Received 2/19/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G071	A. BUILDING ______ B. WING ______	01/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEHAVIOR RESEARCH ASSOCIATES	[redacted] WASHINGTON, DC 20019

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W 000	INITIAL COMMENTS A recertification survey was conducted from 01/09/19 to 01/11/19. A sample of three clients was selected from five males. The survey was conducted utilizing the focus fundamental survey process. The findings of the survey were based on observations, interviews and review of administrative records. The following abbreviations will appear throughout the report: DSP - Direct Support Personnel IPP - Individual Program Plan LPN - Licensed Practical Nurse QIDP - Qualified Intellectual Disabilities Professional F - Farenheit	W 000		
W 120	SERVICES PROVIDED WITH OUTSIDE SOURCES CFR(s): 483.410(d)(3) The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facilty failed to ensure outside services failed to ensure that each staff maintained infection control procedures, for one of three clients in the sample (Client #3). Findings included: On 01/09/19, at 12:05 PM, Client #1 was	W 120	Staff members were not instructed to wash dishes in the basement and were not told that common areas upstairs were just for residential services. Common areas are used by the day program service during the day including the living room, dining room, bathrooms and kitchen. Staff providing that feedback received appropriate disciplinary actions...2-4-19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE QIPD (X6) DATE 2-18-19

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.

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

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W 120	Continued From page 1 observed at his day program eating lunch. After Client #1 completed his lunch, the one to one staff (DSP #1) assisted the client to the bathroom while holding his dishes. Moments later, DSP #1 came out the bathroom with Client #1. Continued observation revealed the client's dishes were washed in the bathroom. On 01/09/19, at approximately 12:10 PM, interview with DSP #1 revealed that he washed the client's dishes in the bathroom with hand soap. Further interview revealed that staff does not use the kitchen that was located upstairs from the day program. At the time of the survey, the day program failed to ensure that each staff maintained infection control procedures to prevent the spread of infection.	W 120	All staff will be retrained on the use of the home space for day services and on proper infection control procedures with emphasis on proper dishwashing...2-20-19 Additionally, the Day Program QIDP will observe lunch meals at minimum twice weekly to ensure that they are properly implemented including set up and cleanup activities...2-20-19	
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to allow each client to exercise their right regarding eating breakfast and dinner with housemates, for one of five clients in the sample (Client #1). Findings included: Observation on 01/09/19 at 6:58 PM, revealed	W 125		

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W 125	Continued From page 2 Clients #2, 3, 4 and 5 sat at the dining room table for dinner. During this time, Client #1 stayed in his bedroom with his one to one staff (DSP #1). When asked, DSP #1 stated that Client #1 will eat after everyone has finished their meal. At 7:32 PM, once Client #2, 3, 4 and 5 completed their meal, DSP #1 assisted Client #1 to the dining room table for dinner. Observation on 01/10/19 at 6:50 AM revealed Client #1 ate breakfast after Client #2, 3, 4, and 5. On 01/10/19 at 1:16 PM, interview with the QIDP revealed that Client #1 should always eat with the other clients. The QIDP also confirmed that Client #1 has a goal to reduce incidents of grabbing the clients food, therefore, the client was required to eat with his peers. On 01/10/19 at 1:30 PM, a second review of Client #1's IPP, dated 06/2018 to 06/2019, revealed an objective that stated, "During mealtime, <Client's name > will reduce incidents of grabbing others food while at the table during mealtime daily for six consecutive months." At the time of the survey, the facility failed to allow Client #1 to eat breakfast and dinner with his housemates.	W 125	The staff member in question received appropriate disciplinary follow up for failing to follow proper procedure in assisting Client #1 during the meal and was retrained on the prescribed procedures...2-5-19 The QIDP will re-train all staff to ensure consistency...2-10-19 The QIDP and Home Manager will observe meals on each shift (separately) at minimum once weekly to ensure ongoing compliance and provide on-the-spot feedback and training if issues are observed during the planned observations...2-20-19	
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation, interview and record	W 130		

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W 130	Continued From page 3 review, the facility failed to ensure privacy while client's used the bathroom, for one of five clients residing in the facility (Client #3). Finding included: On 01/10/19, at 7:17 AM, Client #3 was observed sitting on the toilet with the door wide opened. His pants were observed down, exposing his legs and buttocks. During this time, the one to one staff (DSP #3) was sorting through linens from the linen closet, which was located next to the bathroom. During the aforementioned times, staff and clients were observed within close proximity. Interview with DSP #3 on 01/10/19, at approximately 7:30 AM, revealed that the bathroom door should have been closed to ensure Client #3's privacy. Review of the privacy protocol on 01/10/19, at 2:30 PM, revealed "Residents are afforded privacy during habilitation and care of personal needs." At the time of the survey, the facility failed to ensure Client #3's right to privacy during personal care.	W 130	The staff member in question received appropriate disciplinary action for failure to respect the privacy of Client #3…2-4-19 All staff members were re-trained on privacy and dignity with specific focus on privacy during personal care and intimate self care tasks…2-4-19 The QIDP and Home Manager (separately) will conduct observations during all shifts at minimum once weekly to ensure consistency in follow up; staff will receive immediate feedback when issues are observed…2-20-19	
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, record review and interview, facility staff failed to consistently encourage clients to eat independently, for one of	W 247		

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W 247	Continued From page 4 three clients in the sample (Client #1). Findings included: On 01/09/19 beginning at 12:05 PM, observations at the day program showed DSP #1 (one to one staff) used a built up handle spoon to feed Client #1 during lunch time with hand over hand assistance and verbal prompts. By contrast, dinner observations at 7:34 PM showed DSP #2 feeding Client #1 his dinner with a built up handle spoon throughout the entire dinner meal. At 7:38 PM, DSP #2 was queried as to why Client #1 was not giving the opportunity to feed himself using hand over hand assistance. DSP #2 stated that the client was spoon-fed because he did not know how to eat with hand over hand assistance. On 01/11/19, at 11:30 AM, review of Client #1's occupational therapy assessment dated 06/14/18 showed Client #1 is willing to participate with hand over hand at times during meals. At the time of the survey, the facility's staff failed to allow Client #1 to exercise his independence during each meal to the full extent of his capabilities.	W 247	The staff member in question received appropriate disciplinary action for failure to support Client #1 to eat with his peers and for failure to implement his measure objective to improve his skills in eating independently with others...2-4-19. All staff members were retrained on the measurable objective and on the importance of Client #1 developing both the social skills and the eating skills needed to eat out and among others....2-4-19	
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) 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	W 249		

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W 249	Continued From page 5 plan. This STANDARD is not met as evidenced by: Based on record review, observation, and interview the facility failed to implement each client's recommended active treatment program, for one of three clients in the sample (Client #1). Findings included: On 01/09/19, at 11:25 AM, review of Client #1's IPP, dated 06/2018 to 06/2019, revealed an objective that stated, "During mealtime, <Client's name > will reduce incidents of grabbing others food while at the table during mealtime daily for six consecutive months." Observation on 01/09/19 at 6:58 PM, revealed Clients #2, 3, 4 and 5 sat at the dining room table for dinner. During this time, Client #1 stayed in his bedroom with his one to one staff (DSP #1). When asked, DSP #1 stated that Client #1 will eat after everyone has finish their meal. At 7:32 PM, once Client #2, 3, 4 and 5 completed their meal, DSP #1 assisted Client #1 to the dining room table for dinner. Observation on 01/10/19 at 6:50 AM, revealed Client #1 ate breakfast after Client #2, 3, 4, and 5. On 01/10/19 at 1:16 PM, interview with the QIDP revealed that Client #1 should always eat with the other clients. The QIDP also confirmed that Client #1 has a goal to reduce incidents of grabbing the clients food, therefore, the client was required to eat with his peers. At the time of the survey, facility staff failed to	W 249	The staff member in question received appropriate disciplinary action for failure to support Client #1 to eat with his peers and for failure to implement his measure objective to improve his skills in eating independently with others...2-4-19. All staff members were retrained on the measurable objective and on the importance of Client #1 developing both the social skills and the eating skills needed to eat out and among others....2-4-19	

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W 249	Continued From page 6 implement Client #1's to mealtime IPP objective.	W 249		
W 426	CLIENT BATHROOMS CFR(s): 483.470(d)(3) The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the water temperature did not exceed 110°F, for five of five residents residing in the facility (Client #1, 2, 3, 4, and 5). Findings included: During the environmental inspection on 01/11/19, at 1:35 PM, water from the faucet of the kitchen sink was hot to touch. When measured, the water temperature was determined to be 115°F. Continued inspection of the first floor and second floor sinks and bathrooms also revealed hot water that exceeded 110°F as evidenced by the following: Kitchen faucet - 115°F First floor bathroom - 114°F Basement bathroom - 114°F On 01/11/19 the QIDP was interviewed at 1:38 PM, concerning the hot water temperatures. The QIDP acknowledged that the water was hot and exceeded the required temperature of 110°F. According to the QIDP, two of five residents (resident #2 and 5) have adaptive and cognitive	W 426	The water temperature was lowered to 110 degrees during the survey process…2-1-19 Staff members were retrained to check water temperature daily and record the temperature obtained. If that temperature is above 110 degrees, staff members were instructed to contact the Home Manager for immediate follow up…2-4-19 The Home Manager checked the thermometers for each home to ensure all were working properly (they are)…2-1-19	

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W 426	Continued From page 7 capabilities to control water temperatures. Upon immediate notification of the hot water temperature on 01/11/19, the QIDP reported to the maintenance employee to check the water temperatures. The maintenance employee indicated that the water temperature would be turned down to achieve the 110°F for safety. On 01/11/19, at 2:10 PM, the surveyor and the maintenance employee checked the hot water temperatures again, which revealed the following: Kitchen faucet - 110°F First floor bathroom - 110°F Basement bathroom- 108°F At the time of survey, the facility failed to ensure that the water temperature did not exceed 110°F.	W 426		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility's nursing staff failed to maintain a sanitary environment to avoid sources and potential transmission of infections during medication administration, for one of five clients residing in the home (Client #5). Findings included: Observation of the medication pass on 01/10/19 at 6:20 AM, revealed LPN #1 used a Glucometer	W 454		

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W 454	Continued From page 8 to check Client #2's blood glucose. After the client's blood glucose was taken, the LPN threw the used blood glucose test strip and lancet inside the kitchen trash can. Interview on 01/10/19 at 6:55 AM, the LPN confirmed that the glucose test strip and lancet was thrown out in the trash can. The LPN stated that he should have thrown the test strip and lancet inside the sharps container. Review of the facility's policy and procedures, failed to show infection control procedures for disposal of glucometer blood test strips and lancet . At the time of survey, the facility failed to implement measures to maintain a sanitary environment to avoid sources and transmission of infection.	W 454	The RN retrained the LPN responsible for improperly disposing of the Glucometer on properly disposing of the item after checking blood sugar levels…2-1-19 The task will now be completed in the area where the Sharps container is stored to make it easier for the LPNs to properly dispose of items that need to be disposed of in that manner……..2-1-19	

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I 000	INITIAL COMMENTS A licensure survey was conducted from 01/09/19 to 01/11/19. A sample of three residents was selected from five males. The findings of the survey were based on observations, interviews and review of resident and administrative records. Note: The below are abbreviations that may appear throughout the body of this report. GHIID - Group Home for Individuals with Intellectual Disabilities QIDP - Qualified Intellectual Disabilities Professional F - Farenheit	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHIID failed to ensure that the water temperature did not exceed 110°F, for five of five residents residing in the facility (Client #1, 2, 3, 4, and 5). Findings included: During the environmental inspection on 01/11/19, at 1:35 PM, water from the faucet of the kitchen sink was hot to touch. When measured, the water temperature was determined to be 115°F. Continued inspection of the first floor and second floor sinks and bathrooms also revealed hot water that exceeded 110°F as evidenced by the	I 090	The water temperature was lowered to 110 degrees during the survey process…2-1-19 Staff members were retrained to check water temperature daily and record the temperature obtained. If that temperature is above 110 degrees, staff members were instructed to contact the Home Manager for immediate follow up…2-4-19 The Home Manager checked the thermometers for each home to ensure all were working properly (they are)…2-1-19	

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE QIPD (X6) DATE 2-4-19

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I 090	Continued From page 1 following: Kitchen faucet - 115°F First floor bathroom - 114°F Basement bathroom - 114°F On 01/11/19 the QIDP was interviewed at 1:38 PM, concerning the hot water temperatures. The QIDP acknowledged that the water was hot and exceeded the required temperature of 110°F. According to the QIDP, two of five residents have adaptive and cognitive capabilities to control water temperatures. Upon immediate notification of the hot water temperature on 01/11/19, the QIDP reported to the maintenance employee to check the water temperatures. The maintenance employee indicated that the water temperature would be turned down to achieve the 110°F for safety. On 01/11/19, at 2:10 PM, the surveyor and the maintenance employee checked the hot water temperatures again, which revealed the following: Kitchen faucet - 110°F First floor bathroom - 110°F Basement bathroom- 108°F At the time of survey, the facility failed to ensure that the water temperature did not exceed 110°F.	I 090		
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident.	I 095		

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I 095	Continued From page 2 This Statute is not met as evidenced by: Based on observation and interview, the GHIID failed to store poisonous agents in a locked cabinet and/or out of direct reach of each resident, for five of five residents of the facility (Residents #1, 2, 3, 4 and 5). Findings included: During the entrance conference on 01/09/19 at approximately 11:30 AM, the QIDP revealed that Resident #1, 2, 3, 4 and 5 are not competent to make decisions regarding their health and safety. According to the QIDP, the resident's functioning level is profound. On 01/11/19, beginning at 1:22 PM, observations revealed cleaning supplies such as Windex, oven cleaner, disinfectants and bathroom cleaners were labeled poisonous if swallowed. These poisonous agents were stored in an unlocked closet in the basement bathroom and a bottle of disinfectant was located under the sink in the first floor bathroom. The QIDP who was present at the time of the inspection confirmed that the cleaning supplies were not locked and secured. At the time of the survey, the facility failed to ensure potentially poisonous and/or caustic agent was stored and locked and out of the potential reach of each resident, as required.	I 095	A combination lock has been purchased and placed on the storage area where the cleaning products and other poisonous items are stored. Only appropriate staff was given the combination and staff was re-trained on ensuring these materials are properly stored at all times when not in use…2-4-19	
I 226	3510.5(c) STAFF TRAINING Each training program shall include, but not be limited to, the following:	I 226		

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I 226	Continued From page 3 (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on observations, interview and record review, the GHIID's nursing staff failed to maintain a sanitary environment to avoid sources and potential transmission of infections during medication administration, for one of five residents residing in the home (Resident #5). Findings included: Observation of the medication pass on 01/10/19 at 6:20 AM, revealed LPN #1 used a Glucometer to check Resident #2's blood glucose. After the resident's blood glucose was taken, the LPN threw the used blood glucose test strip and lancet inside the kitchen trash can. Interview on 01/10/19 at 6:55 AM, the LPN confirmed that the glucose test strip was thrown out in the trash can. The LPN stated that he should have thrown the test strip and lancet inside the sharps container. Review of the GHIID's policy and procedures, failed to show infection control procedures for disposal of glucometer blood test strips and lancet. At the time of survey, the GHIID failed to implement measures to maintain a sanitary environment to avoid sources and transmission of infection.	I 226	The RN retrained the LPN responsible for improperly disposing of the Glucometer on properly disposing of the item after checking blood sugar levels…2-1-19 The task will now be completed in the area where the Sharps container is stored to make it easier for the LPNs to properly dispose of items that need to be disposed of in that manner……..2-1-19	
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training	I 422		

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	HFD03-0023	A. BUILDING: ______ B. WING ______	01/11/2019

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I 422	Continued From page 4 and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on record review, observation, and interview the GHIID failed to implement each resident's recommended active treatment program, for one of three residents in the sample (Resident #1). Findings included: On 01/09/19, at 11:25 AM, review of Resident #1's IPP, dated 06/2018 to 06/2019, revealed an objective that stated, "During mealtime, <Resident's name > will reduce incidents of grabbing others food while at the table during mealtime daily for six consecutive months." Observation on 01/09/19 at 6:58 PM, revealed Residents #2, 3, 4 and 5 sat at the dining room table for dinner. During this time, Resident #1 stayed in his bedroom with his one to one staff (DSP #1). When asked, DSP #1 stated that Resident #1 will eat after everyone has finish their meal. At 7:32 PM, once Resident #2, 3, 4 and 5 completed their meal, DSP #1 assisted Resident #1 to the dining room table for dinner. Observation on 01/10/19 at 6:50 AM, revealed Resident #1 ate breakfast after Resident #2, 3, 4, and 5. On 01/10/19 at 1:16 PM, interview with the QIDP revealed that Resident #1 should always eat with the other residents. The QIDP also confirmed that Resident #1 has a goal to reduce incidents of grabbing the residents food, therefore, the resident was required to eat with his peers.	I 422	The staff member in question received appropriate disciplinary action for failure to support Client #1 to eat with his peers and for failure to implement his measure objective to improve his skills in eating independently with others…2-4-19. All staff members were retrained on the measurable objective and on the importance of Client #1 developing both the social skills and the eating skills needed to eat out and among others….2-4-19	

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I 500	Continued From page 5	I 500		
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 observation, interview and record review, the GHIID failed to allow each resident to exercise their right regarding eating breakfast and dinner with housemates, for one of five residents in the sample (Resident #1). Findings included: Observation on 01/09/19 at 6:58 PM, revealed Residents #2, 3, 4 and 5 sat at the dining room table for dinner. During this time, Resident #1 stayed in his bedroom with his one to one staff (DSP #1). When asked, DSP #1 stated that Resident #1 will eat after everyone has finished their meal. At 7:32 PM, once Resident #2, 3, 4 and 5 completed their meal, DSP #1 assisted Resident #1 to the dining room table for dinner. Observation on 01/10/19 at 6:50 AM revealed Resident #1 ate breakfast after Resident #2, 3, 4, and 5. On 01/10/19 at 1:16 PM, interview with the QIDP revealed that Resident #1 should always eat with the other residents. The QIDP also confirmed that Resident #1 has a goal to reduce incidents of grabbing the residents food, therefore, the resident was required to eat with his peers. On 01/10/19 at 1:30 PM, a second review of Resident #1's IPP, dated 06/2018 to 06/2019,	I 500	The staff member in question received appropriate disciplinary action for failure to support Client #1 to eat with his peers and for failure to implement his measure objective to improve his skills in eating independently with others...2-4-19. All staff members were retrained on the measurable objective and on the importance of Client #1 developing both the social skills and the eating skills needed to eat out and among others....2-4-19	

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I 500	Continued From page 6 revealed an objective that stated, "During mealtime, <Resident's name > will reduce incidents of grabbing others food while at the table during mealtime daily for six consecutive months." At the time of the survey, the facility failed to allow Resident #1 to eat breakfast and dinner with his housemates.	I 500		

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E 000	Initial Comments An emergency preparedness survey was conducted from 01/09/19 through 01/11/19. The findings of the survey were based on interviews and review of the emergency preparedness program. Note: The below are abbreviations that may appear throughout the body of this report. DSP - Direct Support Professional EP - Emergency Plan EPP - Emergency Preparedness Program HM - House Manager QIDP - Qualified Intellectual Disabilities Professional	E 000		
E 037	EP Training Program CFR(s): 483.475(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness	E 037		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE QIPD (X6) DATE 1-18-19

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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E 037	Continued From page 1	E 037		

policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least annually.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency

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E 037	Continued From page 2	E 037		

procedures.
(iv) Maintain documentation of all emergency preparedness training.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.

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*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually.

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to ensure each staff demonstrated knowledge of the emergency procedures (specifically describing and/or demonstrating the tracking system used to document locations of clients and staff during an emergency event), for two of fifteen staff (DSP #4 and 5).

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E 037	Continued From page 4 Findings included: On 01/10/19 beginning at 1:32 PM, the QIDP was asked about the facility's emergency procedures for tracking the location(s) of staff and sheltered clients during an evacuation. The QIDP said that staff would take a head count, call the manager and fill out the facility's relocation form. The QIDP also said if staff and clients' had to evacuate via the facility's vans, the vans have tracking devices and can be tracked by telephone and computers. When asked, the QIDP stated that all staff was trained on the EPP initially and in August 2018. On 01/10/19 at 2:03 PM, review of the facility's EP dated 05/20/18 confirmed the QIDP's interview that staff would take a head count, call the manager and fill out the facility's relocation form. The QIDP also said if staff and clients' had to evacuate via the facility's vans, the vans have tracking devices and can be tracked by telephone and computers. On 01/10/19 at approximately 4:15 PM and on 01/11/19 at 1:19 PM respectively, DSP #4 and DSP #5 said during their interviews that they both received initial and additional training on the facility's emergency procedures. When asked if they were aware of the facility's tracking system used to track clients and staff during an emergency event, DSP #4 and DSP #5 said "yes". When asked further to describe the tracking system to document the location of the clients and staff during an emergency, both DSP #4 and DSP #5 stated that they would call the HM and QIDP. At the time of the survey, the facility failed to ensure all staff demonstrated knowledge of the	E 037	The Senior QIDP retrained all staff members on the protocols for properly responding to emergency situation with specific attention given to preparing for and properly evacuating the locations when necessary…2-4-19 Staff will receive refresher training at minimum twice annually and will be observed during fire and emergency drills by management staff. They will receive feedback immediately after the drill on what was done well and what needs to be improved and this training will be documented…2-20-19	

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E 037	Continued From page 5 emergency procedures.	E 037		