

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

PRINTED: 04/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                    |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>09G174 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   | (X3) DATE SURVEY COMPLETED<br><br>03/27/2014 |
| NAME OF PROVIDER OR SUPPLIER<br><br>SYMBRAL FOUNDATION                              |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>4422 20TH STREET, NE<br>WASHINGTON, DC 20011  |  |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  | (X5) COMPLETION DATE                         |
| W 000   | <p><b>INITIAL COMMENTS</b></p> <p>A recertification survey was conducted from March 25, 2014 through March 27, 2014. A sample of two clients was selected from a population of four men with varying degrees of intellectual disabilities. This survey was conducted utilizing the fundamental survey process.</p> <p>The findings of the survey were based on observations, interviews and review of client and administrative records.</p> <p>Note: The below are abbreviations that may appear throughout the body of this report.</p> <p>Bowel Movement - BM<br/>Behavior Support Plan - BSP<br/>Day Program Staff - DPS<br/>Discontinue - D/C<br/>Direct Support Professional - DSP<br/>Emergency Room - ER<br/>Group Home for Individuals with Intellectual Disabilities - GHIID<br/>Grams - gm<br/>House Manager - HM<br/>Intermediate Care Facility - ICF<br/>Individual Support Plan - ISP<br/>Licensed Practical Nurse - LPN<br/>Medication Administration Record - MAR<br/>Milligrams - mg<br/>Milliliters - ml<br/>PCP - Primary Care Physician - PCP<br/>POS - Physician's Orders - POS<br/>Administer medications as needed - PRN<br/>Qualified Intellectual Disabilities Professional - QIDP<br/>Registered Nurse - RN</p> | W 000  | <p style="text-align: center;"><b>RECEIVED</b><br/>APR 27 2014</p> <p>BY: .....</p> <p style="text-align: right;">Department of Health<br/>Health Regulation &amp; Licensing Administration<br/>Intermediate Care Facilities Division<br/>899 North Capitol St., N.E.<br/>Washington, D.C. 20002</p> |  |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE               |   | TITLE  |  | (X6) DATE                                    |
|  |   | CEO  |  | 4/18/2014                                    |

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 60 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 4 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 189   | <p><b>483.430(e)(1) STAFF TRAINING PROGRAM</b></p> <p>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.</p> <p>This STANDARD is not met as evidenced by:<br/>Based on observation, interview and record review, the facility failed to ensure that all staff received effective and continuous training on clients' mealtime protocols, for one of two clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>On March 25, 2014, at 7:21 a.m., DSP #1 was observed to begin feeding Client #2 his breakfast. The meal, which consisted of pancakes, scrambled eggs and cold cereal, had been processed to a pureed texture. DSP #1 spoon fed the client two spoonfuls of food, using a weighted spoon with a built-up handle. DSP #1 then offered the client a sip of water which had been thickened to a nectar consistency. The staff then resumed spoon feeding the client.</p> <p>On March 25, 2014, at 5:20 p.m., DSP #2 was observed to open a container of vanilla yogurt and begin spoon feeding Client #2, using the same weighted spoon with a built-up handle observed that morning. The same staff, however, was observed using a different technique while assisting Client #2 with his dinner at 6:50 p.m. DSP #2 was observed providing hand-over-hand assistance with the weighted spoon, and the client willingly participated with the feeding process.</p> | W 189   | <p>All staff have been trained on 4/2/14 on Individual #2's Meal Time Protocol, to ensure consistent implementation of his meal time protocols.</p> <p>The House Manager will ensure the effective implementation daily/ as needed and the QIDP will continue to monitor monthly and as needed.</p> | 4/4/14 and ongoing   |   |

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| W 189  | Continued From page 2.<br><br>On March 27, 2014, at 11:40 a.m., review of Client #2's mealtime protocol, dated February 17, 2014, revealed that staff were to provide hand-over-hand assistance to encourage the client's participation.<br><br>On March 27, 2014, beginning at 12:23 p.m., review of the facility's records of staff in-service training revealed that the former QIDP (QIDP #2) had provided training on Client #2's mealtime protocol on June 1, 2012. Neither DSP #1's nor DSP #2's signature was noted on the June 1, 2012 signature sheet. The HM stated "I know they are trained because they know what to do." No additional in-service training records were presented for verification before the survey ended at 2:30 p.m. that day.<br><br>At the time of the survey, the facility failed to ensure that all staff received effective training to ensure consistent implementation of clients' mealtime protocols. | W 189  | Continued from page 2.  |                      |  |
| W 252  | 483.440(e)(1) PROGRAM DOCUMENTATION<br><br>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.<br><br>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that all staff in the home documented each incident of maladaptive behaviors in accordance with clients' BSPs, for one of two clients in the   | W 252  | See page 4.   |                      |  |

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| W 252  | <p>Continued From page 3 sample. (Client #1)</p> <p>The finding includes:</p> <p>During dinner observations on March 25, 2014, at 6:52 p.m., Client #1 shrieked loudly and began biting his right hand. Staff asked the client to stop and asked him what was happening. The client, who was nonverbal, stopped biting his hand and pushed the plate of food away from him. Staff redirected his attention and had him stand up from the table. A short while later, staff presented an alternate meal, which he was observed to consume without hesitation.</p> <p>On March 26, 2016, beginning at 2:45 p.m., review of Client #1's psychological records revealed a BSP dated September 19, 2013. The BSP reflected a targeted behavior of "self-injurious behavior: skin picking and hand biting" and instructed staff to document each episode of an observed maladaptive behavior. At 3:34 p.m., review of the corresponding behavior data collection sheet revealed that staff had not documented the incident of hand biting observed during dinner on the evening before, in accordance with the BSP. The QIDP and HM were present at the time of the review. They indicated they would ask their direct support staff if there were other incidents of hand biting that had gone undocumented.</p> <p>Review of staff in-service training records on March 26, 2014, at 11:00 a.m., revealed the facility documented having trained staff on Client #1's BSP on August 12, 2013 and on November 1, 2013. At the time of the survey, however, the facility failed to ensure that every incident of a</p> | W 252  | <p>The House Manager and all staff were trained on 4/4/14 on individual #1's Maladaptive Behaviors (self-injurious behavior, skin picking and hand biting) to ensure the implementation and documentation in accordance with Individual #1's Behavior Support Plan.</p> <p>The House Manager will monitor the implementation and documentation daily/as needed and the QIDP will review monthly.</p> | 4/4/14 and ongoing   |  |

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| W 252  | Continued From page 4<br>targeted maladaptive behavior was documented in the client's record, in accordance with the client's BSP.  | W 252  | Continued from page 4.   |   |  |
| W 331  | 483.460(c) NURSING SERVICES<br><br>The facility must provide clients with nursing services in accordance with their needs.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility's nursing services failed to seek clarification of each clients' POS (specific to bowel management) when indicated, for one of two clients in the sample. (Client #2)<br><br>The finding includes:<br><br>On March 25, 2014, at 8:58 a.m., Client #2 was observed being administered a mixture of polyethylene glycol powder (Miralax), 17 grams, with water. The medication nurse (Nurse #1) indicated that the stool softener was prescribed to manage chronic constipation.<br><br>On March 25, 2014, at approximately 9:20 a.m., interview with the QIDP and the HM revealed Client #2 had been sent to a hospital ER in December 2013 and was subsequently admitted due to gastro-intestinal pain. Further interview revealed the client underwent an unscheduled colonoscopy to "untwist" his intestine while he was in hospital.<br><br>On March 25, 2014, beginning at 1:10 p.m., review of Client #2's readmission orders (post-hospitalization), dated December 13, 2013 and his current POS, dated March 1, 2014, | W 331  | The Director of Nursing have called the primary doctor to seek clarification and clarified the POS in regards to the consistent bowel management and in compliance with physician's orders.<br><br>The DON/LPN's will continue to call the PCP for clarifications of all general orders to specific/clear orders.<br><br>The PLN Case Manager and the medication nurses were trained/ inserviced on Medication Orders Protocol. All Staffs were also trained on the Bowel Movement implementation and daily documentation at every shift at every 1 to 2 hours.<br><br>The LPN staff will review the Bowel Movement weekly and the DON will complete an oversight every other week | 3/27/14 and ongoing<br><br>4/4/14 and ongoing |  |

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| W 331  | <p>Continued From page 5</p> <p>reflected that the client's Miralax was changed from PRN use to once daily after the hospitalization. Other routine and PRN medications (unchanged from before the hospitalization) read as follows: docusate sodium softgels 100 mg capsule (Colace) 1 capsule by mouth every day for bowel regimen; and polyethylene glycol 17gm/1 dose powder (Miralax) give 17gm in liquid by mouth every day for constipation. PRN medications included: bisacodyl 10mg suppository rectal (Dulcolax) insert 1 rectally every day as needed for constipation; Constulose 10gm/15ml solution (Lactulose) 30ml by mouth every day as needed for constipation; and enema disposable (Fleet) 1 enema rectally every other day as needed for constipation.</p> <p>-On March 25, 2014, beginning at 2:00 p.m., review of Client #2's per-shift BM charts revealed three periods for which staff documented no BMs for 2 days or longer and for which the client's MARs did not indicate that he had received any PRN medications, as follows</p> <ul style="list-style-type: none"> <li>- 1 BM evening shift on December 29, 2013 the no BM until evening shift January 1, 2014;</li> <li>- 1 BM morning shift on February 11, 2014 then no BM until morning shift February 14, 2014; and,</li> <li>- 1 BM evening shift on February 17, 2014 then no BM until morning shift February 20, 2014.</li> </ul> <p>The facility's RN (Nurse #2) was interviewed on</p> | W 331  | Continued from page 5.  |                      |  |

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| W 331   | <p>Continued From page 6</p> <p>March 25, 2014, beginning at 2:40 p.m. She stated that nurses typically would not administer PRN constipation medications until the third day without a BM. Nurse #2 said the client would first receive 30ml constulose PRN, then a rectal suppository and lastly, a fleet enema. After reviewing Client #2's POS, Nurse #2 acknowledged that Client #2's POS as currently written ("every day as needed for constipation") failed to provide clear direction regarding the proper order and time of administration of the client's PRN medications. She agreed to seek clarification from the PCP.</p> <p>On March 27, 2014, at 11:30 a.m., Nurse #2 presented the following telephone order, dated March 25, 2014, 7:00 p.m, which clarified how Client #2's PRN medications would be administered: "(1) Give Lactulose 30ml by mouth every day as needed for constipation if no bowel movements for 1 to 2 days. D/C previous Lactulose order. (2) Give Bisacodyl 10mg suppository (Dulcolax) every third day as needed for constipation. (3) D/C previous Dulcolax order. (4) D/C previous Fleet Enema Pediatric order. (5) Give Fleet Enema, Pediatric by rectal &lt;sic&gt; every three days as needed for constipation if no result from Dulcolax suppository."</p> <p>At the time of the survey, there was no evidence that the facility's nursing services routinely clarified orders when indicated, to ensure consistent bowel management and compliance with physician's orders.</p> | W 331   | Continued from page 6.  |                      |   |

Health Regulation & Licensing Administration

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| 1 000   | <p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted from March 25, 2014 through March 27, 2014. A sample of two residents was selected from a population of four men with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations, interviews and review of resident and administrative records.</p> <p>Note: The below are abbreviations that may appear throughout the body of this report.</p> <p>Bowel Movement - BM<br/>                     Behavior Support Plan - BSP<br/>                     Day Program Staff - DPS<br/>                     Discontinue - D/C<br/>                     Direct Support Professional - DSP<br/>                     Emergency Room - ER<br/>                     Group Home for Individuals with Intellectual Disabilities - GHID<br/>                     Grams - gm<br/>                     House Manager - HM<br/>                     Intermediate Care Facility - ICF<br/>                     Individual Support Plan - ISP<br/>                     Licensed Practical Nurse - LPN<br/>                     Medication Administration Record - MAR<br/>                     Milligrams - mg<br/>                     Milliliters - ml<br/>                     PCP - Primary Care Physician - PCP<br/>                     POS - Physician's Orders - POS<br/>                     Administer medications as needed - PRN<br/>                     Qualified Intellectual Disabilities Professional - QIDP<br/>                     Registered Nurse - RN</p> | 1 000   |   |                    |   |
| 1 229   | 3510.5(f) STAFF TRAINING  | 1 229   |   |                    |   |

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

*Chonda Wiley-Riv*

TITLE  
*CEO*

(X5) DATE  
*4/18/2014*

Health Regulation & Licensing Administration

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| I 229  | <p>Continued From page 1</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(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;</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the GHIID failed to ensure that all staff received effective training on each resident's mealtime protocol, for one of two residents in the sample. (Resident #2)</p> <p>The finding includes:</p> <p>On March 25, 2014, at 7:21 a.m., DSP #1 was observed to begin feeding Resident #2 his breakfast. The meal, which consisted of pancakes, scrambled eggs and cold cereal, had been processed to a pureed texture. DSP #1 spoon fed the resident two spoonfuls of food, using a weighted spoon with a built-up handle. DSP #1 then offered the resident a sip of water which had been thickened to a nectar consistency. The staff then resumed spoon feeding the resident.</p> <p>On March 25, 2014, at 5:20 p.m., DSP #2 was observed to open a container of vanilla yogurt and begin spoon feeding Resident #2, using the same weighted spoon with a built-up handle observed that morning. The same staff, however, was observed using a different technique while assisting Resident #2 with his dinner at 6:50 p.m. DSP #2 was observed providing hand-over-hand assistance with the weighted spoon, and the</p> | I 229   | <p>All staff have been trained on 4/2/14 on Individual #2's Meal Time Protocol, to ensure consistent implementation of his meal time protocols.</p> <p>The House Manager will ensure the effective implementation daily/ as needed and the QIDP will continue to monitor monthly and as needed.</p> | 4/4/14 and ongoing                           |

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| I 229  | <p>Continued From page 2</p> <p>resident willingly participated with the feeding process.</p> <p>On March 27, 2014, at 11:40 a.m., review of Resident #2's mealtime protocol, dated February 17, 2014, revealed that staff were to provide hand-over-hand assistance to encourage the resident's participation.</p> <p>On March 27, 2014, beginning at 12:23 p.m., review of the facility's records of staff in-service training revealed that the former QIDP (QIDP #2) had provided training on Resident #2's mealtime protocol on June 1, 2012. Neither DSP #1's nor DSP #2's signature was noted on the June 1, 2012 signature sheet. The HM stated "I know they are trained because they know what to do." No additional in-service training records were presented for verification before the survey ended at 2:30 p.m. that day.</p> <p>At the time of the survey, the facility failed to ensure that all staff received effective training to ensure consistent implementation of residents' mealtime protocols.</p> | I 229   | Continued from page 3.  |  |



GOVERNMENT OF  
THE DISTRICT OF  
COLUMBIA

**DEPARTMENT OF HEALTH  
HEALTH REGULATION & LICENSING  
ADMINISTRATION**

Mailing Address  
899 North Capitol St., NE  
Washington DC 20002  
2<sup>nd</sup> Floor  
202-724-8800

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Rev. 9/02

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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| <b>Name of Facility:</b><br>Symbal Foundation for<br>Community Services, Inc. |  | <b>Street Address, City, State, ZIP Code:</b><br>4422 20 <sup>th</sup> St. NE<br>Washington, DC 20018 | <b>Survey Date:</b><br>3/27/14<br><br><b>Follow-up Dates(s):</b> |
| <b>Regulation Citation</b><br><br>4701.2                                      | <b>Statement of Deficiencies</b><br><br><u>Background Check Requirement</u><br><br>Each facility...shall cause each prospective employee or contract worker who will have, or foreseeably may have direct patient, resident or client access, to undergo a criminal background check that shall reveal the criminal history, if any, in the District of Columbia and the fifty (50) states. Finger printing or live scan shall be performed in the District of Columbia utilizing the Metropolitan Police department (MPD) or a private agency. The criminal background check shall be performed, following finger printing or live scan, by the MPD and Federal Bureau of Investigation (FBI) in an FBI-approved environment. The results of the criminal background checks shall be forwarded to the Department of Health. | <b>Ref. No.</b>   | <b>Plan of Correction</b><br><br>See page 2.                     |
|   |  | <b>Completion Date</b>  |  |

*[Signature]* 4/8/14  
 Name of Inspector Date issued

*[Signature]* 4/25/2014  
 Facility Director/Designee Date



**DEPARTMENT OF HEALTH  
HEALTH REGULATION & LICENSING  
ADMINISTRATION**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

Based on review of the staff schedule and personnel records and interviews with management staff, it was determined that the facility failed to obtain a finger print or live scan, for one of three employees hired since December 2012. (DSP #5)

The findings include:

On March 26, 2014, beginning at 11:25 a.m., review personnel records revealed the facility had 19 direct support professionals (DSP) working directly with residents. Three DSPs had been hired since the Chapter 47 regulations were amended. Of those three, there was no evidence that one DSP had obtained a finger printed, FBI background check, as follows:

According to the application form, DSP #5 applied for employment on November 12, 2013 and was hired, effective January 16, 2014. He was observed working in the facility with residents on March 25, 2014. The personnel record included a DC Department of Health document (not dated) that indicated "Current Fitness Determination: New application must be submitted."

Prior to the December 1, 2012 amendments, Chapter 47 read as follows:  
The facility shall obtain a criminal background check from the Metropolitan Police Department, from the U.S. Department of Justice, or from a

DSP #5's New application has been completed and the current fitness determination is still in process according to the BCS Summary record (attached)

3/27/14

4701.5  
(previous)



DEPARTMENT OF HEALTH HEALTH REGULATION & LICENSING ADMINISTRATION

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private agency <which> shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check.

Based on review of the staff schedule and personnel records and interviews with management staff, it was determined that the facility failed to obtain a comprehensive criminal background check, for three of 17 employees hired prior to December 1, 2012. (DSP #3, DSP #4 and Maintenance Staff #6)

The findings include:

- 1. On March 26, 2014, at 12:35 p.m., review DSP #3's personnel record revealed an application form dated June 13, 2011 that reflected he had attended university in Arkansas in 2005 and was been employed in Annandale, Virginia from January 2006 until December 2010. A Work Agreement form indicated he began employment effective July 22, 2011. Continued review of the personnel record revealed a criminal background check obtained through a private agency, dated June 14, 2011, that covered Maryland (statewide), the District of Columbia and Dallas, Texas. There was no evidence, however, of a background check that covered Arkansas or Virginia.

DSP #3 has completed a comprehensive criminal finger print background check on 4/2/14 and DSP #4 completed his criminal finger print background check on 4/1/14.

Maintenance Staff #6 worked as a volunteer /maintenance assistant when initially hired 1994. Previous background check was not located during the survey. Update background check in 2013 was located. HR personnel researched archived files in storage and retrieved back check completed in 2009. Sybral is creating Electronic Records for back up of personnel files to ensure that records are stored and available.

4/2/14

4/1/14

4/7/14



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2. At approximately 12:50 p.m., review of DSP #4's personnel record revealed an application form dated April 24, 2012 that reflected she had been employed in Federal Way, Washington from October 2011 until February 2012. A Work Agreement form indicated she began employment effective May 10, 2012. Continued review of the personnel record revealed a criminal background check obtained through a private agency, dated February 21, 2012, that covered the District of Columbia. There was no evidence, however, of a background check that covered Washington state.

3. At approximately 1:00 p.m., review of Maintenance Staff #6's personnel record revealed a contract agreement signed June 30, 1994. There was no evidence that a criminal background check had been performed in 1994. There was a criminal background check obtained through a private agency, dated March 22, 2013 that covered the District of Columbia and Maryland. However, there was no documentation in the record showing the jurisdiction(s) in which the contractor had worked or resided for 7 years prior to the 1994 contract, or for the 7 years prior to the March 22, 2013 background check.

On March 26, 2014, at 2:01 p.m., the QIDP agreed to ask their agency's human resources officials for additional information about the four aforementioned

Symbral Human Resources Department will ensure that all new hired employees completed their Fingerprint Background Check prior to working.

The QIDP will also ensure that a fingerprint background check is completed for every new hired staff before working.

Ongoing



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employees. On March 27, 2014, both DSP #3 and DSP #4 presented for review sales receipts that documented their having been to a private agency on that same morning, requesting background checks that covered Arkansas, Virginia and Washington state, respectively. The QIDP stated that management had instructed DSP #5 to seek a finger print for FBI background check in accordance with current DC regulations. No additional information was made available for review regarding Maintenance Staff #6.

Continued from page 4.