

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

PRINTED: 05/31/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/16/2013
NAME OF PROVIDER OR SUPPLIER SYMBRAL FOUNDATION			STREET ADDRESS, CITY, STATE, ZIP CODE 722 "L" STREET, NE WASHINGTON, DC 20002		
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W 000	INITIAL COMMENTS A recertification survey was conducted from May 15, 2013 through May 16, 2013. A sample of two clients was selected from a population of two males with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process. The findings of the survey were based on observations in the home and one day program, interviews with one client, direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	W 000			
W 136	483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. This STANDARD is not met as evidenced by: Based on client and staff interviews and record verification, the facility failed to provide opportunities for each client to participate in community outings/ recreational activities of choice, for one of two clients in the sample. (Client #1) The findings include: I. On May 15, 2013, beginning at 7:00 a.m., a	W 136	Individual's one on one Staff and Manager will meet semi-monthly to develops schedule of preferred activities. Staff have been retrained to identify, respect and accept individual input in choosing activity. The QIDP has identified a gym for the individual #1 since 5/19/13. All staff has been trained to make sure individual #1 goes to the gym of his choice. The QIDP will monitor quarterly to make sure that individual #1 goes to Rosedale Recreation or place of his choice twice a week.	5/19/13 and ongoing	

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

Thouda N. [Signature]

TITLE

CEO

(X6) DATE

6/19/2013

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 136	<p>Continued From page 1</p> <p>direct support staff (Staff #6) was observed working alongside Client #1. She stayed by his side as they prepared breakfast and set the table. Staff #6 stated that she was assigned as his one-to-one. Continued observations and interviews during the survey revealed Client #1 had an assigned one-to-one staff 24 hours per day, 7 days per week.</p> <p>On May 15, 2013, at 3:35 p.m., interview with Client #1 revealed that he enjoyed playing basketball. He further stated, however, that his current day program was without a basketball court. When asked if he had opportunities to play basketball on evenings or weekends in community parks or recreation centers, he replied no. The house manager (HM, Staff #2) and the qualified intellectual disabilities professional (QIDP, Staff #1) were present during the interview. The HM indicated that he had previously expressed interest in playing basketball and mentioned having taken him to see the Washington Wizards play professional basketball. She confirmed that the client had not been to local parks, explaining that this was due to his past history of making inappropriate sexual advances towards children. She then stated perhaps staff could take him on evenings when it was less likely children would be present. Both the HM and the QIDP said the facility had not sought to identify an alternative location where Client #1 and his one--to-one staff could play basketball.</p> <p>On May 16, 2013, at approximately 12:00 p.m., review of Client #1's behavior support plan (BSP), dated July 25, 2012, verified the history of making inappropriate comments. The one-to-one staffing</p>	W 136	Continued from page 1.	

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W 136	<p>Continued From page 2 was established to address his behavioral needs.</p> <p>On May 16, 2013, beginning at 12:29 p.m., review of Client #1's community outings records and recreational activities logs failed to show evidence that he had opportunities to play basketball.</p> <p>II. Interview with Client #1 on May 15, 2013, beginning at 3:35 p.m., also revealed that he would like to go to a gym. He described specific exercise equipment and playfully stated that he would like to develop "six-pack abs." The qualified intellectual disabilities professional (Staff #1) and the house manager (Staff #2) were present during the interview. They explained that a female staff had taken Client #1 to her gym once. They also acknowledged that this was not the first time he had expressed such interest. There was no evidence that the facility had addressed his expressed interest in going to a gym for exercise.</p> <p>III. The May 15, 2013 interview with Client #1 also revealed that he would like to vacation in Florida, Jamaica or North Carolina (where an uncle reportedly resides). The client said the facility takes everyone to Ocean City, Maryland each year for vacation. Staff #1 and #2 confirmed that "everyone goes to Ocean City" and they were not aware if Client #1 had been offered a choice of alternate vacation destinations. Plans were already underway for a 2013 trip to Ocean City, MD.</p> <p>On May 16, 2013, beginning at approximately 12:00 p.m., review of Client #1's habilitation records revealed the client had vacationed in Ocean City, MD in August 2012. His Individual</p>	W 136	Continued from page 2.		

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W 136	Continued From page 3 Support Plan, dated July 25, 2012, indicated that he was saving for a vacation in Ocean City, MD. There was no evidence that the facility provided opportunities for clients to participate in preferred community and recreational activities.	W 136	Continued from page 3.	
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that justified the withdrawals/expenditures from each client's personal account, for two of two clients in the sample. (Clients #1 and #2) The findings include: I. On May 15, 2013, at approximately 7:45 a.m., interview with Client #1 revealed that he earned a stipend at his day program. He stated the home helped manage his money. On May 16, 2013, at 11:56 a.m., review of the client's psychological evaluation, dated July 24, 2012, revealed that he was functioning at the moderate level and lacked the capacity to make decisions independently, including financial decisions. The client's Individual Support Plan, dated July 24, 2012, assigned the management of his funds to the facility and the client's service coordinator. On May 16, 2013, beginning at 4:20 p.m., review of Client #1's financial records revealed that \$60	W 140	The receipts for \$60.00 dated 1/17/2013 and \$100.00 dated 12/18/2012 has been found and filed within individual #1 financial records. Individual #2 \$20.00 requisition and receipts of 1/17/2013 and requisition/receipt of \$200.00 on 4/16/2013 has also been removed and placed in individual record. Symbtral Foundation has implemented and put in place the protocol for money request by matching the requisitions with receipts. The protocol in place is for the requisition form to be filled prior to request. The request will be reviewed by QIDP, approved by CFO before monies withdrawn. Receipts for each transaction will be submltted to accounting department for reconciliation within ten (10) days of return. The QIDP will monitor quarterly and as needed.	5/19/13 and ongoing

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W 140	<p>Continued From page 4</p> <p>was withdrawn from his account on January 17, 2013. There was no record of why the funds were withdrawn or how the money was spent. Client #1's bank statement also showed a \$100 withdrawal made on December 18, 2012 for Christmas shopping. Three receipts (\$31.79, \$7.41 and \$7.42 documented how \$46.62 was spent. There was no accounting of what happened to the remaining \$53.38 withdrawn on December 18, 2012.</p> <p>On May 16, 2013, at 4:50 p.m., the qualified intellectual disabilities professional (QIDP, Staff #1) was asked about Client #1's bank withdrawal from December 18, 2012 and January 17, 2013. After reviewing Client #1's financial records, at 4:56 p.m., he confirmed there were no additional receipts available for review, and no evidence that the \$53.38 balance had been deposited back into the client's account. He further explained that there should be a requisition form submitted prior to each withdrawal. Without requisition forms and/or receipts for the two aforementioned withdrawals, he was unable to say how the monies had been spent.</p> <p>II. On May 16, 2013, beginning at 5:07 p.m., review of Client #2's financial records revealed there were no requisition forms or receipts for withdrawals made from his bank account on January 17, 2013 (\$20) and April 16, 2013 (\$200). Review of the client's psychological evaluation, dated August 12, 2012, revealed that he was functioning at the severe level and lacked the capacity to make decisions independently, including financial decisions. The client's Individual Support Plan, dated August 12, 2012, assigned the management of his funds to the</p>	W 140	Continued from page 5.		

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W 140	Continued From page 5 facility and the client's service coordinator. At 5:15 p.m., the QIDP (Staff #1) stated he did not know how the funds withdrawn on January 17, 2013 and April 16, 2013 had been spent. He reviewed Client #2's financial records, confirmed there were no receipts, requisition forms or any other documentation available that would indicate how the funds had been spent. At the time of the survey, the facility failed to maintain a system that assures a complete and accurate accounting of clients' personal funds.	W 140	Continued from page 5.		
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that all staff were effectively trained (i.e. demonstrated the skills and competencies needed) for adherence with a prescribed daily fluid intake restriction, for the one client (of two individuals residing in the facility) with the assessed need. (Client #1) The findings include: [Cross-reference to W331] i. On May 15, 2013, at 7:18 a.m., Client #1 was observed pouring an 8 ounce (oz) glass of milk. He placed it on the breakfast table next to an 8 oz glass of water. He finished both beverages along with his breakfast at approximately 7:30 a.m. At approximately 7:45 a.m., the client informed this	W 192	Symbtral's DON and the LPN Nurse has trained the staff working with individual on 6/1/2013, on the implementation of daily fluid restrictions prescribed by the PCP and recommendations by the Nutritionist. The training materials reflect a fluid intake schedule (# of cups, or fluid ounces per meal and during medication administration), as per PCP orders and Nutritionist recommendations for mealtimes and snacks time including the time the individual spends at the day program. This training will be given to the staff every six (6) months and as needed by the DON/LPN Nurse and the QIDP will monitor quarterly. (see attached training sheet and fluid intake monitoring (new sheet).	6/6/13 and ongoing	

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W 192	<p>Continued From page 6</p> <p>surveyor that he was "on a fluid restriction... I get 8 oz in the morning." His one-to-one staff who had assisted him with breakfast that morning (Staff #6) confirmed that he was on a fluid restriction.</p> <p>On May 15, 2013, at 9:08 a.m., Client #1's current physician's order sheets (POS), dated April 1, 2013, were reviewed in the presence of the licensed practical nurse (LPN) coordinator (Staff #4). Staff #4 stated the fluid restriction was due to low serum sodium levels. The POS reflected a daily fluid intake of 1800 cubic centimeters (cc's), which on July 30, 2012, the nutritionist allocated as follows: - 8 oz + 4 oz at each meal (breakfast, lunch and dinner); - 8 oz at each medication administration (morning and evening); and, - 4 oz at snack time, twice daily.</p> <p>Observations on the morning of May 15, 2013 revealed Client #1 drank 16 oz at breakfast instead of 12 oz. Staff #6 confirmed the observations when interviewed in the facility on May 15, 2013, at approximately 3:40 p.m., stating that he drank 2 cups/16 oz every morning at breakfast.</p> <p>On May 15, 2013, at 2:27 p.m., review of the staff in-service training records revealed that all residential staff had received training for Client #1's 1800 cc fluid restriction on June 18, 2012. The training materials did not, however, reflect a fluid intake schedule (cups or fluid ounces per meal or medication administration). The client's Nutrition Evaluation, dated July 30, 2012, established a schedule that specified how much</p>	W 192	Continued from page 6.		

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W 192	<p>Continued From page 7</p> <p>fluid should be offered at various times. There was no evidence, however, that residential staff had received training since the schedule was established 11 months before the survey.</p> <p>II. Client #1 was observed at his day program on May 15, 2013, beginning at 10:43 a.m. When asked about the client's fluid intake, at approximately 12:05 p.m., the day program case manager (DP #1) and the day program nurse (DP #2) both indicated there were no special instructions. They both indicated they were previously unaware of a dally fluid restriction and had been hired within the past year. The most recent POS observed in Client #1's day program record were dated June 1, 2012, and did not reflect a fluid restriction.</p> <p>On May 15, 2013, at 1:55 p.m., the LPN coordinator (Staff #4) presented a signature sheet of an in-service training he provided for staff at Client #1's day program on July 5, 2012. The signatures of a former day program case manager and a former day program nurse were there, but not those of DP #1 and DP #2. Staff #4 acknowledged that he had not conducted a more recent in-service at the day program, to ensure that all staff were aware of the 1800 cc fluid restriction.</p> <p>It should be noted that on May 15, 2013, beginning at 2:00 p.m., review of Client #1's lab reports revealed the following:</p> <ul style="list-style-type: none"> - 5/29/12 lab report - Sodium 124 Low (137 - 145 millimolars per liter (mmol/L), after which (on 6/15/12) the primary care physician prescribed the 1800 cc fluid restriction; - 8/1/12 Sodium 121 Low; 	W 192	Continued from page 7.		

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W 192	Continued From page 8 - 10/2/12 Sodium 132 Low; - 1/23/13 Sodium 131 Low; and - 4/25/13 Sodium 132 Low. On May 16, 2013, beginning at 10:20 a.m., review of the client's Nutrition Evaluations (dated July 30, 2012, October 30, 2012, January 26, 2013 and April 20, 2013) revealed the desired outcome for the fluid restriction was to get "sodium level no less than 134." Client #1's serum sodium levels, however, remained below normal. At 10:51 a.m., Staff #4 stated the goal was for the client's "sodium levels to bounce back to normal." Continued interview revealed that Client #1 wanted the fluid restriction lifted. When Staff #4 asked the primary care physician about lifting the restriction on the day before, the physician reportedly replied "no, not as long as the levels are borderline."	W 192	Continued from page 8.	
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 ensure that each client who was prescribed a restriction on fluid intake received nursing oversight to ensure compliance with the physician's orders, for the one client (of two individuals residing in the facility) with the assessed need. (Client #1) The findings include: I. On May 15, 2013, at 7:18 a.m., Client #1 was observed pouring an 8 ounce (oz) glass of milk. He placed it on the breakfast table next to an 8 oz	W 331	Symbtral's DON and the LPN Nurse has trained the staff working with individual on 6/1/2013, on the implementation of daily fluid restrictions prescribed by the PCP and recommendations by the Nutritionist. The training materials reflect a fluid intake schedule (# of cups, or fluid ounces per meal and during medication administration), as per PCP orders and Nutritionist recommendations for mealtimes and snacks time including the time the individual spends at the day program. This training will be given to the staff every six (6) months and as needed by the DON/LPN Nurse and the QIDP will monitor quarterly. (see attached training sheet and fluid intake monitoring (new sheet).	6/1/2013 and ongoing

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W 331	<p>Continued From page 9</p> <p>glass of water. He finished both beverages along with his breakfast at approximately 7:30 a.m. At approximately 7:45 a.m., the client informed this surveyor that he was "on a fluid restriction... I get 8 oz in the morning." His one-to-one staff who had assisted him with breakfast that morning (Staff #6) confirmed that he was on a fluid restriction.</p> <p>On May 15, 2013, at 9:08 a.m., Client #1's current physician's order sheets (POS), dated April 1, 2013, were reviewed in the presence of the licensed practical nurse (LPN) coordinator (Staff #4). Staff #4 stated the fluid restriction was due to low serum sodium levels. The POS reflected a daily fluid intake of 1800 cubic centimeters (cc's), which on July 30, 2012, the nutritionist allocated as follows:</p> <ul style="list-style-type: none"> - 8 oz + 4 oz at each meal (breakfast, lunch and dinner); - 8 oz at each medication administration (morning and evening); and, - 4 oz at snack time, twice daily. <p>Observations on the morning of May 15, 2013 revealed Client #1 drank 16 oz at breakfast instead of 12 oz scheduled. Staff #6 confirmed the observations when interviewed in the facility on May 15, 2013, at approximately 3:40 p.m., stating that he drank 2 cups/16 oz every morning at breakfast.</p> <p>ii. Client #1 was observed at his day program on May 15, 2013, beginning at 10:43 a.m. When asked about the client's fluid intake, at approximately 12:05 p.m., the day program case manager (DP #1) and the day program nurse (DP #2) both indicated there were no special</p>	W 331	Continued from page 9.	

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W 331	<p>Continued From page 10</p> <p>instructions. They both indicated they were previously unaware of a daily fluid restriction. Client #1's day program record contained POS dated June 1, 2012, which did not reflect a fluid restriction (Note: It was later revealed that the 1800 cc restriction was ordered by the physician on June 15, 2012).</p> <p>On May 15, 2013, beginning at 2:39 p.m., review of Client #1's fluid intake records and day program records in the home failed to show evidence that his fluid intake at day program was being documented. On May 15, 2013, at 3:20 p.m., interview with the one-to-one direct support staff (Staff #7) who accompanied Client #1 to his day program that day revealed the client routinely drank an 8 oz cup of tea at morning break and a "small" carton of milk. She was unsure of the exact amount of milk. On May 16, 2013, at 2:58 p.m., interview with another one-to-one staff (Staff #8) who accompanied him to day program on that day revealed a similar answer. However, both the QIDP (Staff #1) and the LPN coordinator (Staff #4) were unable to locate any documentation regarding Client #1's fluid intake during day program hours.</p> <p>III. Similarly, on May 16, 2013, at approximately 10:45 a.m., Staff #1 and Staff #4 stated they could not locate records of Client #1's fluid intake during midday hours on Saturdays and Sundays. They further acknowledged that the chart format, in its present design, did not capture the amount of fluid the client received at snacks, midday and at medication administrations. There was no evidence the facility maintained a complete and accurate record of Client #1's fluid intake.</p>	W 331	Continued from page 10.	

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W 331	<p>Continued From page 11</p> <p>IV. On May 15, 2013, beginning at 2:39 p.m., review of Client #1's fluid intake records in the home revealed 18 days (out of 30) in March 2013, 4 out of 31 days in April 2013 and 4 out of 14 days thus far in May 2013 for which staff documented the client received at least 1920 cc's in the home. On March 9, 2013, staff documented he drank 9 cups (2160 cc's). The May 2013 fluid intake chart reflected the initials of the LPN coordinator (Staff #4) recorded each day. When interviewed on May 16, 2013, at 10:23 a.m., Staff #4 stated that he initialed the chart each evening but he had not identified the facility's failure to adhere to Client #1's prescribed fluid restriction.</p> <p>V. Review of Client #1's nursing records and fluid intake sheets revealed no evidence the facility's registered nurse (RN, Staff #3) had reviewed his fluid intake data.</p> <p>VI. Initial interview with the LPN coordinator (Staff #4) on May 15, 2013, at 9:08 a.m., revealed Client #1's fluid restriction was prescribed due to low serum sodium levels. On May 15, 2013, beginning at 2:00 p.m., review of the client's lab reports revealed the following:</p> <ul style="list-style-type: none"> - 5/29/12 lab report - Sodium 124 Low (137 - 145 millimolars per liter (mmol/L), after which (on 6/15/12) the primary care physician prescribed the 1800 cc fluid restriction; - 8/1/12 Sodium 121 Low; - 10/2/12 Sodium 132 Low; - 1/23/13 Sodium 131 Low; and - 4/25/13 Sodium 132 Low. <p>On May 16, 2013, beginning at 10:20 a.m., review of the client's Nutrition Evaluations (dated July 30, 2012, October 30, 2012, January 26, 2013 and April 20, 2013) revealed the desired outcome for</p>	W 331	Continued from page 11.	

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/16/2013
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W 331	Continued From page 12 the fluid restriction was to get "sodium level no less than 134." Client #1's serum sodium levels, however, remained below normal. At 10:51 a.m., Staff #4 stated the goal was for the client's "sodium levels to bounce back to normal." Continued interview revealed that Client #1 wanted the fluid restriction lifted. When Staff #4 asked the primary care physician about lifting the restriction on the day before (May 15, 2013), the physician reportedly replied "no, not as long as the levels are borderline."	W 331	Continued from page 12.		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, facility staff failed to consistently implement the use of each client's adaptive equipment, for one of two clients in the sample. (Client #2) The finding includes: Observation on May 15, 2013, at 8:26 a.m., revealed Client #2 drinking water with Miralax powder dissolved in it. The cup had a long handle down one side and an open top. The morning medication nurse (Staff #5) instructed the client to "slow down" while he drank. No spillage was observed. The client's one-to-one direct support	W 436	The DON/LPN Nurse has re-trained / inservice all the staff working with individual #2 for the proper use and implementation of adaptive equipment (sippy cup) having lid and spout on it at all time when it is being used. Monitoring tools have been put in place for a daily monitoring the proper use of sippy cup with a lid and spout. The LPN Nurse will review daily and DON will monitor randomly thereafter and re-training as needed.	6/1/13 and ongoing	

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W 436	<p>Continued From page 13</p> <p>staff (Staff #9) was also with him at the time. [Note: The client showed no indication of distress.]</p> <p>On May 15, 2013, at 9:20 a.m., review of Client #2's current physician's order sheets, dated April 1, 2013 revealed that he was prescribed a "sippy cup." Upon request, the licensed practical nurse (LPN) coordinator (Staff #4) presented a sippy cup from the kitchen. It was the same cup he was observed using during the medication administration, however, it now had a lid with a spout on it. Staff #4 said it was an "aspiration precaution" and the spout controlled the flow. Neither the medication nurse (Staff #5) nor the one-to-one (Staff #9) was observed that morning to make the spout lid available for the client's use. At 3:30 p.m., on May 15, 2013, Client #2 was observed using the sippy cup with lid at snack time.</p> <p>On May 16, 2013, at 1:50 p.m., follow-up interview with the LPN coordinator (Staff #4) revealed that he had spoken with Staff #5 by telephone. She had acknowledged the spout lid was not on the sippy cup when she administered the Miralax, adding that she "stood by his side and was monitoring him."</p> <p>This is a repeat deficiency. See Federal Deficiency Report dated May 24, 2012.</p>	W 436	Continued from page 13.		

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NAME OF PROVIDER OR SUPPLIER SYMBRAL FOUNDATION		STREET ADDRESS, CITY, STATE, ZIP CODE 722 "L" STREET, NE WASHINGTON, DC 20002		
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I 000	INITIAL COMMENTS A licensure survey was conducted from May 15, 2013 through May 16, 2013. A sample of two residents was selected from a population of two males with varying degrees of intellectual disabilities. The findings of the survey were based on observations in the home and one day program, interviews with one resident, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	I 000		
I 189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents' funds received and disbursed. This Statute is not met as evidenced by: Based on interview and record review, the group home for individuals with intellectual disabilities (GHID) failed to maintain a system that ensured a complete accounting of each resident's personal funds, for two of two residents in the sample. (Residents #1 and #2) The findings include: 1. On May 15, 2013, at approximately 7:45 a.m., interview with Resident #1 revealed that he earned a stipend at his day program. He stated the home helped manage his money. On May 16, 2013, at 11:56 a.m., review of the resident's psychological evaluation, dated July 24, 2012, revealed that he was functioning at the moderate	I 189	The receipts for \$60.00 dated 1/17/2013 and \$100.00 dated 12/18/2012 has been found and filed within individual #1 financial records. Individual #2 \$20.00 requisition and receipts of 1/17/2013 and requisition/receipt of \$200.00 on 4/16/2013 has also been removed and placed in Individual record. Symbtral Foundation has implemented and put in place the protocol for money request by matching the requisitions with receipts. The protocol in place is for the requisition form to be filled prior to request. The request will be reviewed by QIDP, approved by CFO before monies withdrawn. Receipts for each transaction will be submitted to accounting department for reconciliation within ten (10) days of return. The QIDP will monitor quarterly and as needed.	5/19/13 and ongoing

Health Regulation & Licensing Administration

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

Shonda N. [Signature]

TITLE

CEO

(X6) DATE

6/19/2013

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER HFD03-0005	A. BUILDING: _____ B. WING _____	COMPLETED 05/16/2013
NAME OF PROVIDER OR SUPPLIER SYMBRAL FOUNDATION		STREET ADDRESS, CITY, STATE, ZIP CODE 722 "L" STREET, NE WASHINGTON, DC 20002		
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I 189	<p>Continued From page 1</p> <p>level and lacked the capacity to make decisions independently, including financial decisions. The resident's Individual Support Plan, dated July 24, 2012, assigned the management of his funds to the facility and the resident's service coordinator.</p> <p>On May 16, 2013, beginning at 4:20 p.m., review of Resident #1's financial records revealed that \$60 was withdrawn from his account on January 17, 2013. There was no record of why the funds were withdrawn or how the money was spent. Resident #1's bank statement also showed a \$100 withdrawal made on December 18, 2012 for Christmas shopping. Three receipts (\$31.79, \$7.41 and \$7.42 documented how \$46.62 was spent. There was no accounting of what happened to the remaining \$53.38 withdrawn on December 18, 2012.</p> <p>On May 16, 2013, at 4:50 p.m., the qualified intellectual disabilities professional (QIDP, Staff #1) was asked about Resident #1's bank withdrawal from December 18, 2012 and January 17, 2013. After reviewing Resident #1's financial records, at 4:56 p.m., he confirmed there were no additional receipts available for review, and no evidence that the \$53.38 balance had been deposited back into the resident's account. He further explained that there should be a requisition form submitted prior to each withdrawal. Without requisition forms and/or receipts for the two aforementioned withdrawals, he was unable to say how the monies had been spent.</p> <p>II. On May 16, 2013, beginning at 5:07 p.m., review of Resident #2's financial records revealed there were no requisition forms or receipts for withdrawals made from his bank account on January 17, 2013 (\$20) and April 16, 2013</p>	I 189	Continued from page 1.	

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I 189	Continued From page 2 (\$200). Review of the resident's psychological evaluation, dated August 12, 2012, revealed that he was functioning at the severe level and lacked the capacity to make decisions independently, including financial decisions. The resident's Individual Support Plan, dated August 12, 2012, assigned the management of his funds to the facility and the resident's service coordinator. At 5:15 p.m., the QIDP (Staff #1) stated he did not know how the funds withdrawn on January 17, 2013 and April 16, 2013 had been spent. He reviewed the resident's financial records, confirmed there were no receipts, requisition forms or any other documentation available that would indicate how the funds had been spent. At the time of the survey, the GHIID failed to maintain a system that assures a complete and accurate accounting of residents' personal funds.	I 189	Continued from page 2.	
I 207	3509.7 PERSONNEL POLICIES A new employee 's physical examination shall have been performed within ninety (90) days prior to employment. This Statute is not met as evidenced by: Based on record review and interview, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that each new employee's physical examination was performed within ninety (90) days prior to employment, for 1 of 17 employees. (Staff #1) The finding includes: On May 16, 2013, beginning at 2:39 p.m., review of the personnel records for all employees revealed that Staff #1's first day of employment	I 207	A new physical examination has been completed by staff #1 on 6/7/2013. Symbtral's Personnel Department will ensure that all new staff physical examination was performed within ninety (90) days prior to employment. Personnel staff have been retrained and schedule of expected timelines have been updated to reflect Regulatory expectation. House Manager and QA will review employee file within thirty (30) days of hire to ensure all documents are in compliance.	6/7/13 and ongoing

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I 207	Continued From page 3 was November 2, 2012. His health certificate was dated June 20, 2012 (greater than 90 days prior to the date he was hired). On May 16, 2013, at approximately 3:55 p.m., Staff #1 confirmed the aforementioned findings.	I 207	Continued from page 3.	
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 group home for individuals with intellectual disabilities (GHID) failed to ensure that staff received effective training on implementing prescribed daily fluid restrictions, for the one resident (of two individuals residing in the facility) with the assessed need. (Resident #1) The finding includes: [Cross-reference to I401] On May 15, 2013, at 7:18 a.m., Resident #1 was observed pouring an 8 ounce (oz) glass of milk. He placed it on the breakfast table next to an 8 oz glass of water. He finished both beverages along with his breakfast at approximately 7:30 a.m. At approximately 7:45 a.m., the resident informed this surveyor that he was "on a fluid restriction... I get 8 oz in the morning." His one-to-one staff who had assisted him with breakfast that morning (Staff #6) confirmed that he was on a fluid	I 229	Symbtral's DON and the LPN Nurse has trained the staff working with individual on 6/1/2013, on the implementation of daily fluid restrictions prescribed by the PCP and recommendations by the Nutritionist. The training materials reflect a fluid intake schedule (# of cups, or fluid ounces per meal and during medication administration), as per PCP orders and Nutritionist recommendations for mealtimes and snacks time including the time the individual spends at the day program. This training will be given to the staff every six (6) months and as needed by the DON/LPN Nurse and the QIDP will monitor quarterly. (see attached training sheet and fluid intake monitoring (new sheet).	6/1/13 and ongoing

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I 229	Continued From page 4 restriction. On May 15, 2013, at 9:08 a.m., Resident #1's current physician's order sheets (POS), dated April 1, 2013, were reviewed in the presence of the licensed practical nurse (LPN) coordinator (Staff #4). Staff #4 stated the fluid restriction was due to low serum sodium levels. The POS reflected a daily fluid intake of 1800 cubic centimeters (cc's), which on July 30, 2012, the nutritionist allocated as follows: - 8 oz + 4 oz at each meal (breakfast, lunch and dinner); - 8 oz at each medication administration (morning and evening); and, - 4 oz at snack time, twice daily. Observations on the morning of May 15, 2013 revealed Resident #1 drank 16 oz at breakfast instead of 12 oz. Staff #6 confirmed the observations when interviewed in the facility on May 15, 2013, at approximately 3:40 p.m., stating that he drank 2 cups/16 oz every morning at breakfast. On May 15, 2013, at 2:27 p.m., review of the staff in-service training records revealed that all residential staff had received training for Resident #1's 1800 cc fluid restriction on June 18, 2012. The training materials did not, however, reflect a fluid intake schedule (cups or fluid ounces per meal or medication administration). The resident's Nutrition Evaluation, dated July 30, 2012, established a schedule that specified how much fluid should be offered at various times. There was no evidence, however, that residential staff had received training since the schedule was established 11 months before the survey. It should be noted that on May 16, 2013,	I 229	Continued from page 4.	

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I 229	Continued From page 5 beginning at 10:20 a.m., review of the resident's Nutrition Evaluations (dated July 30, 2012, October 30, 2012, January 26, 2013 and April 20, 2013) revealed the desired outcome for the fluid restriction was to get "sodium level no less than 134." Resident #1's serum sodium levels, however, remained below normal. At 10:51 a.m., Staff #4 stated the goal was for the resident's "sodium levels to bounce back to normal." Continued interview revealed that Resident #1 wanted the fluid restriction lifted. When Staff #4 asked the primary care physician about lifting the restriction on the day before, the physician reportedly replied "no, not as long as the levels are borderline."	I 229	Continued from page 5.	
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 review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that each resident who was prescribed a fluid restriction received nursing and physician monitoring and oversight, to ensure proper implementation of the physician's order, for the one resident (of two individuals residing in the facility) with the assessed need. (Resident #1) The finding includes: i. On May 15, 2013, at 7:18 a.m., Resident #1	I 401	Crossed referenced with I229 (see staff training) Symbtral's DON/LPN Nurse has trained all the day program staff working with individual #1 on June 6, 2013 concerning proper implementation and documentation of fluid intake. The training entails fluid intake restriction 1800cc/day. While at the day program, individual #1 is getting 1/2 cup at the snack; 1 1/2 cups at the lunch (total 2 cups). (Refer attached sheet day program staff's will be trained by Symbtral Nursing Team every six (6) months and monitored by the QIDP as needed.	6/1/13 & 6/6/13 and ongoing

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I 401	<p>Continued From page 6</p> <p>was observed drinking an 8 ounce (oz) glass of milk and an 8 oz glass of water with breakfast. At approximately 7:45 a.m., the resident informed this surveyor that he was "on a fluid restriction... I get 8 oz in the morning." His one-to-one staff who had assisted him with breakfast that morning (Staff #6) confirmed that he was on a fluid restriction.</p> <p>On May 15, 2013, at 9:08 a.m., Resident #1's current physician's order sheets (POS), dated April 1, 2013, were reviewed in the presence of the licensed practical nurse (LPN) coordinator (Staff #4). Staff #4 stated the fluid restriction was due to low serum sodium levels. The POS reflected a daily fluid intake of 1800 cubic centimeters (cc's), which on July 30, 2012, the nutritionist allocated as follows: - 8 oz + 4 oz at each meal (breakfast, lunch and dinner); - 8 oz at each medication administration (morning and evening); and, - 4 oz at snack time, twice daily.</p> <p>Observations on the morning of May 15, 2013 revealed Resident #1 drank 16 oz. at breakfast instead of 12 oz. scheduled. Staff #6 confirmed the observations when interviewed in the facility on May 15, 2013, at approximately 3:40 p.m., stating that Resident #1 routinely drank 2 cups/16 oz every morning at breakfast.</p> <p>ii. Resident #1 was observed at his day program on May 15, 2013, beginning at 10:43 a.m. When asked about the resident's fluid intake, at approximately 12:05 p.m., the day program case manager (DP #1) and the day program nurse (DP #2) both indicated there were no special instructions. They both indicated they were previously unaware of a daily fluid restriction.</p>	I 401	Continued from page 6.	

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I 401	<p>Continued From page 7</p> <p>Resident #1's day program record contained POS dated June 1, 2012, which did not reflect a fluid restriction (Note: It was later revealed that the 1800 cc restriction was ordered by the physician on June 15, 2012).</p> <p>On May 15, 2013, beginning at 2:39 p.m., review of Resident #1's fluid intake records and day program records in the home failed to show evidence that his fluid intake at day program was being documented. On May 15, 2013, at 3:20 p.m., interview with the one-to-one direct support staff (Staff #7) who accompanied Resident #1 to his day program that day revealed the client routinely drank an 8 oz. cup of tea at morning break and a "small" carton of milk. She was unsure of the exact amount of milk. On May 16, 2013, at 2:58 p.m., interview with another one-to-one staff (Staff #8) who accompanied him to day program on that day revealed a similar answer. However, both the QIDP (Staff #1) and the LPN coordinator (Staff #4) were unable to locate any documentation regarding Resident #1's fluid intake during day program hours.</p> <p>III. Similarly, on May 16, 2013, at approximately 10:45 a.m., Staff #1 and Staff #4 stated they could not locate records of Resident #1's fluid intake during midday hours on Saturdays and Sundays. They further acknowledged that the chart format, in its present design, did not capture the amount of fluid the resident received at snacks, midday and at medication administrations. There was no evidence the facility maintained a complete and accurate record of Resident #1's fluid intake.</p> <p>IV. On May 15, 2013, beginning at 2:39 p.m., review of Resident #1's fluid intake records in the home revealed 18 days (out of 30) in March</p>	I 401	Continued from page 7.	

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I 401	<p>Continued From page 8</p> <p>2013, 4 out of 31 days in April 2013 and 4 out of 14 days thus far in May 2013 for which staff documented the resident received at least 1920 cc's in the home. On March 9, 2013, staff documented he drank 9 cups (2160 cc's). When interviewed on May 16, 2013, at 10:23 a.m., Staff #4 stated that he reviewed the fluid intake chart each evening but he had not identified the facility's failure to adhere to the prescribed fluid restriction.</p> <p>V. Review of Resident #1's nursing records and fluid intake sheets revealed no evidence the facility's registered nurse (RN, Staff #3) had reviewed his fluid intake data.</p> <p>VI. Initial interview with the LPN coordinator (Staff #4) on May 15, 2013, at 9:08 a.m., revealed Resident #1's fluid restriction was prescribed due to low serum sodium levels. On May 15, 2013, beginning at 2:00 p.m., review of the resident's lab reports revealed the following:</p> <ul style="list-style-type: none"> - 5/29/12 lab report - Sodium 124 Low (137 - 145 millimolars per liter (mmol/L), after which (on 6/15/12) the primary care physician prescribed the 1800 cc fluid restriction; - 8/1/12 Sodium 121 Low; - 10/2/12 Sodium 132 Low; - 1/23/13 Sodium 131 Low; and - 4/25/13 Sodium 132 Low. <p>On May 16, 2013, beginning at 10:20 a.m., review of the resident's Nutrition Evaluations (dated July 30, 2012, October 30, 2012, January 26, 2013 and April 20, 2013) revealed the desired outcome for the fluid restriction was to get "sodium level no less than 134." Resident #1's serum sodium levels, however, remained below normal. At 10:51 a.m., Staff #4 stated the goal was for the resident's "sodium levels to bounce back to normal." Continued interview revealed that</p>	I 401	Continued from page 8.	

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I 401	Continued From page 9 Resident #1 wanted the fluid restriction lifted. When Staff #4 asked the primary care physician about lifting the restriction on the day before, the physician reportedly replied "no, not as long as the levels are borderline."	I 401	Continued from page 9.		
I 500	3523.1 RESIDENT'S RIGHTS 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 observations, interviews and record review, the group home for individuals with intellectual disabilities (GHIID) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and federal regulations 42 CFR 483 Sub-Part 1 (for Intermediate Care Facilities for Individuals with Intellectual Disabilities), for two of two residents of the facility. (Residents #1 and #2) The findings include: I. [483.460(c)] The GHIID failed to ensure Resident #1's right to receive health care services, to include monitoring and oversight by licensed professionals, to ensure compliance with his physician-ordered fluid restriction, as follows: A. [Cross-reference to I401] On May 15, 2013, at 7:18 a.m., Resident #1 was observed drinking an 8 ounce (oz) glass of milk and an 8 oz glass of water with breakfast.	I 500	A-D: Crossed reference with I229. The DON/LPN Nurse has put in place a system to review individual #1 records for fluid intake. Symbal LPN Nurse will review weekly and the DON will review the fluid intake chart monthly and as needed. The Nursing Team will train staff every six (6) months and the QIDP will monitor quarterly. (see the attached fluid intake monitoring record.)	5/19/13 and ongoing	

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I 500	Continued From page 10 On May 15, 2013, at 9:08 a.m., Resident #1's current physician's order sheets (POS), dated April 1, 2013, were reviewed in the presence of the licensed practical nurse (LPN) coordinator (Staff #4). Staff #4 stated the fluid restriction was due to low serum sodium levels. The POS reflected a daily fluid intake of 1800 cubic centimeters (cc's), which on July 30, 2012, the nutritionist allocated as follows: - 8 oz + 4 oz at each meal (breakfast, lunch and dinner); - 8 oz at each medication administration (morning and evening); and, - 4 oz at snack time, twice daily. Interview with Staff #6 on May 15, 2013, at approximately 3:40 p.m., revealed that Resident #1 routinely drank 2 cups/16 oz every morning at breakfast instead of 12 oz as scheduled. B. On May 15, 2013, beginning at 2:39 p.m., review of Resident #1's fluid intake records and day program records in the home failed to show evidence that his fluid intake at day program was being documented. Similarly, on May 16, 2013, at approximately 10:45 a.m., Staff #1 and Staff #4 stated they could not locate records of Resident #1's fluid intake during midday hours on Saturdays and Sundays. They further acknowledged that the chart format, in its present design, did not capture the amount of fluid the resident received at snacks, midday and at medication administrations. There was no evidence the facility maintained a complete and accurate record of Resident #1's fluid intake. C. On May 15, 2013, beginning at 2:39 p.m., review of Resident #1's fluid intake records in the home revealed 18 days (out of 30) in March	I 500	Continued from page 10.	

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I 500	Continued From page 11 2013, 4 out of 31 days in April 2013 and 4 out of 14 days thus far in May 2013 for which staff documented the resident received at least 1920 cc's in the home. On March 9, 2013, staff documented he drank 9 cups (2160 cc's). When interviewed on May 16, 2013, at 10:23 a.m., Staff #4 stated that he reviewed the fluid intake chart each evening but he had not identified the facility's failure to adhere to the prescribed fluid restriction. D. Review of Resident #1's nursing records and fluid intake sheets revealed no evidence the facility's registered nurse (RN, Staff #3) had reviewed his fluid intake data. E. Initial interview with the LPN coordinator (Staff #4) on May 15, 2013, at 9:08 a.m., revealed Resident #1's fluid restriction was prescribed due to low serum sodium levels. On May 15, 2013, beginning at 2:00 p.m., review of the resident's lab reports revealed the following: - 5/29/12 lab report - Sodium 124 Low (137 - 145 millimolars per liter (mmol/L), after which (on 6/15/12) the primary care physician prescribed the 1800 cc fluid restriction; - 8/1/12 Sodium 121 Low; - 10/2/12 Sodium 132 Low; - 1/23/13 Sodium 131 Low; and - 4/25/13 Sodium 132 Low. On May 16, 2013, beginning at 10:20 a.m., review of the resident's Nutrition Evaluations (dated July 30, 2012, October 30, 2012, January 26, 2013 and April 20, 2013) revealed the desired outcome for the fluid restriction was to get "sodium level no less than 134." There was no evidence that the facility's medical team, to include the primary care physician, had established and implemented a system of	I 500	The DON/LPN Nurse has re-trained / inservice all the staff working with individual #2 for the proper use and implementation of adaptive equipment (sippy cup) having lid and spout on it at all time when it is being used. Monitoring tools have been put in place for a daily monitoring the proper use of sippy cup with a lid and spout. The LPN Nurse will review daily and DON will monitor randomly thereafter and re-training as needed.	6/1/13 and ongoing

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I 500	<p>Continued From page 12</p> <p>oversight to ensure compliance with the 1800 cc's per day fluid restriction, to achieve the desired outcome.</p> <p>ii. [483.470(g)(2)] The GHIID failed to ensure that all staff utilized Resident #2's specialized adaptive equipment, as follows:</p> <p>Observation on May 15, 2013, at 8:26 a.m., revealed Resident #2 drinking water with Miralax powder dissolved in it. The cup had a long handle down one side and an open top. The morning medication nurse (Staff #5) instructed the resident to "slow down" while he drank. No spillage was observed. The resident's one-to-one direct support staff (Staff #9) was also with him at the time. [Note: The resident showed no indication of distress.]</p> <p>On May 15, 2013, at 9:20 a.m., review of Resident #2's current physician's order sheets, dated April 1, 2013 revealed that he was prescribed a "sippy cup." Upon request, the licensed practical nurse (LPN) coordinator (Staff #4) presented a sippy cup from the kitchen. It was the same cup he was observed using during the medication administration, however, it now had a lid with a spout on it. Staff #4 said it was an "aspiration precaution" and the spout controlled the flow. Neither the medication nurse (Staff #5) nor the one-to-one (Staff #9) was observed that morning to make the spout lid available for the resident's use. At 3:30 p.m., on May 15, 2013, Resident #2 was observed using the sippy cup with lid at snack time.</p> <p>On May 16, 2013, at 1:50 p.m., follow-up interview with the LPN coordinator (Staff #4) revealed that he had spoken with Staff #5 by telephone. She had acknowledged the spout lid</p>	I 500	Continued from page 12.	

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I 500	Continued From page 13 was not on the sippy cup when she administered the Miralax, adding that she "stood by his side and was monitoring him." This is a repeat deficiency. See Federal Deficiency Report dated May 24, 2012. III. [483.420(a)(11)] The GHIID failed to ensure Resident #1's right to participate in community outings/ recreational activities of choice, as follows: A. On May 15, 2013, beginning at 7:00 a.m., a direct support staff (Staff #6) was observed working alongside Resident #1. She stayed by his side as they prepared breakfast and set the table. Staff #6 stated that she was assigned as his one-to-one. Continued observations and interviews during the survey revealed Resident #1 had an assigned one-to-one staff 24 hours per day, 7 days per week. On May 15, 2013, at 3:35 p.m., interview with Resident #1 revealed that he enjoyed playing basketball. He further stated, however, that his current day program was without a basketball court. When asked if he had opportunities to play basketball on evenings or weekends in community parks or recreation centers, he replied no. The house manager (HM, Staff #2) and the qualified intellectual disabilities professional (QIDP, Staff #1) were present during the interview. The HM indicated that he had previously expressed interest in playing basketball and mentioned having taken him to see the Washington Wizards play professional basketball. She confirmed that the resident had not been to local parks, explaining that this was due to his past history of making inappropriate sexual advances towards children. She then	I 500	Individual's one on one Staff and Manager will meet semi-monthly to develops schedule of preferred activities. Staff have been retrained to identify, respect and accept individual input in choosing activity. The QIDP has identified a gym for the individual #1 since 5/19/13. All staff has been trained to make sure individual #1 goes to the gym at least once a week at Rosedale Recreation Center at 1701 Gales St, NE Washington, DC 20002. The QIDP will monitor quarterly to make sure that individual #1 goes to Rosedale Recreation or place of his choice twice a week.	5/19/13 and ongoing

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1500	Continued From page 14 stated perhaps staff could take him on evenings when it was less likely children would be present. Both the HM and the QIDP said the facility had not sought to identify an alternative location where Resident #1 and his one-to-one staff could play basketball. On May 16, 2013, at approximately 12:00 p.m., review of Resident #1's behavior support plan (BSP), dated July 25, 2012, verified the history of making inappropriate comments. The one-to-one staffing was established to address his behavioral needs. On May 16, 2013, beginning at 12:29 p.m., review of Resident #1's community outings records and recreational activities logs failed to show evidence that he had opportunities to play basketball. B. Interview with Resident #1 on May 15, 2013, beginning at 3:35 p.m., also revealed that he would like to go to a gym. He described specific exercise equipment and playfully stated that he would like to develop "six-pack abs." The qualified intellectual disabilities professional (Staff #1) and the house manager (Staff #2) were present during the interview. They explained that a female staff had taken Resident #1 to her gym once. They also acknowledged that this was not the first time he had expressed such interest. There was no evidence that the facility had addressed his expressed interest in going to a gym for exercise. C. The May 15, 2013 interview with Resident #1 also revealed that he would like to vacation in Florida, Jamaica or North Carolina (where an uncle reportedly resides). The resident said the facility takes everyone to Ocean City, Maryland each year for vacation. Staff #1 and #2 confirmed	1500	Depending on individual financial status, Symbtral Foundation and the QIDP will give individual #1 the opportunities to participate in preferred vacation, community and recreational activities, social, religions, and community group activity of his choice including but not limited to: Florida, Jamaica and North Carolina.	5/19/13 and ongoing

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1500	Continued From page 15 that "everyone goes to Ocean City" and they were not aware if Resident #1 had been offered a choice of alternate vacation destinations. Plans were already underway for a 2013 trip to Ocean City, MD. On May 16, 2013, beginning at approximately 12:00 p.m., review of Resident #1's habilitation records revealed the resident had vacationed in Ocean City, MD in August 2012. His Individual Support Plan, dated July 25, 2012, indicated that he was saving for a vacation in Ocean City, MD. There was no evidence that the facility provided opportunities for residents to participate in preferred community and recreational activities.	1500	Continued from page 15.		