RECEIVED 11/13/07

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

PRINTED: 11/01/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G151	A. BUILDING _____ B. WING _____	R 10/26/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLISTIC 08	1600 FRANKLIN STREET, NE WASHINGTON, DC 20017

(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 A monitoring visit was conducted on October 26, 2007. This visit was to review and evaluate the effectiveness of systems implemented to address deficient practices that were cited during the recertification survey conducted in August 2007. The findings of this review were based on interview with one client, the Qualifide Mental Retardation Professional, and record review. The latter included review of clinical and medical records and review of ususal incident reports.	{W 000}		
{W 124}	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the right of each client or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment for two of two clients included in the sample. (Client #1 and #2) The findings include: The follow up survey conducted on October 26, 2007 identified continued deficiencies. The QMRP stated during interview on October 26,	{W 124}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Thomas President 11/13/07

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 124}	Continued From page 1 2007 at 10:30 AM that a medical affidavit, dated September 27, 2007, had been signed by the primary physician regarding the need for guardianship for client #2. The QMRP stated that the clients at this facility need partial guardians primarily for the purpose of health decisions. It could not be determined that this deficient practice had been corrected.	{W 124}		
	1 a. During the medication pass on 8/20/07 at 6:17 PM, Client #1 was administered Abilify 15 mg, and Tegretol 200 mg 2 tabs. Interview with the Trained Medication Nurse (TME) on the same day at approximately 6:20 PM revealed that the medication was prescribed for maladaptive behaviors. Review of the client's physicians orders dated 7/30/07 on 8/21/07 at approximately 3:39 PM revealed that Abilifiy and Tegretol was incorporated in a Behavior Support Plan (BSP) dated 8/1/07, to address behaviors associated with physical aggression, self-injurious behaviors, noncompliance, talking to herself, laughing or grinning inappropriately, covering her face with her hands, and sticking her hands into her pants.		QMRP is in communication w/case manager regarding follow-up for limited health care guardian. All documents required by provider have been submitted to case manager. Once guardian has been appointed, QMRP will incorporate in to consent process.	on-going
	Interview with the Qualified Mental Retardation Professional (QMRP) on 8/22/07 at approximately 1:35 PM revealed that Client #2's mother was very involved in her life and gives consents for treatment. Review of Client #1's December 2007 Psychological Assessment on 8/21/07 at approximately 2:50 PM revealed that she did not evidence the capacity to make independent decisions or provided meaningful input into decisions regarding her habilitation planning, placement, treatment, financial, or medical matters. The Client could not execute a durable power of attorney. There was no documented evidence that the facility informed			

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{W 124}	Continued From page 2 Client #1's mother or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity. b. Review of the Client #1's current (7/30/07) physician's order sheet on 8/21/07 at approximately 11:39 AM revealed an order on 2/5/07 for deep conscious sedation for Gyn appointment. Further record review failed to evidence that consent had been obtained prior to the administration of the medication. Interview with the Qualified Mental Retardation Professional (QMRP) 8/21/07 revealed that Client #1's mother signs all consents for medications and medical procedures. Further interview with the QMRP revealed that Human Rights Committee (HRC) had approved the use of the sedative medications prior to the implementation. c. On 12/8/06, Client #1's medication of abilify was discontinued at its currently prescribed dosage and increased to abilify 15 mg Q AM and PM. Interview with the Qualified Mental Retardation Professional (QMRP) 8/21/07 revealed that Client #1's mother signs all consents for medications and medical procedures. The facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity. 2 a. During the medication pass on 8/20/07 at 6:06 PM, Client #2 was administered Lorazepam 0.5 mg, Seroquel 200 mg 2 tabs, Zyprexa 10 mg,	{W 124}		

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{W 124}	Continued From page 3 and Haldol 5 mg.. Interview with the TME on the same day revealed that the medication was prescribed for maladaptive behaviors. Interview with the Qualified Mental Retardation Professional (QMRP) on 8/21/07 at approximately 2:00 PM revealed that Client #2 had an involved sister, but had not been able to establish contact in over a year with the sister. Review of Client #2's August 2007 Psychological Assessment on 8/21/07 at approximately 1:50 PM revealed that she did not evidence the capacity to make independent decisions on her behalf or provided meaningful input into decisions regarding her habilitation planning, placement, treatment, financial, or medical matters. There was no documented evidence that the facility informed Client #2 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity. b. On 12/4/06, a new medication of abilify 15 mg was added to Client #2's medication regimen and the medication Clozaril was discontinued. There was no documented evidence that the facility informed Client #1 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity. c. On 3/5/07, a new medication Seroquel 400 mg	{W 124}		

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{W 124}	Continued From page 4 was added to Client #2's medication regimen to address increasing symptoms of paranoia. There was no documented evidence that the facility informed Client #1 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity. Note: The QMRP has submitted an affidavit form for Client #2 to obtain guardianship to the doctor and was still awaiting the doctor's review and approval.	{W 124}		
{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. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to integrate, coordinate and monitor its clients active treatment programs. The findings include: The follow up survey conducted on October 26, 2007 identified continued deficiencies in the below referenced citations. 1. The QMRP failed to ensure that informed consent were obtained from family/legal	{W 159}		

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{W 159}	Continued From page 5	{W 159}		
	guardians for psychotropic medications, sedation, and the implementation of Behavior Support Plans prior to their implementation. [See W124 and W263]		See W124 & W263	
	3. The QMRP failed to ensure Client #1 was provided opportunities for continuous active treatment in accordance the Physical Therapist recommendations. [See W249]		See W249	
	4. The QMRP failed to ensure to teach clients to use and make informed choices about the use of their adaptive equipment (glasses). [See W436]		See W436	
	5. The QMRP failed to monitor facility compliance with the established fire drill schedule, to ensure that drills were held at least quarterly on every shift. [See W440]		See W440	
{W 249}	483.440(d)(1) PROGRAM IMPLEMENTATION	{W 249}		
	As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.			
	This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure as soon as the interdisciplinary team formulated the individual program plan (IPP), each client received a continuous active treatment plan consisting of needed interventions to achieve identified objectives for two of two clients in the sample.			

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{W 249}	Continued From page 6 (Clients #1 and #2) The findings include: Observations conducted on 8/20/07 at 4:54 PM revealed Client #1 standing up with ankle weights on holding onto a chair and doing leg swings and knee bends (range of motion exercises). Review of Client #1's Individual Support Plan (ISP) book on 8/21/07 at 2:50 PM revealed a Physical Therapist (PT) assessment dated 12/6/06. According the PT's recommendation, staff should encourage repetitive activities such as vacuuming, going up and down the steps to increase her energy expedition. Further review of the PT's assessment revealed a goal that Client #1 will go up and down a flight of stairs 2/2 trials every hour at 100% of the trials five (5) times a week. Interview with the Qualified Mental Retardation Professional (QMRP) on 8/22/07 at approximately 1:45 PM revealed that she was unaware of the recommendation. The QMRP further indicated that she would follow up with the PT for verification. There was no evidence that the goal had been implemented in accordance with the PT's recommendations. Review of the POC for the August 2007 recertification revealed that the facility responded that they would provide physical therapy training to the staff and implement the objective that had not been implemented at the time of the survey. At the time of the survey, the training documentation to reflect staff attendance was not made available. The QMRP did attempt to locate the document. According to interview with the QMRP on October 26, 2007 at 2:20 PM, the goal cited for was	{W 249}		

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{W 249}	Continued From page 7 implemented during the previous year and that it was now considered an "informal objective". The QMRP stated that the objective was to walk. Review of the PT assessment dated December 2006 reflected that the objective was to "perform exercises for 15 repititions three times weekly" The QMRP stated again that this objective was informal. No skill documentation was being taken at the time of the re-visit. Review of the PT notation dated June 1, 2007 reflected that the client "will continue to benefit from those exercises not only to improve her fitness but to increase her strength". It could not be determined that the intervention written as the objective had been implemented as reflected by the PT assessment.	{W 249}	QMRP has clarified w/pt and program is informed and documentation to this shall be procides by PT and QMRP and placed in the record.	11/22/07
{W 263}	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's specially-constituted committee (Human Rights Committee) failed to ensure that restrictive programs were used only with written consents, for two of two clients included in the sample. (Client #1 and #3) The findings includes: The facility's human rights committee failed to ensure that informed consent had been obtained for the use of Client #1's and #2's Behavior	{W 263}	Upon assignment of limited legal guardian provider shall ascertain written consent prior to use of restrictive programs.	on-going

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{W 263}	Continued From page 8 Support Plan (BSP) in conjunction with the use of prescribed psychotropic medications as evidenced below. 1. There was no evidence that written consent had been obtained for Client #1's Behavior Support Plan (BSP), for the use of prescribed psychotropic medications, and sedation prior to medical appointments. Interview with the Qualified Mental Retardation Professional (QMRP) on 8/22/07 at approximately 1:35 PM revealed that Client #2's mother is very involved in her life and gives consents for treatment. [See W124] 2. There was no evidence that written consent had been obtained for Client #2's Behavior Support Plan (BSP), for the use of the prescribed psychotropic medications, and the addition of new medications. Interview with Qualified Mental Retardation Professional (QMRP) on 8/22/07 at approximately 2:00 PM revealed that Client #2 did not have written informed consent signed by a guardian or any other person identified as responsible at the time of the survey; however, the QMRP submitted paper to obtain guardianship for the client. [See W124] Follow up visit: According to the QMRP during an interview conducted on October 26, 2007, at 2:00 PM, the behavioral management plans that included the use of psychotropic medications had not been consented to by a legally approved individual.	{W 263}		
{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	{W 436}		

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{W 436}	Continued From page 9 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, the facility failed to teach clients to use and make informed choices about the use of their adaptive equipment (glasses) for one of two clients Included in the sample. (Client #2) The finding includes: Observations during the survey period from 8/20/07 through 8/22/07, Client #2 was not observed to wear her glasses in the home or the day program. Interview with House Manager and the Qualified Mental Retardation Professional (QMRP) on 8/22/07 at approximately 2:10 PM revealed that the client refused to wear them. Client #2's Individual Support Plan (ISP) dated 12/11/06 was reviewed on 8/21/07 at 1:36 PM. According the ISP, Client #2 wears eye glasses to compensate for her left eye impairment. There was no evidence that staff documented Client #2's refusal to wear her glasses. Additionally, there was no evidence of any program objective designed to train/teach Client #2 when to wear her eyeglasses. Follow up visit: During the AM observation, on the morning of October 26, 2007 at 8:30 AM, it was observed that none of the clients were wearing visible adaptive equipment. According to the QMRP during an interview conducted on	{W 436}	QMRP has drafted program to train client #2 on the use of her glasses. IDT shall approve program prior to implementation	11/22/07

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{W 436}	Continued From page 10 October 26, 2007 at 12:20 PM, client #2 does wear eyeglasses. It was stated that client #2 does not like wearing eyeglasses regardless of the level of encouragement offered. The QMRP stated that a plan to encourage, teach, and to maintain client #2's eyeglasses had not been offered to the client. Furthermore, there was no documented evidence of the clients refusals. During the AM observation, on the morning of October 26, 2007 at 8:30 AM, it was observed that client #2 had missing teeth. According to the QMRP during interview at 12:20 PM, "dentures have not been considered." Review of the client's dental records dated July 24, 2007, revealed that client #2 had missing teeth 23 thru 27 and that a large carious lesion was on tooth #27. The dentist's recommendation further reflected "replace missing teeth with PL". At the time of this survey, the QMRP was unfamiliar with what "PL" stood for.	{W 436}		
{W 440}	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to hold evacuation drills quarterly on all shifts. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on 8/20/07 at 3:50 PM revealed the scheduled shifts are as follows:	{W 440}		

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{W 440}	Continued From page 11	{W 440}		
	Weekdays/Weekends 1st Shift 8 AM to 4 PM 2nd Shift 4 PM to 12 AM 3rd Shift 12 AM to 8 PM Further interview with the QMRP revealed that the staff was required to conduct a drill once per month on each shift. Review of the fire drill log for August 2006 through October 2006 revealed that the facility failed to hold fire evacuation drills for the third shift. Further review of the fire drills logs for November 2006 through January 2007 revealed the facility failed to hold fire evacuation drills for the second shift. There was no evidence that fire drills were conducted quarterly on all shifts.			
	Follow up visit: The fire drill log was reviewed on October 26, 2007 at approximately 10:00 AM. A fire drill schedule was observed in the fire drill log book . In review of the dates assigned for fire drills for August, September, and October 2007, the staff had not instituted the drills as scheduled. Drills for September were noted as scheduled for September 29, 19th, and 3rd. One drill was documented on the 15th at 8:37 AM and another on the 25th at 4:30 PM. The drill for September 7, 2007 had not been documented. There were no documented drills for October 2007. It could not be determined that fire drills were conducted quarterly per shift.		The quarterly schedule begins on the calendar year. Thus: Jan - Mar Apr - Jun Jul - Sept Oct - Dec Surveyors should not select quarters basen on aggregate data or survey year. Please find Wholistic Policy attached.	11/12/07
{W 441}	483.470(l)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions.	{W 441}		

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(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 441}	Continued From page 12 This STANDARD is not met as evidenced by: Based on staff interview and record verification, the facility failed to hold evacuation drills under varied conditions. The finding includes: Review of the facility's fire drill records on 8/20/07 at approximately 3:50 PM revealed that most of the fire drills were conducted via the front and back door exits. Review of the fire drill record revealed that the exit to basement had not been used at any time. Interview with the Qualified Mental Retardation Professional (QMRP) revealed that the facility had at least four method of egress. Further interview with the QMRP revealed that the clients primarily used the front and back door exits during the past year. There was no evidence that evacuation drills were held under varied conditions. Follow up visit: According to the plan of corrections (POC), the facility indicated that the clients did not use the basement area; therefore, they had not exited from there during drills. The POC further reflected that exiting from the basement area "would be incorporated into fire drills prospectively". There was no evidence that the POC response had been implemented.	{W 441}	Three of the four exits has been used. Provider shall use basement over the next survey year. Fire drills conducted on 11/8/07 using basement.	11/12/07

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G151	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED R 10/26/2007
NAME OF PROVIDER OR SUPPLIER WHOLISTIC 08	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 FRANKLIN STREET, NE WASHINGTON, DC 20017		

(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) COMPLETE DATE
{I 000}	INITIAL COMMENTS A monitoring visit was conducted on October 26, 2007. This visit was to review and evaluate the effectiveness of systems implemented to address deficient practices that were cited during the recertification survey conducted in August 2007. The findings of this review were based on interview with one client, the Qualifide Mental Retardation Professional, and record review. The latter included review of clinical and medical records and review of ususal incident reports.	{I 000}		
{I 135}	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to hold evacuation drills quarterly on all shifts. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on 8/20/07 at 3:50 PM revealed the scheduled shifts are as follows: Weekdays/Weekends 1st Shift 8 AM to 4 PM 2nd Shift 4 PM to 12 AM 3rd Shift 12 AM to 8 PM Further interview with the QMRP revealed that the staff was required to conduct a drill once per	{I 135}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Thomas TITLE President (X6) DATE

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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 08	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 FRANKLIN STREET, NE WASHINGTON, DC 20017		

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{I 135}	Continued From page 1	{I 135}		
	month on each shift. Review of the fire drill log for August 2006 through October 2006 revealed that the facility failed to hold fire evacuation drills for the third shift. Further review of the fire drills logs for November 2006 through January 2007 revealed the facility failed to hold fire evacuation drills for the second shift. There was no evidence that fire drills were conducted quarterly on all shifts.		See W440	
	Also see FederalDdeficiency Citation W441.		See W441	
{I 420}	3521.1 HABILITATION AND TRAINING	{I 420}		
	Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning.			
	This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide habilitation and training to its residents that would enable them to acquire and maintain life skills needed to cope with their environments and achieve optimum levels of physical, mental and social functioning.			
	The finding includes:			
	(See Federal Deficiency Report Citations W249)		See W249	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G151	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED R 10/26/2007
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{R 000}	INITIAL COMMENTS A monitoring visit was conducted on October 26, 2007. This visit was to review and evaluate the effectiveness of systems implemented to address deficient practices that were cited during the licensure survey conducted in August 2007. The findings of this review were based on interview with one client, the Qualifide Mental Retardation Professional, and record review. The latter included review of clinical and medical records and review of ususal incident reports.	{R 000}		
{R 125}	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of records, the GHMRP failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions who have worked or resided within the seven (7) years prior to the check. The finding includes: Review of the personnel files on 8/22/07 at 11:38 AM revealed the GHMRP failed to evidence criminal background checks for six of eight staff for the state of Maryland in which they reside: [S1, S2 S3, S5, S6, and S8]	{R 125}	All State have multi-jurisdictional criminal background checks completed.	11/12/07

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Thomas TITLE President (X6) DATE 11/13/07

STATE FORM 6899 2ME612 If continuation sheet 1 of 1

Wholistic Services, Inc.
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To: Mrs Wallace From: Mitha Thomas

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Phone: 11/13/07

Re: Franklin St (Poc) CC:

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