

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

12460

PRINTED: 02/11/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G162	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2008
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NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 4424 20TH STREET, NE WASHINGTON, DC 20019
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W 000	INITIAL COMMENTS A recertification survey was conducted from January 29, 2008 through February 1, 2008. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a client population of three females and three males with various disabilities. The findings of the survey were based on observations, interviews with one client, staff in the home and three day programs, as well as a review of client records, administrative records, and incident reports. Investigation reports were also reviewed.	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, staff interview, and record review, the facility failed to establish a system that would ensure clients that were informed of their risks and benefits of their medication for one of the three clients in the sample. (Client #3) The finding includes: Client #3 was observed during the evening medication pass on January 29, 2008, at 5:49 PM being administered Carbamazepine 200 mg, Carbamazepine 100 mg, and Moban 50 mg by mouth. Interview with the Licensed Practical	W 124		<p style="writing-mode: vertical-rl; transform: rotate(180deg);"> RECEIVED DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 2008 FEB 21 A 11:48 </p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Susan J. Sloan RN,BSN,MA</i>	TITLE <i>VP-Operations</i>	(X6) DATE <i>2/15/08</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 124	Continued From page 1 Nurse (LPN) on January 29, 2008 at approximately 5:55 PM revealed that Client #3 was prescribed the medication for behavior management. Review of the physician's order sheet (POS) dated December 1, 2007 on January 30, 2008 at approximately 1:18 PM revealed that Client #3 has diagnoses of Intermittent Explosive Disorder (IED) and Psychotic Disorder NOS. Interview with the Qualified Mental Retardation Professional (QMRP) on January 29, 2008 at approximately 2:21 PM revealed that Client #3's step mother and father was very involved in her life but was not the client's legal guardian. Review of Client #3's, psychological assessment dated January 17, 2008 on January 30, 2008 at approximately 1:30 PM revealed that the client was not competent to make independent or informed decisions concerning her treatment, placement, medical/psychological treatment, or finances based on her current cognitive/adaptive level of functioning. There was no documented evidence that the facility informed Client #3 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of his psychotropic medications. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity.	W 124	W 124 The Agency has a policy on Psychotropic medication administration. All psychotropic medications are started after consent has been obtained from the client, guardian or legal representatives. The consent form includes the explanation of the side effects of the medications. Client #3 had all her HRC and consents in order prior to beginning medication and this is filed under the HRC sections in the ISP and Medical records. See attached guardian consent forms with explanation of medication side effects for Client #3	2/15/08
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 observations, interviews with the	W 159		

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W 159	Continued From page 2 Qualified Mental Retardation Professional (QMRP) and record review, the QMRP failed to ensure integration, coordination and monitoring of client's active treatment regimen. The findings include: 1. The QMRP failed to ensure that held fire evacuation drills quarterly on all shifts. [See W440] 2. The QMRP failed to ensure clients were provided with opportunities for choice and self-management. [See W247] 3. The QMRP failed to staffs implemented programs as outlined in the Individual Program Plans (IPPs). [See W249] 4. The QMRP that data was collected in the form and required frequency. [See W252]	W 159	W 159 1. refer to I 135 2. refer to I 420 #2 3. refer to I 420 #3 4. refer to I 420 #4		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each employee was provided with continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently.	W 189	W 189 Refer to I 420		

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W 189	Continued From page 3 The finding includes: The facility failed to ensure that staff had received effective training in implementing programs as outlined in the Individual Program Plans (IPPs). [See W249]	W 189		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure clients were provided with opportunities for choice and self-management, for six of six clients residing in the facility. (Client #1, #2, #3, #4, #5, and #6) The findings include: 1. The facility failed to ensure Client #1, #2, #3, #4, #5, and #6 were afforded opportunities for choice and/or self-management during snack time as evidence below: On January 29, 2008 at 4:57 PM, direct care staff was observed to place bananas on the dining table along with water and napkins. Although the clients accepted and ate their banana, there were no other choices presented to the clients to identify their snack preferences. 2. The facility failed to Client #1, #2, #3, #4, #5, and #6 were afforded opportunities to choose dressings for their salad as evidence below: Observation of the dinner meal on January 29,	W 247	W 247 1. refer to I 420 #2 2. Refer to I 420 #2	

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W 247	Continued From page 4 2008 at 6:15 PM, revealed staff pouring "Lite Italian Dressing" on the clients salads. Further observations revealed the clients were not presented with any other salad dressings to choose from as their preference. Interview with the staff who prepared the meal on the same day at approximately 6:50 PM revealed their were other salad dressings to choose from. The staff further revealed that she usually includes the clients with selecting condiments and salad dressings for their salads and meals.	W 247			
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION 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 implement programs as outlined in the Individual Program Plans (IPPs), for one of three clients included in the sample. (Client #3) The finding includes: On January 29, 2008 at approximately 6:36 PM, Client #3 was observed with food on her mouth as she finished her dinner meal and beverage. The direct support staff was observed to wipe Client #3's mouth with a napkin. At no time did the staff encourage Client #3 to wipe her mouth	W 249			

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W 249	Continued From page 5 after she had finished her dinner meal. Interview with the direct care staff on the same day at approximately 7:00 PM revealed that Client #3 had an objective to wipe her mouth after dinner. Review of Client #3's Individual Program Plan (IPP) dated February 19, 2007 on January 31, 2008 at approximately 11:13 AM revealed a program that stated "the client will successfully wipe her mouth after meals with physical assistance on 80% of trials for 12 consecutive months." There was no evidence that the Client #3 was afforded the opportunity for self-management and encourage to participate in her programs.	W 249	W 249 Refer to I420 #3		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observations interview, and record review, the facility failed to ensure that data was collected in the form and frequency required by the clients' Individual Program Plans (IPP) for two of three clients included in the sample. (Client #1 and #2) The findings include: 1. Observation at Client #1's day program on January 30, 2008 revealed that the client was not in the facility. Interview with Client #1's 1:1 staff on January 31, 2008 revealed that the client had been out in the community where he made small purchases. Further interview with another	W 252			

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W 252	<p>Continued From page 6</p> <p>member who provides 1:1 staffing on January 31, 2008 at approximately 4:15 PM revealed that Client #1 enjoyed spending money at the local stores in the community.</p> <p>The client's 1:1 staff stated Client #1 had an objective for making purchases. On January 31, 2008 at approximately 12:00 PM the client's IPP dated October 23, 2007 was reviewed and revealed a program objective which read "Once a week, the client will independent make purchase with quarters from a vending machine on 80% trials for 6 consecutive months. Review of the data collection sheets on January 31, 2008 at 2:33 PM revealed no documentation for the week of 1/1/08 thru 1/5/08 and week fourth 1/20 thru 1/26/08. There was no evidence that data was being collected in the frequency as required IPP.</p> <p>2a. On January 29, 2008 at approximately 5:30 PM Client #2 was observed sitting at the dining table practicing writing bank checks. Interview with staff revealed that Client #2 has programs to fill out checks, and bank deposit slips. Review of the client's Individual Program Plan (IPP) dated October 23, 2007 on January 31, 2008 at approximately 12:35 PM revealed a program objective which read "the client will independently write a check as shown on the sample check three times a week on 80% trials for 6 consecutive months". Review of the data collection sheets on January 31, 2008 at 2:45 PM revealed that staff were not consistently documenting the client's progress as required by the IPP.</p> <p>b. On January 29, 2008 at approximately 5:02 PM Client #2 was observed entering the facility using a roller walker for mobility. Interview with</p>	W 252	<p>W 252</p> <ol style="list-style-type: none"> 1. Staff were re trained in client #1 and #2's IPPs 2. a. Staff were re trained on documentation of data 3. b. Staff were trained on documentation of data <p>In the future the QMRP and House Manager will ensure that there is close supervision of staff to ensure staff follow guidelines for documentation and implementation of all programs.</p>	2/15/08	

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W 252	Continued From page 7 staff on the same day at approximately 6:51 PM revealed Client #2 participates in Range of Motion (ROM) exercises to help with mobility and transfers. Review of the client's Individual Program Plan (IPP) dated October 23, 2007 on January 31, 2008 at approximately 12:35 PM revealed a program objective which read "the client will participate in lower extremity strengthening programs (such as sitting quad sets, knee raises, arm chair push and knee bends) once daily 5 days a week. Review of the data collection sheets on January 31, 2008 at 2:45 PM revealed that staff were not consistently documenting the client's progress as required by the IPP.	W 252			
W 261	483.440(f)(3) PROGRAM MONITORING & CHANGE The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility. This STANDARD is not met as evidenced by: Based on review of the Human Rights Committee (HRC) minutes, the facility failed to ensure that persons with no ownership or controlling interest in the facility consistently participated on this committee. The findings include: 1. Review of the Human Rights Committee (HRC) meeting minutes was conducted on	W 261			

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W 261	Continued From page 8 January 29, 2008 at 3:03 PM. According to the HRC minutes dated February 15, 2007, Client #1's annual Psychotropic Medications and Behavior Support Plan (BSP) were reviewed and approved. Further review of the corresponding signature sheet attached to the minutes failed to evidence that the facility's HRC committee included persons with no ownership or controlling interest in the facility was present. 2. Review of the Human Rights Committee (HRC) meeting minutes was conducted on January 29, 2008 at 4:46 PM. According to the HRC minutes dated January 18, 2007, Client #3's annual Psychotropic Medications and Behavior Support Plan (BSP) were reviewed and approved. Further review of the corresponding signature sheet attached to the minutes failed to evidence that the facility's HRC committee included persons with no ownership or controlling interest in the facility was present.	W 261	W261 1 & 2. The Agency has a Policy on HRC meetings . There is always a community representative present. See attached meeting sign in record and Agency's policy on HRC.	2/15/08	
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 observation, 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 one of three clients included in the sample. (Client #3) The finding includes:	W 263			

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W 263	Continued From page 9 [Cross Reference W124] The facility's human rights committee failed to ensure that informed consent had been obtained for the use of Behavior Support Plan (BSP) that incorporated the use of prescribed psychotropic medications. Interview with Qualified Mental Retardation Professional (QMRP) on 1/29/08 at approximately 2:21 PM revealed that Client #3 did not have written informed consent signed by a guardian. It should noted, according to the QMRP, the client's step mother and father were "very involved" in her life, but there was no evidence that they had been informed of the use of psychotropic medications.	W 263	W 263 Refer to W 124		
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, the facility failed to ensure that maintenance and up-keep of a client's adaptive equipment for one of three clients included in the sample. (Client #2) The finding includes: On January 29, 2008 through February 1, 2008 Client #3 was observed to use a roller walker for mobility at his residence and at his day program. The client was observed to ambulated with the walker by dragged his feet. Interview with the day	W 436			

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W 436	Continued From page 10 program staff at approximately 12:00 PM on January 30, 2008 revealed that Client #2 was not wearing his custom molded shoes. Interview with the client on the same day at 12:10 PM revealed that his custom molded shoes were in the shop for repairs. Interview with the Qualified Menta Retardation Professional (QMRP) on February 1, 2008 at 10:19 AM confirmed that the client's custom molded shoes were in the shop for repair due to damages cause by him dragging his feet. The QMRP stated that Essential Rehabilitation had picked up the old shoes on December 10, 2007 for repair and had not return the shoes. Note: An order for new custom molded shoes was ordered September 19, 2007. To date, the client has not received the new shoes.	W 436	W 436 Client #2 has received his custom molded shoes. He has Medicare and the process to obtain authorization for new equipment and obtain repairs on existing equipment usually takes 3-6mths. The QMRP and nursing staff had clearly documented progress of the process in their monthly notes.	2/15/08
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 January 29, 2008 at approximately 2:00 PM revealed the scheduled shifts were as follows: Weekdays 1st Shift 8 AM to 4 PM 2nd Shift 2 PM to 10 PM, 4 PM to 12 AM	W 440		

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W 440	Continued From page 11 3rd Shift 10 PM to 8 AM, 12 AM to 8 AM Weekends/Saturday and Sunday 8:00 AM to 12 AM 12 AM to 8:00 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 book from May 2007 to July 2007 revealed that the facility failed to hold fire evacuation drills on each shifts. There was no evidence that fire drills were conducted quarterly on all shifts.	W 440	W 440 Refer to I 135	

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I 000	INITIAL COMMENTS A licensure survey was conducted from January 29, 2008 through February 1, 2008. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a client population of three females and three males with various disabilities. The findings of the survey were based on observations, interviews with one client, staff in the home and three day programs, as well as a review of client records, administrative records, and incident reports. Investigation reports were also reviewed.	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 GHMRP 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 January 29, 2008 at approximately 2:00 PM revealed the scheduled shifts are as follows: Weekdays 1st Shift 8 AM to 4 PM 2nd Shift 2 PM to 10 PM, 4 PM to 12 AM 3rd Shift 10 PM to 8 AM, 12 AM to 8 AM Weekends/Saturday and Sunday	I 135	I 135 The facility has developed a fire drill schedule to include fire drills being done on each shift throughout the year as per the Agency's policy and procedures. All staff was re trained in fire safety and evacuation policy and procedures. See attached training records and fire drill schedule	2/15/08

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TITLE
VP - Operations

(X6) DATE
2/15/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G162	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2008
NAME OF PROVIDER OR SUPPLIER METRO HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 4424 20TH STREET, NE WASHINGTON, DC 20019		
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I 135	Continued From page 1 8:00 AM to 12 AM 12 AM to 8:00 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 book from May 2007 to July 2007 revealed that the facility failed to hold fire evacuation drills on each shifts. There was no evidence that fire drills were conducted quarterly on all shifts.	I 135		
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees. The findings include: Review of the personnel files conducted on 1/31/08 at approximately 3:36 PM revealed the GHMRP failed to provide evidence of current signed job descriptions two staffs. (Staff #1 and #5)	I 203	I 203 Staff #5 is currently not employed in this facility as per the facility's monthly staff schedule. The HR Department has developed a quarterly review schedule to ascertain that current certifications and licensing needs are kept current. Attached is the job description for staff#1	2/15/08
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties.	I 206		

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I 206	Continued From page 2 This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that all staff had current health certificates on file. The findings include: 1. Review of the personnel files conducted on 1/31/08 at approximately 3:36 PM revealed the GHMRP failed to provide evidence of current current health certificates for two staffs. (S #1 and 10) 2. Review of the personnel files conducted on 1/31/08 at approximately 3:36 PM at revealed the GHMRP failed to provide evidence of current current health certificates for one consultant. (C #7)	I 206	I 206 The HR Department has developed a quarterly review schedule to ascertain that current certifications and licensing needs are kept current. Attached are the health certificates for staff # 1 and #10 and consultant #7	2/15/08
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current training in first Aid and CPR for employees. The findings include: On 1/31/08 at approximately 3:36 PM, review of personnel records/training records revealed that the following staffs were without current First Aid	I 227	I 227 The HR Department has developed a quarterly review schedule to ascertain that current certifications and licensing needs are kept current. Attached CPR and First Aid certifications for S#2, #8, and # 11	2/15/08

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I 227	Continued From page 3 and CPR, or both. 1. Current CPR - S#2, S#8 and S#11 2. First Aid - S#8 and S#11	I 227		
I 420	3521.1 HABILITATION AND TRAINING 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 observations, interviews with the Qualified Mental Retardation Professional (QMRP) and record review, the QMRP failed to ensure integration, coordination and monitoring of resident's active treatment regimen. The findings include: 1. The QMRP failed to ensure that held fire evacuation drills quarterly on all shifts. [See W440] 2. The QMRP failed to ensure clients were provided with opportunities for choice and self-management. [See W247] 3. The QMRP failed to staffs implemented programs as outlined in the Individual Program Plans (IPPs). [See W249] 4. The QMRP that data was collected in the form	I 420	I 420 1. The facility has developed a fire drill schedule to include drills being done on each shift though out the year. 2. Staff was re trained in client's rights and choices. The QMRP and House Manager will ensure staff will provide clients with choices. 3. Staff was re trained in all client's IPPs. 4. Staff were re trained in accurate documentation practices. See attached training records	2/15/08

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I 420	Continued From page 4 and required frequency. [See W252]	I 420			
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to implement programs as outlined in the Individual Program Plans (IPPs), for one of three resident included in the sample. (Resident #3) The finding includes: On January 29, 2008 at approximately 6:36 PM, Resident #3 was observed with food on her mouth as she finished her dinner meal and beverage. The direct support staff was observed to wipe Resident #3's mouth with a napkin. At no time did the staff encourage Resident #3 to wipe her mouth after she had finished her dinner meal. Interview with the direct care staff on the same day at approximately 7:00 PM revealed that Resident #3 had an objective to wipe her mouth after dinner. Review of Resident #3's Individual Program Plan (IPP) dated February 19, 2007 on January 31, 2008 at approximately 11:13 AM revealed a program that stated "the resident will successfully wipe her mouth after meals with physical assistance on 80% of trials for 12 consecutive months." There was no evidence that the Resident #3 was afforded the opportunity for self-management and encourage to participate in her programs.	I 422	I 422 Staff were re trained on client#3's IPP. In the future the QMRP and House Manager will ensure staff are monitored and trained to implement client programming to ensure self-management. See attached training records	2/15/08	

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R 125	<p>4701.5 BACKGROUND CHECK REQUIREMENT</p> <p>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.</p> <p>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 where staff had worked or resided within the seven (7) years prior to the check for one of staff.</p> <p>The finding includes:</p> <p>Review of the review of personnel files on 2/1/08 at 9:16 AM revealed the GHMRP failed provide evidence of a criminal background checks for the previous seven years in all jurisdiction where severn one staff had worked or resided. (Staff #10)</p>	R 125	<p>R 125</p> <p>The Agency has a policy for obtaining criminal background checks prior to employment.</p> <p>Attached criminal check for staff#10</p>	2/15/08

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