyeglasses and is required to wear either one at all times.</p>	W 436	<p>1. See page 17.</p> <p>2. 1:1 staff working with individual #1 was given disciplinary action.</p> <p>House Manager and all staff were re-inserviced on consistency in usage of adaptive equipment (eye glasses).</p> <p>QA Team, DON, QMRP, LPN Charge Nurse, House Manager will monitor to ensure compliance.</p>	6/16/10 and ongoing
W 440	483.470(i)(1) EVACUATION DRILLS	W 440		

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W 440	<p>Continued From page 18</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills at least quarterly, for four of the four clients residing in the facility. (Clients #1, #2, #3 and #4)</p> <p>The finding includes:</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on June 14, 2010, at 2:44 p.m., revealed the following primary staffing pattern:</p> <p>Monday - Friday 8:00 a.m. - 4:00 p.m.; 3:00 p.m. - 11:00 p.m.; and 11:00 p.m. - 9:00 a.m.;</p> <p>Sunday - Saturday 9:00 a.m. - 9:00 p.m.; and 9:00 p.m. - 9:00 a.m.</p> <p>Review of the fire drill log from June 2009 to June 2010 revealed the following:</p> <p>The 8:00 a.m. - 4:00 p.m., shift there was one fire drill held on April 7, 2010; and</p> <p>The 11:00 p.m., - 9:00 a.m., shift, drills were held on June 11, 2009, December 1, 2009 and May 13, 2010. Interview with the qualified mental retardation professional (QMRP) on June 15, 2010, at approximately 12:30 p.m., revealed that the staff failed to hold fire evacuation drills for every shift, as required.</p>	W 440	<p>Fire Drill calendar was amended on 6/15/10 reflecting a drill scheduled for 6/16/10 @ 10:00 am.</p> <p>In addition fire drill calendar for the month of July was also completed indicating schedule drills for 8:00 am - 4:00 pm. (see attached)</p> <p>QA Team, QMRP and House Manager will continue to monitor to ensure compliance as per regulatory code.</p>	6/15/10 and ongoing

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W 455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide an active program for the prevention and control of infection and communicable diseases, for one of four clients residing at the home. (Client #4)</p> <p>The finding includes:</p> <p>On June 14, 2010, at approximately 8:30 a.m., licensed practical nurse (LPN) was observed washing her hands, opening the kitchen cabinets, retrieving four cups, opening the basement door, going downstairs, opening the medication cabinet, and opening another locked box, all prior to administering medications to Client #4. The LPN was not observed to wash her hands or use hand sanitizer. She then touched the Medication Administration Records (MAR's), and the rim of Client #4's medication cup.</p> <p>During a face to face interview with LPN on June 14, 2010, after the medication administration, it was acknowledged she touched many unsanitary items prior to preparing and administering Client #4's medication cup.</p> <p>There was no evidence the facility's nursing staff provided an active program for the prevention and control of infection.</p>	W 455	<p>INFECTION CONTROL: Each Nurse shall practice infection control as per regulation and standard of practice.</p> <p>RN completed a training for the LPN on 7/5/10 to ensure compliance with Infection Control Protocol and Nursing standard of practice.</p> <p>QA Team, QMRP, LPN Charge Nurse, DON, House Manager and staff will monitor to ensure compliance.</p>	7/5/10 and ongoing

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R 000	<p>INITIAL COMMENTS</p> <p>An recertification survey was conducted from June 14, 2010, through June 15, 2010, utilizing the full survey process. A random sample of two residents was selected from a population of four males with various levels of mental retardation and disabilities.</p> <p>The findings of the survey were based on observations at the group home and one day program, interviews with residents and staff, and the review of clinical and administrative records including incident reports.</p>	R 000	<p>Symbtral's governing body has re-implemented protocols that will ensure compliance to regulatory codes as per monitoring agencies in prevention of re-occurrences of deficiencies cited.</p>	7/1/10 and ongoing
R 125	<p>4701.5 BACKGROUND CHECK REQUIREMENT</p> <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 review of records, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure criminal background checks disclosed the criminal history of any 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, for two of the eighteen staff.</p> <p>The finding includes:</p> <p>Review of the personnel files on June 14, 2010, at 3:30 p.m., revealed the GHMRP failed to provide evidence of criminal background checks,</p>	R 125	<p>Symbtral's governing body has increased its core of Office Personnel delegating job responsibility of checking and updating staff file to the new office manager.</p> <p>Current background checks were received for staff #3 & staff #5 and have been placed in their personnel files.</p> <p>A monitoring tool to ensure updated records are present in personnel files (Consultants, Nurses and Direct Care Staff) was developed and implemented.</p> <p>QA Team, QMRP and House Manager will monitor to ensure compliance.</p>	6/16/10 and ongoing

Health Regulation Administration LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO	(X6) DATE 7/12/2010
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R 125	Continued From page 1 for two of the eighteen staff. (Staff #3 and #5)	R 125	See page 1.	

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1 000	<p>INITIAL COMMENTS</p> <p>An licensure survey was conducted from June 14, 2010, through June 15, 2010, utilizing the full survey process. A random sample of two residents was selected from a population of four males with various levels of mental retardation and disabilities.</p> <p>The findings of the survey were based on observations at the group home and one day program, interviews with residents and staff, and the review of clinical and administrative records including incident reports.</p>	1 000	<p>Symbtral's governing body has increased its QA Team. Team is expected to work collaboratively with QMRP, House Managers and direct care staff to ensure diagnostic, preventative and corrective measures are enforced to maintain compliance to the regulatory codes governing environmental care and upkeep.</p>	6/16/10 and ongoing
1 075	<p>3503.3(d) BEDROOMS AND BATHROOMS</p> <p>Each bedroom shall be equipped with at least the following items for each resident:</p> <p>(d) Night stand.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure that each bedroom was equipped with a night stand for each resident for two of four residents. (Residents #2 and #3)</p> <p>The finding includes:</p> <p>During the inspection of the environment on June 15, 2010, beginning at 3:00 p.m., the bedrooms of Residents #2 and #3 were observed to have no nightstands for the individuals. In an interview at the the same time, the house manager (HM) acknowledged that the nightstands had not been provided for the residents' bedrooms.</p> <p>At the time of the survey, there was no evidence</p>	1 075	<p>A Requisition form for acquisition of household items was filled out by House Manager and signed off on by CFO.</p> <p>Both bedrooms for individuals' #2 and #3 have been equipped with night stands and lamps.</p> <p>QA Team, QMRP and House Manager will continue to monitor to ensure compliance.</p>	7/8/10 and ongoing

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: CEO

STATE FORM 77FB11 (X6) DATE: 7/12/2010

If continuation sheet 1 of 12

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I 075	Continued From page 1 that each bedroom had been equipped with the minimum required items, as required.	I 075	See page 1.	
I 135	<p>3505.5 FIRE SAFETY</p> <p>Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to hold evacuation drills at least quarterly, for four of the four residents residing in the facility. (Residents #1, #2, #3 and #4)</p> <p>The finding includes:</p> <p>Interview with the acting Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on June 14, 2010, at 2:44 p.m., revealed the following primary staffing pattern:</p> <p>Monday - Friday 8:00 a.m. - 4:00 p.m.; 3:00 p.m. - 11:00 p.m.; and 11:00 p.m. - 9:00 a.m.;</p> <p>Sunday - Saturday 9:00 a.m. - 9:00 p.m.; and 9:00 p.m. - 9:00 a.m.</p> <p>Review of the fire drill log from June 2009 to June 2010 revealed the following:</p> <p>The 8:00 a.m. - 4:00 p.m., shift there was one fire drill held on April 7, 2010; and</p> <p>The 11:00 p.m., - 9:00 a.m., shift, drills were held</p>	I 135	<p>Fire Drill calendar was amended on 6/15/10 reflecting a drill scheduled for 6/16/10 @ 10:00 am.</p> <p>In addition fire drill calendar for the month of July was also completed indicating schedule drills for 8:00 am - 4:00 pm. (see attached)</p> <p>QA Team, QMRP and House Manager will continue to monitor to ensure compliance as per regulatory code.</p>	6/15/10 and ongoing

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I 135	Continued From page 2 on June 11, 2009, December 1, 2009 and May 13, 2010. Interview with the qualified mental retardation professional (QMRP) on June 15, 2010, at approximately 12:30 p.m., revealed that the staff failed to hold fire evacuation drills for every shift., as required.	I 135	See page 2.	
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review and staff interview, the group home for the mentally retarded person (GHMRP) failed to ensure one out of eighteen staff was provided the opportunity to annually review their written job descriptions as required by this section. (Staff #4) The finding includes: Interview with the qualified mental retardation professional (QMRP) and review of the GHMRP's personnel files conducted on June 14, 2010, beginning at 3:30 p.m., revealed the GHMRP failed to provide evidence that the facility discussed the contents of job descriptions.	I 203	Job description review was done with staff #4 and the relevant document signed as per protocol.	6/16/10 and ongoing
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties.	I 206	Symbtral's governing body has increased its core of Office Personnel delegating job responsibility of checking and updating staff file to the new office manager. Current health certificates were received for staff #1, #2, #4, #5 & #6 and Consultant (Speech Pathologist) and have been placed in their files.	6/16/10 and ongoing

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I 206	Continued From page 3 This Statute is not met as evidenced by: Based on interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure each staff and consultant had a current health certificate, for three of the eighteen direct care staff (Staff #2, #4, and #5), one of the nine consultants (speech pathologist). The finding includes: Interview with the qualified mental retardation professional (QMRP), house manager and review of the personnel records on June 14, 2010, beginning at 3:30 p.m., revealed the GHMRP failed to provide evidence that current health certificates were on file for four of the eighteen staff (Staff #1, #2, #4 and #6) and one of the nine consultants (speech pathologist).	I 206	A monitoring tool to ensure updated records are present in personnel files (Consultants, Nurses and Direct Care Staff) was developed and implemented. QA Team, QMRP and House Manager will monitor to ensure compliance.	6/16/10 and ongoing
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for the Mentally Retarded Person (GHMRP) failed to ensure staff received effective training to address the needs of the residents, for one of two residents in the sample. (Resident #1) The findings include: A. The GHMRP failed to ensure staff was adequately trained to implement the calorie	I 222	Nutritionist re-inserviced all 1:1 staff and other direct care staff on implementation of dietary order as per menu and caloric restrictions / texture. Nutritionist, QA Team, DON, QMRP, LPN Case Manager and House Manager will continue to monitor to ensure compliance 1st 30 days x 3 weekly, 2nd 30 days x 1 weekly.	7/7/10 and ongoing

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I 222	<p>Continued From page 4</p> <p>restricted and texture diet.</p> <p>On June 14, 2010, at 12:14 p.m., resident #2 was observed eating a jelly sandwich on wheat bread and vanilla pudding. Review of the spring/summer menu on June 15, 2010, at approximately 11:15 a.m., revealed resident #2 menu consisted of peanut butter and jelly, celery and jello. Moments later, interview with the QMRP revealed that the client was allergic to peanuts, however no substitution was provided.</p> <p>B. TheGHMRP staff failed to follow pureed diet as order.</p> <p>On June 14, 2010, at 12:07 p.m., resident #1 was observed eating pureed peanut butter and jelly, celery and jello. Review of the spring/summer menu on June 15, 2010, at approximately 11:15 a.m., revealed clients on a non-pureed diet should receive the aforementioned lunch. Clients on a pureed diet were required to receive a 1/2 cup of pureed tuna, two slices of soaked bread, 1/2 cup of pureed vegetables and plain jello.</p> <p>On June 15, 2010, at 11:30 a.m., interview with the license practical nurse revealed that the staff did not follow the menu as required.</p> <p>Review of the facility's in-service training records on June 15, 2010, at approximately 10:40 a.m., revealed that all staff had received nutritional training on November 17, 2009. There was no evidence that training had been effective.</p>	I 222	See page 4.	
I 401	<p>3520.3 PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>Professional services shall include both diagnosis and evaluation, including identification of</p>	I 401	A second provale cup was purchased for individual #1.	6/16/10 and ongoing

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I 401	<p>Continued From page 5</p> <p>developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to provide professional services that included 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, for two of two residents included in the sample. (Residents #1 and #2)</p> <p>The findings include:</p> <p>During the entrance conference on June 14, 2010, at 10:10 a.m., the qualified mental retardation professional (QMRP) stated that Resident #1 does not attend his day program due to medical reasons. The QMRP indicated that the resident will go back to his day program once his wheezing is under control and his primary care physician (PCP) recommends him to attend his day program.</p> <p>On June 14, 2010, at 12:07 p.m., Resident #1 was observed drinking milk from a provale cup independently. Minutes later, Resident #1 was drinking water from a regular glass with assistance from his one to one direct support staff. Further observation on the same day at 5:49 p.m., revealed Resident #1 drinking milk, water and prune juice from a regular glass.</p> <p>Review of Resident #1's medical records on June 14, 2010, at 12:23 p.m., revealed the Resident</p>	I 401	<p>A second provale cup was purchased for individual #1.</p> <p>All staff including individual #1 1:1 were re-inserviced on usage of prescribed adaptive equipment at all times.</p> <p>Speech and Language Therapist visited home on 6/16/10 and noted that adaptive equipment as specified was effective in satisfying individual #1 medical/nutritional needs.</p> <p>(DCHRP) Occupational Therapist did an evaluation on 7/8/10 and stated that adaptive equipments were effectively meeting Individual's #1 medical needs. Other recommendations were made and will be followed through accordingly.</p>	<p>6/16/10 and ongoing</p> <p>7/30/10 and ongoing</p>

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I 401	Continued From page 6 was hospitalized on February 25, 2010 for acute exacerbation of asthma. Interview with the QMRP on June, 15, 2010, at 10:52 a.m., indicated that the resident functional status had change after he was discharged on March 3, 2010. Further record review on June 15, 2010, at approximately 10:00 a.m., revealed Resident #1 received a barium swallow test on April 19, 2010, at the hospital. As a result, the resident's diet was changed from pureed with honey thickened liquids to pureed with nectar thickened liquids. The video fluoroscopic report also revealed a change from a regular glass to a proval cup. According to a PCP note dated March 2009, revealed that Resident #1 was in need of an occupational therapy assessment. However, review of the resident's Individual Support Plan (ISP) dated June 2, 2010 on June 15, 2010 at approximately 2:00 p.m., revealed an occupational assessment was not apart of his ISP. It should be noted that although the group home had modified the diet textures (pureed with nectar thickened liquids) and were utilizing the use of adaptive cup as recommended, there was no evidence that speech and occupational therapy assessments had been obtained to verify if these modifications were effectively meeting his needs.	I 401	See page 5.	
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan. This Statute is not met as evidenced by:	I 422	All 1:1 staff were re-trained on 6/18/10 on implementation of IPP goals along with offering choices as per checklist of activities individual's interest.	6/18/10 and ongoing

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1422	<p>Continued From page 7</p> <p>Based on observation, staff interview, and record verification, the facility failed to implement a resident's Individual Support Plan (ISP), for one of the two residents in the sample. (Resident #1)</p> <p>The finding includes:</p> <p>On June 14, 2010, at 8:15 a.m., the one to one support staff was observed handing Resident #1 playing cards. At 8:38 a.m., the one to one staff began to play dominoes with the resident without offering him a choice. At 11:50 a.m. the one to one support staff took the client into the kitchen then she began to prepare his lunch. At 12:38 p.m., the one to one support staff informed the license practical nurse (LPN) that the resident was wheezing. The LPN listened to his chest and lungs, shortly after, the LPN told the one to one staff/trained medication employee to administer his treatment for wheezing.</p> <p>Review of Resident #1's IPP dated June 2, 2010, on June 15, 2010, at 1:45 p.m., revealed an objective stated that the resident will be provided the opportunity to engage in an activity of choice during ill health or when at home during routine day program hours. However, at no time during the survey were any of the 1:1 staff observed giving the resident the opportunity to decide what activity he wanted to engage in.</p> <p>Interview with the qualified mental retardation professional (QMRP) on June 15, 2010, at approximately 3:00 p.m., revealed Resident #1 should be given a choice of activities depending on how he feels.</p> <p>There was no evidence that one to one direct support staff implemented Resident #1's day program goal as recommended in the IPP.</p>	1422	See page 7.	

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I 458	<p>3521.11 HABILITATION AND TRAINING</p> <p>Each resident ' s activity schedule shall be available to direct care staff and be carried out daily.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to develop an alternative active treatment schedule that outlined the current active treatment programs, for one of the two residents in the sample. (Resident #1)</p> <p>The findings include:</p> <p>During the entrance conference on June 14, 2010, at 10:10 a.m., the qualified mental retardation professional (QMRP) stated that Resident #1 does not attend his day program due to medical reasons. The QMRP indicted that the resident will go back to his day program once his wheezing is under control and his primary care physician recommends him to attend his day program.</p> <p>Review of the resident's habilitation record on June 15, 2010, at 12:30 p.m., revealed a list of things to do with Resident #1, however, there was no documented evidence of an alternative activity schedule.</p>	I 458	An alternative schedule of activities was developed, staff training done and schedule implemented.	6/16/10 and ongoing
I 472	<p>3522.3 MEDICATIONS</p> <p>The physician who identifies the self-administration of medications as a goal for a resident shall develop and monitor the plan for implementation.</p> <p>This Statute is not met as evidenced by:</p>	I 472	Informal Self Medication program was in-placed for individual #2. However, nurse failed to implement program. Burse has resigned on 6/15/10. New medication Nurse was in-serviced on self medication program for individual #2. Program has been made formal and progress being documented as per data sheet.	6/17/10 and ongoing

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I 472	<p>Continued From page 9</p> <p>Based on interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) 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 levels of physical, mental and social functioning, for one of the two residents included in the sample. (Resident #1)</p> <p>The finding includes:</p> <p>On June 14, 2010, at 9:05 a.m., the licensed practical nurse (LPN) was observed preparing the Resident #2's medications, pouring a cup of water and giving the resident the medication and a cup of water. The resident consumed the medications and the water. Interview with the LPN, after the medication administration, indicated that the resident usually punches his medications, but since the surveyor is here, "I did it." According to the self medication assessment dated February 6, 2009, on June 15, 2010, at approximately 11:00 a.m., the resident was recommended to participate in a self-medication program, but the specific goal and corresponding program objective was not documented on the assessment. Interview with the qualified mental retardation professional (QMRP) and LPN Coordinator and further record review on June 15, 2010, at 11:10 a.m., revealed Resident #2's IPP dated February 17, 2010. Review of the plan and discussion with the QMRP, the facility failed to provide evidence of an objective written to assist the resident with acquiring skills in the domain of self-medication administration.</p>	I 472	QA Team, DON, QMRP, LPN Case Manager will continue to monitor to ensure compliance.	6/17/10 and ongoing
I 473	<p>3522.4 MEDICATIONS</p> <p>The Residence Director shall report any</p>	I 473	See page 11.	

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I 473	<p>Continued From page 10</p> <p>irregularities in the resident ' s drug regimens to the prescribing physician.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that all drugs were administered in compliance with the physician's orders, for three of the four residents residing in the facility. (Resident #1 #2 and #4)</p> <p>The finding includes:</p> <p>On June 14, 2010, at 7:30 a.m., the surveyor entered the facility. Interview with the direct care support at 7:36 a.m., revealed that the medication nurse had not arrived. At 8:24 p.m., a LPN was observed entering the facility. Interview with the LPN, at 8:32 a.m., revealed that she would be administering the client's morning medications. The LPN began administering Client #4's medication at 8:42 a.m., and ended with Client #1's medication administration at approximately 9:25 a.m.</p> <p>Review and reconciliation of the physician orders on June 14, 2010, at 10:00 a.m., revealed that Clients #1, #2 and #4 should have received their medications at 7:00 a.m. Interview with the LPN, after the medication administration, indicated that she was running late because she had other homes to pass medications. Inquiry was made to the qualified mental retardation professional (QMRP) on June 15, 2010, at approximately 10:00 a.m., of an incident report regarding the medication error that occurred on June 14, 2010. She had no knowledge of an incident report. Further inquiry was made to the LPN Coordinator at approximately 11:15 a.m., and she revealed that the LPN was asked to report to the facility's</p>	I 473	<p>An updated incident report which included individuals #1, 2, 4 was faxed to DOH on 7/7/10. CEO was then notified as indicated on form.</p> <p>DON will complete an in-service training with all the medication nurses on 7/5/10. Medication time frame schedule shall be maintained to accommodate the 1 hour before and after window.</p> <p>In cases of emergency the medication staff contact the DON to report any lateness. A late medication pass order shall be obtained from the PCP whenever occurrences are passed the allowed 1 hour window.</p> <p>DON will monitor time frame of medication pass as per telephone calls via checklist for the next 30 days. Direct Care Staff and House Manager was given a memo by QMRP to provide notification of nurse's arrival 5 minutes before and 5 minutes past given the 1 hour window before and after for medication pass.</p> <p>QA Team, DON, QMRP, LPN Case Manager, House Manager and Direct Care Staff will continue to monitor to ensure compliance.</p>	7/5/10 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0187	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2010
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 473	Continued From page 11 headquarters office and an incident report would be generated at that time. According to the incident report, the LPN completed the incident report on June 15, 2010, at 3:35 p.m. Review of the incident report revealed that Client #3 was the only client mentioned in the report. However Clients #1, #2, and #4 should have been included in the report.	I 473	In addition Medication Nurse was requested to met with CEO on 6/15/10 to received disciplinary action. Instead she completed an incident report and then turned in her resignation. New Medication Nurse was employed and trained on specific time of medication pass given 1 hour window before and after along with other Nursing protocols.	6/15/10 and ongoing
I 999	FINAL OBSERVATIONS The following observations were made during the survey process. It is recommended that these areas be reviewed and determinations be made regarding appropriate actions in order to prevent potential non-compliant practices: During the environmental walk through on June 15, 2010, at approximately 3:15 p.m., sixteen of the thirty one bath towels available in the linen closet were observed to have either discoloration, tears or were unraveling around the edges. Interview with the house manager at the same time revealed she would replace the sixteen towels.	I 999	QMRP, QA Team, DON LPN Case Manager will continue to monitor to ensure compliance. 999. House Manager was given disciplinary action to this effect. Sixteen torn or discolored towels were discarded on 6/11/10. New bath towels were purchased to replace discarded towels. QA Team, QMRP, House Manager and staff will monitor to ensure compliance.	6/15/10 and ongoing