PRINTED: 05/21/20
FORM APPROVE
OMB NO. 0938-03

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	09G087		05/02/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	722 "L" STREET, NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000		
	This recertification survey was conducted on April 30, 2008 through May 2, 2008. The survey was initiated utilizing the fundamental survey process. A random sampling of two clients from the residential population of three clients with varying degrees of disabilities was identified. The findings of this survey were based on observations at the group home and two day programs, interviews with a resident, interviews with day program staff and residential staff, the review of clinical and administrative records and the review of the facility's unusual incident reports.			
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the governing body failed to provide general operating direction over the facility. The findings include: 2. The facility failed to ensure that the clinic providing weekly sexual therapy sessions to Client #2 was available to provide uninterrupted services to the client. On April 30, 2008 at 8:00 AM, Client #2 was observed walking around in the group home accompanied by a staff. Interview with the client revealed he was assigned a 1:1 staff because of his behavior. Record review a diagnosis of	W 104	During the period of 8/5/07-11/11/07 there was no therapist available to provide services. Individual #2 has resumed his weekly session on 11/19/07. The QMRP will communicate with the therapist concerning disruptions in service. Therapist will provide two weeks notification as well as the name of replacement therapist in her absence. QMRP and DON will monitor to ensure compliance.	6/5/08

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HEALTH REGULATION
ADMINISTRATION
2008 MAY 29 P 4: 22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Yvonne Mohamed | TITLE: CEO | (X6) DATE: 5/29/08

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 104	Continued From page 1 inappropriate sexual conduct (paraphilia). The individual support plan dated 7/9/07 included a recommendation that the client attend programs designed to teach healthy sexual and social behavior. Interview with the home manager and the Qualified Mental Retardation Professional (QMRP) indicated that the client attended weekly sexual therapy sessions. These sessions, as recommended by the social worker, the psychologist and the interdisciplinary team, were conducted at a clinic. Record review revealed the client did not participate in the sex therapy session between 8/5/07 and 11/11/07. Further interview with the home manager revealed the client was available to go for the sexual therapy sessions; however, the sessions were suspended by the clinic because no therapist was available to conduct them. There was no evidence the client received the continuos active treatment (weekly sexual therapy sessions), recommended by the interdisciplinary team (IDT) to address his targeted behavior.	W 104		
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 interview and record review, the facility failed to ensure that outside services met the needs of one of two clients in the sample (Client #1). The findings include:	W 120	Symbral will continue to document its efforts to ensure that services are received in a timely manner. Symbral has provided the Dentist with an updated list of all the individuals' information and contacts. The Dentist has been requested to provide the Residential provider and DDS with document of the approval/s of prior authorizations. When a procedure is ordered and is delayed by more that (45) days a case- conference will be convened.	6/20/08 an ongoing

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W 120	Continued From page 2 1. The dental provider failed to ensure that the group home was notified timely after authorization was received from the funding agency to provide recommended dental treatment services for Client #1. Interview with staff on 5/01/08 revealed that Client #1 had recently been to the dentist. A consultation report dated 3/12/08 indicated that Client #1 had a gingivectomy. Record review revealed the following information concerning the client's dental status prior to his most recent dental procedure: On 3/12/07 the dentist assessed that the client had hypertropic gingival areas due to Dilantin therapy. The dentist indicated that subgingival calculus may cause swelling. Scaling of the client's teeth twice a year was recommended. Full mouth scaling, possibly under sedation was also recommended. The dentist documented that preauthorization to perform treatment would be sought and that the group home would be notified to schedule an appointment after the authorization was received. On 5/8/07 the Licensed Practical Nurse (LPN) called the dental office to ascertain the status of the authorization. On 6/12/07 the LPN called the dental office again to follow-up on the status of the authorization. On 9/17/07 the facility received a telephone call from the dentist's office indicating that the office had the wrong contact information for the client. The office did however schedule a 11/6/07 appointment to perform a full mouth scaling. On 11/06/07 the dentist reassessed the client	W 120		

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W 120	Continued From page 3 again and diagnosed moderate calculus deposits and gingival hyperplasia. Scaling of teeth and a gingivectomy were recommended. General scaling and polishing of the client's teeth were performed on 2/27/08. The gingivectomy was again recommended. There was no evidence that the client received services timely as recommended for the maintenance of his dental health. 2. The facility failed to ensure that Client #1's slumped posture due to constraints in his neck was assessed. During the survey, Client #1 was observed to sit with his head in a forward flexed position and/or with his head hanging downward. Staff was observed requesting him to hold up his head; however the client was observed to be unable to consistently maintain his head above the flexed position. Interview with staff revealed the client required assistance in all activities of daily (ADL), except eating. During the survey observations, Client #1 was observed to sit in a slumped position while eating his meals and to sit with his head hanging down, requiring verbal prompts to hold up his head. The review of Client #1's physical therapy assessment dated 12/22/07 revealed his head and neck were aligned and that his balance and coordination were good. Further review of Client #1's Physical therapy assessment revealed that he had good upper and lower extremity, trunk, and head control, and no significant postural	W 120	Individual was seen at National Rehabilitation Center on 4/23/08 as it relates to his safety in ambulating stairs, at this time physical therapy exercises were recommended. Exercises that were recommended have been signed off on by PCP and have been sent to P.T. for review and or implementation contingent upon staff training. P.T. has also been requested to review SLP evaluation with findings / recommendations dated 01/01/08, National Rehab, and P.T. consult on 4/23/08. Orthopedic consult on 5/12/08 and P.T. own assessment done on 12/22/07. P.T. is requested to provide new assessment for individual #1 in light of the findings and recommendations made by above specialties.	6/20/08 and ongoing

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W 120	Continued From page 4 issues. The physical therapy assessment also indicated the client was independent in all ADL functions, including eating, bathing, grooming and dressing. According to the speech and language evaluation of the client dated 1/1/08, the client's posture was slumped due to constraints in his neck area that rendered him unable to maintain an erect posture. Swallowing appeared to be difficult when he was presented with a glass, however he was able to drink through a straw. A updated physical therapy evaluation to address problems arising from poor posture and apparent constraints in neck area was recommended. Further record review revealed the client's diagnoses included cerebral palsy and seizure disorder. Interview with the QMRP indicated that the client was referred to a rehabilitation facility on 4/23/08 for a consultation to assess his safety needs when on stairs. Also, on 5/2/08, the primary LPN scheduled an orthopedic appointment for the client. At the time of the survey, however, there was no evidence the recommendation to have the client's upper back posture and constraints in his neck evaluated had been implemented.	W 120	LPN scheduled orthopedic evaluation to address individual's upper back posture, constraints in his neck shoulders and knees. Individual made visit on 5/12/08 and areas of concerns were addressed. Upon completing specialty assessment i.e. SLP, orthopedic, NRH etc. The P.T. will receive copies of report. Case-conference will be convened should the findings/ recommendations significantly differ from current assessed level. PCP will review recommendations of specialty assessment.	6/20/08 ongoing
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.	W 159		

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W 159	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP) for two (Clients #1 and #2) of two clients in the sample. The findings include: A. Observation of the medication administration on April 30, 2008 at 7:55 PM revealed that Client #1 received Zolpidem 10 mg. Interview with the medication nurse indicated the client was scheduled to receive the medication at the 8:00 PM to prevent insomnia. The review of the medication administration record (MAR) revealed the Zolpidem 10 mg was prescribed to be given at bedtime. The QMRP failed to monitor Client #1's sleeping patterns as recommended by the psychologist for determination of its defectiveness as evidenced below: 1. The QMRP failed to ensure the consistent documentation on Client #1's sleep data chart. Although interview with the Qualified Mental Retardation Professional (QMRP) indicated that staff monitored and documents the client's sleep patterns, review of the log did not reflect that data was collected hourly. The log and/or shift notes documented an estimate of three entries a night. The log/shift notes indicated that the client was sleeping during the night; however, client observation and interviews with revealed that he was also sleeping and dozing during the day as evidence below:	W 159	Changes have been effected to Individual #1 programs that were highlighted. A memo was sent to house manager and staff which referred to the importance of monitoring individual #1 sleep cycle per half hourly as requested by psychologist on 5/23/08. A standard data collection sheet was also provided during in service conducted by psychologist on 5/23/08. QMRP, QA, House Manager and Psychologist will continue to monitor active treatment programs monthly to ensure integration and coordination.	5/23/08 and ongoing

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W 159	Continued From page 6 a) On 4/30/08 at 7:55 AM, Client #1 was observed seated and appeared drowsy. At approximately 8:20 AM the client was observe sitting with his head almost on his shoulder, in a slumped position as he remained seated on the couch. Staff asked him him he could sit up several times, however he remained in the same position. b) At 8:35 PM the client appeared very drowsy, had his mouth close to his plate and attempted to eat with his hands. During this time he drooled heavily. Staff verbally prompted him to sit up, wipe his mouth, and offered eating assistance, which was declined by the client. Interview with the LPN on May 2, 2008 indicated the Zolpidem was not administered until 8:00 PM, because by that time most of the active treatment and routine ADL activities had usually been completed. c) On 5/2/08 at 8:45 AM Resident #1 was observed sleeping on the couch at the group home while he waited for the van. 2. The QMRP failed to address the client's sleeping and drowsiness during morning activities at his day program. Interview with the day program instructor and the review of the day program's "15 minute Interval Observation Data Sheets" indicated that Client #1 was often drowsy in the morning. For example, review of the data sheets for April 2008 revealed the client dozing/sleeping at intervals in his classroom on 14 of the 19 days he attended his day program. NOTE: During the medication administration on 4/30/08 between the hours of 6:15 PM and 6:25	W 159	**Individual has an informal program that aids drooling. Program was recommended to be continually implemented by staff at meal-time at other times specified throughout the habilitation process as outlined in ISP on 2/4/08.** **LPN has contacted PCP on 12/19/07, regarding individual #1 drowsiness during morning at day program, monitoring to this effect has been on-going inclusive of discussions with House Manager, Staff, Social Worker, PCP, Psychiatrist and Day Program.** **Individual #1 medication was adjusted to appropriately address his drowsiness both at residence and at day program.** **PCP medication adjustment was done on 5/1/08 and Psychiatrist medication administration from a.m. – p.m adjustment was done on and on 5/14/08 as per request of neurologist.** **Neurologist on visit made by individual on 5/28/08 has recommended that sleep medication, Ambien 5mg be discontinued. Consult with neurologist's recommendation will be forwarded to psychiatrist and PCP for review and possible implementation.**	5/28/08 and ongoing

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W 159	Continued From page 7 PM. Client #1 was administered Haloperidol 6 mg, Dilantin 225 mg, Depakote 1250 mg, Clonazepam 2 mg, and Gabapentin 1200 mg. Record review revealed the client was also prescribed the same medications in the morning, except the Haloperidol. Additionally he received Mirtazepine 15 mg in the morning as an antidepressant. B. The QMRP failed to coordinate services to ensure weekly sexual therapy sessions as recommended for Client #2 by the interdisciplinary team. [See W104 1]	W 159		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record, the facility failed to ensure continuing training was provided to each employee to enable them to perform duties effectively and competently for one (Client #1) of two clients in the sample. The finding includes: Review of the training records revealed that Client's #1's direct care staff had been trained by the psychologist to collect sleep pattern data on the sleep log. However, the training was no effective to ensure that data had been collected as instructed [See W159].	W 189		
W 212	483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must	W 212	Staff has been in-serviced on 5/23/08. QMRP, QA, Psychologist and House Manager will continue to monitor to ensure compliance.	5/23/08 and ongoing

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W 212	Continued From page 8 identify the presenting problems and disabilities and where possible, their causes. This STANDARD is not met as evidenced by: Based on observation, interview and the record review, the facility failed to ensure Client #1 received a comprehensive assessment to determine his specific occupational therapy (OT) needs. The finding includes: On April 30, 2008 during dinner, beginning at approximately 8:15 PM, the client required close supervision. When he appeared tired and drowsy, he required some physical assistance to eat his meal. Further observation of the dinner meal observation revealed the client drooled heavily and some food was observed to fall from his mouth as he ate. He used a fork to eat approximately half of his meal, then started eating with his fingers. The staff sitting beside the client verbally prompted him to resume eating with the fork. He continued to eat slowly until 8:57 PM, when he was observed eating his dessert. Interview with staff revealed the client usually required some assistance in all ADL, except eating, and that times he was non-compliant. According to the client's speech and language evaluation dated 1/1/08, during the assessment "his posture was slumped due to constraints in his neck area that rendered him unable to maintain an erect posture. The Speech and Language Pathologist (SLP) identified that the client had difficulty keeping food in his mouth due to poor lip closure. An OT consultation was	W 212	On 4/23/08 individual #1 was taken to National Rehab. Center for P.T. consultation. The request was also made for SLP and O.T. services; however, nurse was told that National Rehab Center does not provide such services for the MR population. Symbral has continued its efforts in recruiting an O.T. Consultant. An advertisement was placed in the Washington Post on 5/28/08.	5/28/08 ongoing

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W 212	Continued From page 9 recommended to address the client's poor posture while eating, and to address an apparent constraint in his neck area. There was no evidence that the client had been assessed since 4/3/04. It should be noted that in the 2004 assessment it was recommended that the client receive annual evaluations.	W 212		
W 310	483.450(e)(1) DRUG USAGE The facility must not use drugs in doses that interfere with the individual client's daily living activities. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that drugs were not administered in doses that interfered with the daily living activities for one of two clients in the sample. (Client #1). The finding includes: There was no evidence that Client #1 had been closely monitored to ensure that prescribed drugs did not interfere with his daily living activities. During the medication administration on 4/30/08 between the hours of 6:15 PM and 6:25 PM, Client #1 was administered Haloperidol 6 mg, Dilantin 225 mg, Depakote 1250 mg, Clonazepam 2 mg, and Gabapentin 1200 mg. Record review revealed the client was also prescribed the same medications in the morning, except the Haloperidol. Additionally he received Mirtazepine 15 mg in the morning as an antidepressant. Interview with the day program instructor and the	W 310	Cross reference and adopted with w159.	5/28/08

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W 310	Continued From page 10 review of the day program's "15 minute Interval Observation Data Sheets" indicated that Client #1 was often drowsy in the morning. For example, review of the data sheets for April 2008 revealed the client dozing/sleeping at intervals in his classroom on 14 of the 19 days he attended his day program. Client observations during the survey on 4/30/08 and 5/2/08 revealed the following: a) On 4/30/08 at 7:55 AM, Client #1 was observed seated and appeared drowsy. At approximately 8:20 AM the client was observe sitting with his head almost on his shoulder, in a slumped position as he remained seated on the couch. Staff asked him him he could sit up several times, however he remained in the same position. b) At 8:35 PM the client appeared very drowsy, had his mouth close to his plate and attempted to eat with his hands. During this time he drooled heavily. Staff verbally prompted him to sit up, wipe his mouth, and offered eating assistance, which was declined by the client. Interview with the LPN on May 2, 2008 indicated the Zolpidem was not administered until 8:00 PM, because by that time most of the active treatment and routine ADL activities had usually been completed. c) On 5/2/08 at 8:45 AM Resident #1 was observed sleeping on the couch at the group home while he waited for the van.	W 310	Cross reference and adopted with w159.	5/28/09

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W 310	Continued From page 11	W 310		
	1. On April 30, 2008 between the hours of 6:15 PM and 6:25 PM, Client #1 was observed to be administered Haloperidol 6 mg, Dilantin 225 mg, Depakote, 1250 mg, Clonazepam 2 mg, and Gabapentin 1200 mg. Record review revealed the client was also prescribed to receive all of the same medication in the morning except the Haldol. He additionally received Mirtazepine 15 mg in the morning as an antidepressant, which had an uncommon side effect of drowsiness. Interview with the medication nurse revealed the Dilantin, Depakote, and Gabapentin were prescribed for seizures. Further interview with the nurse indicated the Haloperidol and the Clonazepam were prescribed for maladaptive behaviors. On April 30, 2008 at 7:55 PM Client #1 was observed to be administered Zolpidem 10 mg by the nurse. Interview with the medication nurse revealed the Zolpidem was prescribed to be given at bedtime for insomnia. Further interview with the nurse on May 2, 2008 indicated that the Zolpidem was not administered until 8:00 PM, because by that time most of the active treatment and routine ADL activities had usually been completed. On April 30, 2008, the following observations were made of the client: ...8:10 PM - Client #1 was observed sitting on the couch with his chin almost on his chest and appeared drowsy. ...8:25 PM to 8:57 PM - Client was observed		Cross reference and adopted with w-159.	5/28/08

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	09G087		05/02/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMBRAL	722 "L" STREET, NE WASHINGTON, DC 20002

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W 310	Continued From page 12 while eating his dinner. He was observed leaning forward, and at times required verbal prompts to chew his food, to hold up his head while eating, and to swallow. At 8:33 PM he was observed eating with his mouth in front of the plate, intermittently drooling and spilling some food from his plate onto his clothing. At 8:35 PM he drooled heavily and began to eat with his hands. A staff beside him verbally prompted him to sit up while eating and offered him assistance with eating. The client was becoming very drowsy, initially accepted the staff's assistance with eating, then again wanted to eat independently. He continued to eat the rest of his meal with his mouth several inches from the plate, drooling heavily and requiring verbal prompts to hold up his head. He was offered fluids throughout the meal which he drank using a straw. At 8:51 PM staff requested the client's permission to feed him the remaining food on his plate with a spoon and he client agreed.. The client was observed eating sherbet for dessert at 8:57 PM. Interview with staff revealed that the client enjoyed eating by himself and indicated that he was allowed the opportunity to do as much for himself as possible to encourage his independence. Interview with the day program instructor and the review of interval observation data collected by the day program from Day program staff revealed Client #1 was often drowsy in the morning, but alert by lunch time. For example, review of the day program 15 minute Interval Observation Data Sheets for April 2008 revealed the client dozing/sleeping at intervals in his classroom on 14 of the 19 day he attended his	W 310	Cross reference and adopted with w-159.	5/28/08

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W 310	Continued From page 13 day program	W 310		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide preventive and general medical care for one (Client #1) of two clients in the sample. The finding includes: [Cross Refer to W159] Record review revealed the client was prescribed Zolpidem 10 mg at bedtime on July 3, 2007 for insomnia. On 8/20/07 the Human Rights Committee (HRC) recommended for Client #1 that the facility should "Monitor sleep pattern, discuss with the psychologist sleep pattern issue and data collection at home day program and other settings." The HRC recommended to continue the use of the least restrictive intervention possible. The neurologist ordered a sleep study which was scheduled for 8/28/08. During a consultation on September 19, 2007, the neurologist indicated that the client's major problem at that time was his insomnia. The neurologist described the client's insomnia as sleeping, then waking up yelling and screaming. The neurologist indicated that a side effect of the Depakote may be insomnia; however, he recommended that the cause of Client #1's insomnia be investigated. Interview with the home manager and the record review revealed the client was not compliant for	W 322	**Sleep study recommended by Neurologist was done on 8/28/07.** **However, individual was non-compliant. Consultation with Neurologist to be scheduled concerning issue of sleep study that was unsuccessful. Copies of consultation Psychologist, Psychiatrist and sleep data will be forward to Neurologist for review.** **Staff has been in-serviced on 5/23/08 on using specified data collection sheet with hourly monitoring as specified by Psychologist, QMRP, QA, House Manager, PCP and Psychologist will continue to monitor.**	6/20/08

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W 322	Continued From page 14 the recommended sleep study and it could not be completed. Record review revealed the psychologist provided a form on which the client's sleep or the lack thereof was to be documented hourly to monitor his sleeping pattern. This information was to be communicated to the client's psychologist and primary care physician (PCP). There was no evidence that the data had been collected or communicated accurately to determine the effectiveness of the sleeping medication.	W 322	Cross reference and adopted with w-322.	6/20/08 an ongoing
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide nursing services in accordance with the needs of two (Clients #1 and #2) of two clients in the sample. The findings include: 1. The nursing staff failed to assessed the potential effects of sleep medications during mealtime for Client #1. On 4/30/08 between the hours of 6:15 PM and 6:25 PM, Client #1 was observed to be administered Haloperidol 6 mg, Dilantin 225 mg, Depakote, 1250 mg, Clonazepam 2 mg, and Gabapentin 1200 mg. Interview with the medication nurse revealed the Dilantin, Depakote, and Gabapentin were prescribed for seizures.	W 331		

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W 331	Continued From page 15 Further interview with the nurse indicated the Haloperidol and the Clonazepam were prescribed for maladaptive behaviors. The nurse also revealed that the client was prescribed Zolpidem 10 mg to be administered at bedtime for insomnia. At 7:55 PM Client #1 received Zolpidem 10 mg. Interview with the nurse on May 2, 2008 indicated the Zolpidem was not administered until 8:00 PM, because by that time most of the active treatment and routine ADL activities had usually been completed. The following observations were made after the client received Zolpidem for insomnia: ...8:10 PM - Client #1 was observed sitting on the couch with his chin almost on his chest and appeared drowsy. ...8:25 PM to 8:57 PM - Client was observed while eating his dinner. He leaned forward, and at times required verbal prompts to chew his food, to hold up his head while eating, and to swallow. At 8:33 PM he was observed eating with his mouth in front of the plate, intermittently drooling and spilling some food from his plate onto his clothing. At 8:35 PM he drooled heavily and began to eat with his hands. A staff beside him verbally prompted him to sit up while eating and offered him assistance with eating. Although client had become very drowsy, he initially accepted the staff's assistance with eating, and then a wanted to eat independently again. He continued to eat the rest of his meal with his mouth several inches from the plate, drooled heavily and required verbal prompts to hold up his head. Fluids which were encouraged throughout	W 331		

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W 331	Continued From page 16	W 331		
	the meal were drank with a straw. At 8:51 PM staff requested the client's permission to feed him the remaining food on his plate with a spoon and he client agreed. The client was observed eating sherbet for dessert at 8:57 PM. Interview with staff revealed that client enjoyed eating by himself and indicated that he was provided the opportunity to do as much for himself as possible to encourage his independence. There was no evidence that the nursing services coordinated Client # 1's medication administration to discourage drowsiness during his dinner meal.		Staff/s have been in-serviced on mealtime scheduling and the coordination of medication administration in order to prevent interference (as may result from side effect of drugs) to meal-time, active treatment and or day program activity.	5/28/08 an ongoing
W 340	2. The facility's nursing services failed to ensure that Client #2 was effectively trained on procedures for self-medication. [See W340] 483.460(c)(5)(i) NURSING SERVICES	W 340		
	Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.		Individual #2 was re- trained on procedures for self medication as it relates to 'dropped medication'/ infection control practices on 5/2/08 and 5/22/08. Nurses have been in-serviced on the policy of self medication procedures for individuals, dropped medication/ medication error.	5/10/08 and on going
	This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that one (Client #2) of two clients in the sample was effectively trained on procedures for self medication. The finding includes: On 5/2/08 at 7:40 AM, Client #2 was observed punching Trileptal from the medication card. Interview with the medication nurse (LPN)			

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W 340	Continued From page 17 indicated the client had been approved to participate in a self medication training program with nursing supervision. The client was observed to drop a Trileptal tablet on the floor as he punched it from the card. He then immediately picked up the pill, put it in the cup with his other pills, and placed them in his mouth. He then self administered the pills and drank water. During this time he was being observed by the nurse. There was no evidence that the LPN intervened to provide instructions the the client on what to do if he dropped a pill. Interview with the primary LPN indicated that the medication should have been discarded following the agency's established policy and procedure. There was no evidence the LPN enforced the facility's policy on discarding medication.	W 340		
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure comprehensive treatment services for the maintenance of dental health for Client #1. The finding includes: Observation on April 30, 2008 at 6:25 PM revealed Client #1 was administered Dilantin 225 mg by the medication nurse. Interview with the nurse revealed the client was prescribed Dilantin	W 356	Cross reference and adopted with w-120.	6/20/08 and ongoing

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W 356	Continued From page 18 in the morning and evening to manage his seizure disorder. Record review revealed a dental consultation report dated 3/12/07. The dentist assessed that the client had hypertropic gingival areas due to Dilantin therapy. The dentist indicated that subgingival calculus may cause swelling. Scaling of the client's teeth twice a year was recommended. The dentist recommended that the client be scheduled for full mouth scaling and noted that sedation may be required. The dentist documented that preauthorization to perform treatment would be sought and that the group home would be notified to schedule an appointment after the authorization was received. Record review and interview with the primary LPN revealed that the nurse telephoned the dentist's office on 5/8/07 and again on 6/12/07 to determine if the authorization to perform the recommended treatment had been received. The nurse indicated that during both of the telephone calls, dental office staff reported that the authorization for treatment had not been received. Further record review revealed no correspondence with the dentist's office until a telephone call on 9/17/908 from the dentist's office. At that time, the dentist office reported that it had the wrong contact information for the client and scheduled an appointment for 11/6/07 for a full mouth scaling. During the 11/06/07 appointment, the dentist reassessed the client and diagnosed that he had moderate calculus deposits and gingival hyperplasia. Again, scaling of teeth and a gingivectomy were recommended. The dentist indicated that authorization from the funding	W 356		

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W 356	Continued From page 19	W 356		
	source would be requested to perform the needed treatments. A consultation report dated 2/27/08 revealed that general scaling and polishing of the client's teeth were performed. The need for the gingivectomy and preauthorization to perform the procedure was also indicated. A consultation report dated March 12, 2008 indicated that the gingivectomy was performed. There was no evidence that the client received services timely for the maintenance of his dental health.			
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the consistent implementation of an active infective control program during self-medication for one (Client #2) of two clients in the sample. The finding includes: On 5/2/08 at 7:40 AM, the facility's medication nurse failed to implement infection control measures when Client #2 dropped a pill on the floor while preparing his medications for self-administration. [See W340]	W 455	Symbral has a policy that informs nurse's action for Medication Disposal. A memo was sent to all nurses reminding them of the appropriate procedures regarding dropped medication. Individuals and staff were also in-serviced in the area of safe guarding self and individuals in the event of a dropped medication .	5/10/08 an ongoing

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I 000	INITIAL COMMENTS	I 000		
	This licensure survey was conducted on April 30, 2008 through May 2, 2008. The survey was initiated utilizing the fundamental survey process. A random sampling of two residents from the residential population of three clients with varying degrees of disabilities was identified. The findings of this survey were based on observations at the group home and two day programs, interviews with a resident, and interview with day program staff and residential staff, the review of clinical and administrative records and the review of the facility's unusual incident reports.			
I 090	3504.1 HOUSEKEEPING	I 090		
	The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the interior was maintained in a safe, clean, orderly, attractive, and sanitary manner. The findings include: 1. Blistered paint was observed in the kitchen on the left wall beside the range. The range was observed to be installed directly beside the wall and the wall did not have a protective shield.		Maintenance repair forms highlighting repairs to be effected have been circulated to the maintenance department for corrections. Symbral will ensure that repairs to building and or furniture are implemented in a timely manner as per repair and maintenance policy.	6/20/08 and on going
	2. Dirt and debris were observed behind the washer, dryer and the hot water heater in the		Staff was in-serviced on house keeping on 5/28/08.	5/28/08 and ongoing

Health Regulation Administration

Yvonne Mohammed

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

TITLE CEO

(X6) DATE 5/29/08

STATE FORM

W16911

If continuation sheet 1 of 4

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I 090	Continued From page 1	I 090		
	laundry room.			
	3. Exposed nail heads were were observed in the top drawer of Resident #2's night stand. There was an unsecured piece of wood at front top of the night stand.		Individual #2 night stand was repaired on 5/8/08.	6/20/08
	4. A chair in the front bedroom was observed to have a heavily stained fabric seat covering.		Chair was discarded on 5/8/08.	
	5. Broken tiles were observed on the floor in the front bedroom.		Broken tiles will be repaired.	
	6. The door of the left closet door had a hole in it where the knob was attached.		Closet door will be replaced.	
	7. An uncovered section of the floor which measured approximately 1' (extended across the width of the doorway) was observed between the second floor office and the laundry room. This caused the area of the floor to be uneven creating a potential trip hazard in the doorway.		Floor will be repaired.	
I 229	3510.5(f) STAFF TRAINING	I 229		
	Each training program shall include, but not be limited to, the following:		In-service was provided to all staff on charting sleep cycle by psychologist .QMRP, QA, Psychologist and House Manager will continue to monitor for compliance.	5/23/08 and ongoing
	(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, interview and record, the facility failed to ensure continuos training was provided to each employee to enable them to effectively and competently implement Resident #1's sleep monitoring.			

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I 229	Continued From page 2	I 229		
	The finding includes: The facility failed to ensure staff were trained to accurately and consistently document Resident #1's sleep chart which was developed by the psychologist. See Federal Deficiency Report - W189		Cross reference and adopted with w-189.	5/23/08 and ongoing
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record verification, the GHMRP failed to ensure professional services were provided for two of three residents residing in the GHMRP. (Residents #1 and #2) The findings include: [See Federal Deficiency Report - Citations W120, W159, W212, W322, W331, and W356.]	I 401	Cross reference and adopted with w-120, w-159, w-212, w-322, w-331 & w-356.	6/20/08 and ongoing
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		

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I 422	Continued From page 3	I 422		
	Based on observation, interview and record review, the facility failed to ensure that as soon as the interdisciplinary team formulated the individual program plan (IPP), continuous active treatment plan, consisting of needed interventions to achieve identified objectives was provided for one (Resident #2) of two residents in the sample.		Cross reference and adopted with w-104.	6/20/08 and on g
	The finding includes:			
	The facility failed to ensure that the weekly sexual therapy sessions recommended for Resident #2 by the interdisciplinary team were continuously provided. [See W104, 1]			
I 500	3523.1 RESIDENT'S RIGHTS	I 500		
	Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.			
	This Statute is not met as evidenced by: Based on on observation, interview and record review, the GHMRP failed to ensure that the rights of each resident were protected.			
	The findings include:			
	See Federal Deficiency Report - Citation W212, W249, W310, W322, and W356].		Cross reference and adopted with w-212, w-249, w-310, w-322 and w-356.	6/20/08