

From: paula

To: 2024429430

Received 7/22/11

07/22/2011 14:19

#691 P.002/049

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

Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
800 North Capitol St., N.E.
Washington, D.C. 20002

PRINTED: 07/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/16/2011
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NAME OF PROVIDER OR SUPPLIER SYMBRAL FOUNDATION	STREET ADDRESS, CITY, STATE, ZIP CODE 4422 20TH STREET, NE WASHINGTON, DC 20011
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W 000 INITIAL COMMENTS

A re-certification survey was conducted from 6/14/2011 through 6/16/2011. A random sampling of three clients was selected from a population of five individuals with varying degrees of mental and physical disabilities.

This re-certification was completed utilizing the fundamental survey process. The findings of this survey were based on observations at the group home and two day programs, interview with direct care staff and management, and a review of the habilitation and administrative records including the unusual incident reports.

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, staff interview and record review, the facility failed to ensure outside services maintained the proper implementation of mealtime and ambulation protocols for one of three sampled clients. [Client #3]

The finding includes:

- [Cross reference W194 and W436] Observation at Client #3 's day program on 6/15/2011 at approximately 11:10 a.m. revealed the staff held on to his gait belt from the rear and also held his left shoulder for support as they both walked down the hallway leading to the cafeteria.

Interview and record review with the facility 's

W 000

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

7/19/11 and ongoing

In addition that these policies will be aligned to present health and wellness standards and other best practices guide.

Symbtral's governing body and QA Team will continue to monitor to ensure compliance.

W 120

- Symbtral Physical Therapist will visit day program to conduct training on July 27th, 2011 at 9:00 am.

In addition QIDP or House Manager will conduct scheduled and unscheduled observational visit once per week for the next 30 days post P.T. training to ensure compliance.

7/27/11 and ongoing

- A second copy of updated meal time protocol was forwarded to day program on 7/22/11, at which time meal-time observation was done.

Staff were also re-trained on meal time protocol with emphasis on seating position (upright 90 degrees during meals and to remain as such for at least two hours post meals).

In addition Symbtral's Speech and Laaague Therapist will conduct traiaing at day program on 7/27/11 specific to individuals' #3 meal time protocol and adaptive equipment.

Symbtral's QA Team, QIDP and House Manager will continue to ensure compliance.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Shonda M. Jacob RN</i>	TITLE <i>CEO</i>	(X6) DATE <i>7/22/11</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 120 Continued From page 1

Qualified Intellectual Disability Professional (QIDP) and House Manager (HM) on 6/15/2011 beginning at 11:23 a.m. revealed Client #3 's day program staff inappropriately assisted him during ambulation.

2. Observation of lunch at Client #3 's day program on 6/15/2011 at 11:15 a.m. revealed he was served his meal with a light weight teaspoon, a Provale cup and was not seated in an upright position during his meal. He was leaning back in the chair and at least three spoons of his food fell on his chest during the meal as the staff fed him.

Review of Client #3 's habilitation records on 6/15/2011 at 5:17 p.m. revealed his Mealtime Protocol dated 4/19/2011 recommended that he be seated at 90 degrees during meals and to remain as such for at least two hours after meals.

Further review on the same day at 5:43 p.m. revealed Client #3 's Speech Language assessment dated 4/27/2011 outlined that Client #3 should receive a Sippy Cup and a weighted teaspoon.

Interview with the facility 's Qualified Intellectual Developmental Professional (QIDP) on 6/16/2011 at approximately 2:00 p.m. confirmed, Client #3 should have received a weighted teaspoon, a sippy cup and should have been seated in an upright position during his lunch. The QIDP further indicated she would have to provide additional training at the day program to ensure Client #3 receives his meals in the manner prescribed.

W 120
Continued from page 1.

W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL

W 159 See page 3.

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W 159 Continued From page 2

W 159

Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.

This STANDARD is not met as evidenced by:
Based on observation, staff interview, and record review, the facility failed to ensure the Qualified Intellectual Disability Professional (QIDP) coordinated, integrated, and monitored services, for three of the six clients residing in the facility. Clients #2, #3 and #4)

The findings include:

1. The facility's QIDP failed to ensure outside services maintained the proper implementation of mealtime protocols for all clients. (See W194)
2. The facility's QIDP failed to ensure the Human Rights Committee (HRC) reviewed and approved all sedations for all clients. (See W262)
3. The facility's QIDP failed to ensure all clients were provided the proper and necessary adaptive equipment to ensure their health and well-being. (See W436)
4. The facility's QIDP failed to ensure all three shifts took part in evacuation drills over the past three months (quarter). (See 440)

- | | |
|---|----------------------------|
| 1&3. Symbra's Speech and Language Therapist re-trained staff on adherence to prescribed mealtime protocols and adaptive equipment for individuals served at this location. | 7/22/11 and ongoing |
| 2. Crossed referenced and adopted with W262. | 7/28/11 and ongoing |
| 4. QIDP completed fire drill calendar to reflect conducting of fire evacuation drills on all shifts to specifically include 8:00 am - 4:00 pm. | 6/30/11 and ongoing |
| House Manager and Staff were trained on new calendar schedule. | |
| Symbra's QA Team, QIDP and House Manager will monitor to ensure compliance. | |

W 194 483.430(e)(4) STAFF TRAINING PROGRAM

W 194

Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.

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W 194 Continued From page 3

W 194

This STANDARD is not met as evidenced by:
Based on observation and staff interview, the facility failed to ensure all staff was able to effectively implement a client's mealtime feeding protocol for two of three sampled clients. (Clients #1 and #3)

1&3. Symbra's Speech and Language Therapist re-trained staff on adherence to prescribed mealtime protocols and adaptive equipment for individuals served at this location.

7/22/11 and ongoing

The finding includes:

1. [Cross Reference W436]
Observation on 6/14/2011 beginning at 4:05 p.m. revealed the facility's staff failed to ensure Client #2 and #3 consistently received their proper adaptive eating equipment.

2. Physical Therapist re-trained staff on 7/25/11 on properly utilization individual's #3 gait belt during ambulation.

7/25/11 and ongoing

2. Observation during the survey beginning on 6/14/2011 at 4:00 p.m. revealed, each staff that was assigned to work with Client #3 utilized his gait belt differently. Some staff was observed to walk behind Client #3 and hold the back of the gait belt, other staff was observed to walk on the side of Client #3 and hold his shoulders, and other staff was observed holding him under his armpits as they held the back of the gait belt. There were also different variations of these techniques that were observed being employed based on the strength and height of the staff assisting Client #3 to get around his environment.

Record review on 6/15/2011 at 11:23 a.m. revealed Client #3's 8/4/2010 PT assessment recommended that "[Client #3] will continue to benefit from a gait belt for ambulation at all times."

Interview with the PT on 6/16/2011 at 11:15 a.m.,

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W 194 Continued From page 4
revealed he had provided training and specific instructions on how to support Client #3 when he ambulates which required a full support of his waist and arm (closest to the staff). During the interview, the PT explained to the Licensed Practical Nurse (LPN), Qualified Intellectual Disability Professional (QIDP), and House Manager (HM) how the staff was to properly support Client #3 during times of ambulation. At the close of the interview, the LPN, QIDP and HM confirmed and agreed, the facility's staff was not utilizing his gait belt appropriately and was not providing Client #3 with the level of support he required.

W 194
Continued from page 4.

W 262 483.440(f)(3)(i) PROGRAM MONITORING & CHANGE

The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.

W 262

1-4) DON, LPN will secure documentation for sedation prior to HRC Meetings.

Symbtral's governing body has reiterated compliance to protocol for all sedation prior to medical appointments.

7/28/11 and ongoing

Step 1: HRC will review the doctor's order for sedation and the desensitization intervention implemented prior to the request to ensure that it met the requirement of the least restrictive intervention.

Step 2: If HRC approve sedation recommendation it will only be a one time use only.

Step 3: Physician's order and request for consent for sedation will be forwarded to Medical Guardian / Family member for consent.

This STANDARD is not met as evidenced by:
Based on staff interview and record review, the facility failed to ensure the Human Rights Committee (HRC) reviewed and approved all sedations for one of three sampled clients. [Client #1]

The finding includes:

Record review on 6/15/2011 beginning at 3:40 p.m. revealed Client #1 was sedated for the following medical appointments:

1. Podiatry appointment on 2/4/2011 indicated

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W 262 Continued From page 5

the client was sedated with Xanax 4mg. The client ' s guardian signed consent for this sedation on 2/3/2011. Additional record review revealed the Primary Care Physician (PCP) wrote a prescription on 1/21/2011 for Xanax 2mg x 2 Tabs, PO prior to appt.

2. Sedated for Dental appointment on 10/18/2010. Further review revealed the client ' s guardian signed consent for the sedation on 10/6/2010. Primary Care Physician (PCP) wrote prescription on 10/11/2010 for Xanax 4mg PO 1 Hr prior to appt (telephone order).

3. Sedated for Podiatry appointment on 9/10/2010. Further review revealed the client ' s guardian signed consent on 9/9/2010. Primary Care Physician (PCP) wrote prescription on 9/7/2010 for Xanax 4mg PO 1 Hr prior to appt.

4. Podiatry appointment on 7/3/2010. Further review revealed the client ' s guardian signed consent for the sedation on 6/30/2010. Primary Care Physician (PCP) wrote prescription on 7/1/2010 for Xanax 4mg PO 1 Hr prior to appt

Interview with the facility ' s Qualified Intellectual Disability Professional on 6/15/2011 at approximately 4:49 p.m. confirmed none of the HRC approvals for these sedations were on site at the time of survey or made available for review prior to the close of survey.

W 262

Step 4: Copy of Guardian's consent will be taken to appointment for specified procedure. 7/28/11 and ongoing

QDP will ensure that HRC minutes covering sedation orders be secured on site.

Symbal's QA Team, QDP, DON will continue to monitor to ensure compliance.

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,

W 436
See page 7.

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W 436	Continued From page 6 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 clients were provided the proper and necessary adaptive equipment to ensure their health and well-being for one of three clients in the sample. [Client #3] The finding includes: 1. Observation on 6/14/2011 at approximately 4:05 p.m. revealed Client #3 received a hollow built-up spoon to use during snack and was later observed using a light weight built up spoon during dinner. Record review on 6/15/2011 day at 5.43 p.m. revealed Client #3 's Speech Language assessment dated 4/27/2011 outlined that Client #3 should receive a weighted teaspoon during meals. Interview with the facility 's Qualified Intellectual Disability Professional (QIDP) on 6/16/2011 at approximetely 10:00 a.m. confirmed Client #3 was provided the wrong eating utensils for both snack and dinner on 6/14/2011. In addition, the QIDP also confirmed that they did not have a weighted teaspoon available for Client #3 to use. 2. Observation on 6/14/2011 beginning at approximately 4:00 p.m., revealed Client #3 was wearing a pair of low cut sneakers. He was also observed dragging his feet (the front and side of	W 436	1. Symbra's Speech and Language Therapist re-trained all staff working at this location on adherence and consistency to proper usage of adaptive equipment applicable to individuals served. In addition weighted teaspoon was made available for individual #3 and is being utilized as per meal time protocol.	7/22/11 and ongoing

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W 436 Continued From page 7

the sneaker) as he was being assisted by the staff to navigate the facility.

Interview with the QIDP on 6/15/2011 at approximately 9:30 a.m. revealed he dragged his right foot due to the brace he was wearing. The QIDP also revealed he 's been wearing his foot brace for a few months and he needed time to adjust to wearing it.

Record review on 6/15/2011 at 9:39 a.m. revealed his 2/23/2011 Physical Therapy (PT) assessment recommended, " ...that he discontinue the use of this brace until he receives a proper fitting shoe. Once he receives the proper fitting shoe, he will begin a formal program to tolerate wearing the brace with the proper fitting shoe for 1 hour per day for the first week and increase toleration by 1 hour each week up to 8 hours. " Further record review on same day at 11.23 a.m. revealed Client #3 ' s 8/4/2010 PT assessment identified that this client used " custom molded shoes. "

Further interview with the House Manager (HM), QIDP, and the facility ' s Licensed Practical Nurse (LPN) on the same day at 11:24 a.m. revealed there was no evidence on file that Client #3 received a " proper fitting shoe " as recommended. There was also no evidence on file at the time of survey to reflect that the Physical Therapist (PT) had assessed the sneakers Client #3 was currently wearing. Further interview on the same day at approximately 11:30 a.m., the QIDP, the LPN and the HM all confirmed that the PT had not yet assessed the shoe Client #3 was currently wearing. The PT had yet to confirm that the shoe

W 436

2. In P.T. assessment dated 5/23/11 it was stated that his current shoes was appropriate, however he still needed to be molded for custom molded shoes.

Program was not started as there was no recommendation from P.T to do so as [redacted] at the time was experiencing skin breakdown and a discontinuation of brace was recommended.

On 2/23/11 although P.T had reassessed [redacted] on 5/23/11 since new shoes were purchased, no report was received to this effect.

Since receipt of assessment on 6/20/11 P.T program as recommended was started as evidenced by documentation.

In addition an appointment was scheduled for custom molded shoes at Nascott for July 27, 2011. P.T was also send correspondence requesting that a written evaluation be forwarded to Provider within 72 hours post evaluation.

7/27/11 and ongoing

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W 436 Continued From page 8
was appropriate to use with his foot brace or if he required custom molded shoes.

W 436 **3. Physical Therapist re-trained staff on 7/25/11 on properly utilization individual's #3 gait belt during ambulation.** **7/25/11 and ongoing**

3. [Cross Reference W194]
Observation during the survey beginning on 6/14/2011 at 4:00 p.m. revealed the facility's staff was not properly utilizing Client #3's gait belt during ambulation.

Interview with the LPN, QIDP and HM on 6/16/2011 at approximately 11:35 a.m. confirmed the facility's staff was not utilizing his gait belt appropriately and was also not providing Client #3 with the level of support he required.

W 440 483.470(i)(1) EVACUATION DRILLS

W 440 **QIDP completed fire drill calendar to reflect conducting of fire evacuation drills on all shifts to specifically include 8:00 am - 4:00 pm.** **6/30/11 and ongoing**

The facility must hold evacuation drills at least quarterly for each shift of personnel.

House Manager and Staff were trained on new calendar schedule.

This STANDARD is not met as evidenced by:
Based on staff interview and record review, the facility failed to ensure all three shifts took part in evacuation drills over the past three months (quarter) to ensure the health and safety of all clients residing in the facility during emergent situations. [Clients #1, #2, #3, #4 and #5]

Symbtral's QA Team, QIDP and House Manager will monitor to ensure compliance.

The finding includes:

Review of the fire drill logs on 6/16/2011 at approximately 3:00 p.m. revealed there were no drills on record for the 8-4:00 p.m. shift between the three months period covering 3/2011 to 5/2011.

Interview with the Qualified Intellectual Disability Professional (QIDP) on 6/16/2011 at

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approximately 3:30 p.m. confirmed the facility did not conduct any fire drills during the 8-4:00 p.m. shift for the three months period covering 3/2011, 4/2011 and 5/2011.

The facility failed to ensure fire drills were held at least quarterly for each shift.

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Health Regulation & Licensing Administration

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1 000	INITIAL COMMENTS A re-licensure survey was conducted from 6/14/2011 through 6/16/2011. A random sampling of three residents was selected from a population of five individuals with varying degrees of mental and physical disabilities. The findings of this survey were based on observations at the group home and two day programs, interview with direct care staff and management, and a review of the habilitation and administrative records including the unusual incident reports.	1 000	Symbtral's governing body has received deficiency report as cited and have reiterated compliance to specified protocols to ensure adherence. 7/19/11 and ongoing
1 183	3508.4 ADMINISTRATIVE SUPPORT Each GHMRP shall have a Residence Director who meets the requirements of § 3509.1 and who shall manage the GHMRP in accordance with approved policies and this chapter. This Statute is not met as evidenced by: Based on observation, staff interview, and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure the Qualified Intellectual Disability Professional (QIDP) coordinated, integrated, and monitored services, for two of the three sampled residents. (Residents #1 and #3) The findings include: The findings include: 1. The facility's QIDP facility failed to ensure outside services maintained the proper implementation of mealtime protocols for all residents. (See Federal Deficiency Citation W194)	1 183	1. A second copy of updated meal time protocol was forwarded to day program on 7/22/11, at which time meal-time observation was done. Staff were also re-trained on mealtime protocol with emphasis on seating position (upright 90 degrees during meals and to remain as such for at least two hours post meals). In addition Symbtral's Speech and Language Therapist will conduct training at day program on 7/27/11 specific to individuals' #3 meal time protocol and adaptive equipment. Symbtral's QA Team, QIDP and House Manager will continue to ensure compliance. 7/27/11 and ongoing

Health Regulation & Licensing Administration

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

Phonda M. DeLoe Bin

TITLE *CEO*

(X6) DATE *7/22/11*

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0167	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/16/2011
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I 183	Continued From page 1 2. The facility 's QIDP facility failed to ensure the Human Rights Committee (HRC) reviewed and approved all sedations for all residents. (S See Federal Deficiency Citation ee W262) 3. The facility 's QIDP failed to ensure all residents were provided the proper and necessary adaptive equipment to ensure their health and well-being. (See Federal Deficiency Citation W436) 4. The facility 's QIDP facility failed to ensure all three shifts took part in evacuation drills over the past three months (quarter). (See Federal Deficiency Citation 440)	I 183	2. Step 1: HRC will review the doctor's order for sedation and the desensitization intervention implemented prior to the request to ensure that it met the requirement of the least restrictive intervention. Step 2: If HRC approve sedation recommendation it will only be a one time use only. 7/28/11 and ongoing Step 3: Physician's order and request for consent for sedation will be forwarded to Medical Guardian / Family member for consent. Step 4: Copy of Guardian's consent will be taken to appointment for specified procedure. 3. Symbra's Speech and Language Therapist re-trained staff on adherence to prescribed mealtime protocols and adaptive equipment for individuals served at this location. 7/22/11 and ongoing
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to ensure all staff was effectively trained to provide resident 's their meals in the manner prescribed by the primary care physician for two of three sampled residents. [Residents #1 and #3] The findings include: The facility failed to ensure all residents received their proper and necessary adaptive equipment:	I 229	4. QIDP completed fire drill calendar to reflect conducting of fire evacuation drills on all shifts to specifically include 8:00 am - 4:00 pm. 6/30/11 and ongoing I229 1. Symbra's Speech and Language Therapist re-trained all staff working at this location on adherence and consistency to proper usage of adaptive equipment applicable to individuals served. 7/22/11 and ongoing In addition weighted teaspoon was made available for individual #3 and is being utilized as per meal time protocol.

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I 229 Continued From page 2 I 229

1. Observation on 6/14/2011 at approximately 4:05 p.m. revealed Resident #3 received a hollow built-up spoon to use during snack and was later observed using a light weight built up spoon.

Record review on 6/15/2011 day at 5:43 p.m. revealed Resident #3's Speech Language assessment dated 4/27/2011 outlined that Resident #3 should receive a weighted teaspoon during meals.

Interview with the facility's Qualified Intellectual Disability Professional (QIDP) on 6/16/2011 at approximately 10:00 a.m. confirmed Resident #3 was provided the wrong eating utensils for both snack and dinner on 6/14/2011.

2. Observation on 6/14/2011 beginning at approximately 4:00 p.m., revealed Resident #3 was wearing a pair of low cut sneakers. He was also observed dragging his feet (the front and side of the sneaker) as he was being assisted by the staff to navigate the facility.

Interview with the QIDP on 6/15/2011 at approximately 9:30 a.m. revealed he dragged his right foot due to the brace he was wearing. The QIDP also revealed he's been wearing his foot brace for a few months and he needed time to adjust to wearing it.

Record review on 6/15/2011 at 9:39 a.m. revealed his 2/23/2011 Physical Therapy (PT) assessment recommended, "...that he discontinue the use of this brace until he receives a proper fitting shoe. Once he receives the proper fitting shoe, he will begin a formal program to tolerate wearing the brace with the proper fitting shoe for 1 hour per day for the first week and increase toleration by 1 hour each week up to

Continued from page 2.

2. In P.T. assessment dated 5/23/11 it was stated that his current shoes was appropriate, however he still needed to be molded for custom molded shoes.

Program was not started as there was no recommendation from P.T. to do so as [redacted] at the time was experiencing skin breakdown and a discontinuation of brace was recommended. 8/30/11 and ongoing

On 2/23/11 although P.T had reassessed [redacted] on 5/23/11 since new shoes were purchased, no report was received to this effect.

Since receipt of assessment on 6/20/11 P.T program as recommended was started as evidenced by documentation.

In addition an appointment was scheduled for custom molded shoes at Nascott for July 27, 2011. P.T was also send correspondence requesting that a written evaluation be forwarded to Provider within 72 hours post evaluation.

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I 229 Continued From page 3
8 hours. " Further record review on same day at 11 23 a.m. revealed Resident #3 ' s 8/4/2010 PT assessment identified that this resident used " custom molded shoes. "

I 229 Continued from page 3.

Further interview with the House Manager (HM), QIDP, and the facility ' s Licensed Practical Nurse (LPN) on the same day at 11:24 revealed there was no evidence on file that Resident #3 received a " proper fitting shoe " as recommended. There was also no evidence on file at the time of survey to reflect that the Physical Therapist (PT) had assessed the sneakers Resident #3 was currently wearing. The QIDP, the LPN and the HM all confirmed that the PT had not yet assessed the shoe Resident #3 were currently wearing to confirm it was appropriate to use with his foot brace or if he required custom molded shoes.

3. [Cross Reference W194]
Observation during the survey beginning on 6/14/2011 at 4:00 p.m. revealed the facility ' s staff was not properly utilizing Resident #3 ' s gait belt during ambulation.

3. Physical Therapist re-trained staff on 7/25/11 on properly utilization individual's #3 gait belt during 7/25/11 and ongoing ambulation.

Interview with the LPN, QIDP and HM on 6/16/2011 at approximately 11:35 a.m. confirmed the facility ' s staff was not utilizing his gait belt appropriately and was also not providing Resident #3 with the level of support he required.

I 375 3519 6 EMERGENCIES

I 375

See page 5.

Each GHMRP shall document each emergency and enter the follow-up actions into the resident ' s permanent record, which shall be made available for review by authorized individuals.

This Statute is not met as evidenced by:

Health Regulation & Licensing Administration

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1375	<p>Continued From page 4</p> <p>Based on record review and staff interview, the facility failed to ensure the Department of Health was notified of an incident which required a resident to receive emergent care for one of three sampled residents. [Resident #4]</p> <p>The finding includes:</p> <p>Record review on 6/14/2011 at 11:27 a.m. revealed and incident report dated 5/25/2011 detailed Resident #4 was sitting in the day program 's van when it was struck by a moving vehicle. According to the documentation on site at the facility, Resident #4 was taken to a local Emergency Room (ER) for treatment.</p> <p>Interview with the facility ' s Qualified Intellectual Disability Professional (QIDP) on the same day at 11:30 a.m. confirmed, Resident #4 was taken to the ER for treatment and care, but was discharged with no injury noted by the hospital. The QIDP also confirmed that the facility failed to generate an incident report after they became aware of the accident.</p> <p>Further record review revealed the Department of Health had no record of this ER visit or of the vehicular accident. The facility failed to ensure all officials received notice of emergent care as required to ensure the health and safety of its residents.</p>	1375	<p>As per protocol Day Program is responsible for reporting incidents requiring ER visits to DOH as well as providing relevant notification to all officials.</p> <p>A letter was sent to Day Program to this effect. However, Symbal will ensure that in such case, the relevant notification and follow up will be provided.</p> <p>Symbal's Incident Manager, QA Team, QIDP and House Manager will continue to monitor to ensure compliance.</p>	<p>7/22 /11 and ongoing</p>
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