STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G037	A. BUILDING _____ B. WING _____	02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	[redacted] WASHINGTON, DC 20008

(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	W 000		

A recertification survey was conducted from 02/06/19 through 02/08/19. Three clients were selected from a population of six men with intellectual disabilities. A fourth person, Client #5, was added for a focused review of the client's nutritional needs. This survey was conducted using the focused fundamental survey process.

The findings of the survey were based on observations, interviews and review of client and administrative records.

Note: The below are abbreviations that may appear throughout the body of this report.

% - Percent
DSP - Direct Support Professional
IPP - Individual Program Plan
MAR - Medication Administration Record
MG - Milligram
POS - Physician's Orders Sheets
QIDP - Qualified Intellectual Disabilities Professional
RN - Registered Nurse
TME - Trained Medication Employee

W 189 STAFF TRAINING PROGRAM — W 189
CFR(s): 483.430(e)(1)

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, record review and staff interview, the facility failed to ensure that each

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese — TITLE: Program Director — (X6) DATE: 3/6/19

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W 189	Continued From page 1 client's mealtime protocol was implemented consistently for one of three clients in the sample (Client #2). Findings included: On 02/06/19 at 3:45 PM, Client #2 was drinking ensure as he sat in the living room. At 5:32 PM, Client #2 was served fish, macaroni salad, broccoli and a muffin. Client #2 refused to eat his meal and walked back to the living room at 5:36 PM. On 02/07/19 at 11:27 AM review of Client #2's mealtime protocol dated 07/03/18 revealed staff should offer ensure two hours after breakfast and dinner. On 02/07/19 at 11:46 AM, review of the staff in-service training records showed that all staff received training on Client #2's mealtime protocol on 01/09/19. During an interview on 02/08/19 at 4:15 PM, DSP #16 confirmed that Client #2 has a feeding protocol. DSP #16 stated that Client #2 receives his ensure two hours after his meal. At the time of the survey, observations revealed that the training on Client #2's mealtime protocol had not been effective.	W 189	QIDP has provided training for DSP# 16 on Client #2 feeding protocol and will document the date/time when the ensure for Client #2 is given. All DSPs will receive training on Client #2 mealtime protocol and will document the date/time ensure is given to Client #2. QIDP/Nursing Staff will continue to monitor documentation and implementation of feeding protocol.	2/28/19
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	W 249		

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W 249	Continued From page 2 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 staff failed to ensure each client's physical fitness and exercise program was implemented at the recommended frequency, for one of three clients in the core sample (Client #1). Findings included: On 02/06/19 at 7:30 AM, observations showed Client #1 sitting in the living room while the television was on the news channel. The client extended his hand when greeted by the surveyor. Client #1 appeared to be non-verbal. The client, who stayed home from his day program that day, was observed leaving the facility at 10:35 AM with a staff, who said they were going for a walk in the community. At 3:20 PM, the QIDP provided the surveyor with the clients' IPPs. Client #1 had an exercise objective (IPP dated 12/06/18) that stated: "[Client's name] will participate in an exercise activity with a Direct Support Professional independently for 30 minutes 5 days a week." Further review revealed the following: "Direct Support Professionals will encourage [client's name] to use the exercise bike/treadmill, do jumping jacks, and/or community walks." [Note: The client had similar exercise objectives in both his day program IPP as well as his residential	W 249	The QIDP will review the active treatment goals for both day program and residential for client in home to ensure implementation as stated in each person's ISP. QIDP will monitor for accurate and proper documentation for Client #1. All DSP staff will be re-trained on Client #1 active treatment goals.	3/4/19

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W 249	Continued From page 3 IPP.]	W 249		

Continued observations showed at 4:15 PM, DSP #11 tapped on Client #1's shoulder and said they were going for a walk. The client immediately turned off his radio, grabbed his coat and went out the front door with DSP #11. Client #1 was observed reentering the facility with others at 5:05 PM.

Beginning at 4:20 PM, review of Client #1's performance data sheets for his exercise program revealed staff had documented the following:
- 01/2019: ball toss, dancing, bike riding, walking or some other form of exercise on 10 of 31 days; and,
- 12/2018: jumping jacks or other exercises on 8 of 31 days.
The data showed Client #1 did not meet the criteria of 20 days per month.

On 02/07/19 at 9:48 AM, the QIDP and RN were asked about Client #1's exercise program. The RN stated that it had been recommended by the nutritionist for good health and weight management. The QIDP concurred, adding that the client would benefit from staying fit because he (Client #1) enjoyed assisting staff with chores around the house. Immediate review of Client #1's nutrition assessment (dated 12/05/18) confirmed the nutritionist's recommendation for the exercise program. The QIDP stated that Client #1 readily participated in exercise and guessed that perhaps he had not met the criteria due to cold weather outdoors during the winter months. When this was again discussed during the exit conference on 02/08/19 at approximately 5:00 PM, it was pointed out that staff had

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W 249	Continued From page 4 documented indoor exercises, such as riding the stationary bike and/or dancing to music. At the time of the survey, the facility failed to ensure that Client #1's exercise objective was implemented at the recommended frequency.	W 249		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client's medications were administered in accordance with the POS, for two of six clients residing in the facility (Clients #2 and 6). Findings included: 1. On 02/06/19 at 8:26 AM, Client #6 came to the nurse's area with his assigned one-to-one staff, DSP #5. At 8:34 AM, another staff, DSP #8 was observed to administer the client's medications, including Metoclopramide 10 mg. [Note: DSP #8 was a certified TME.] The client and DSP #5 left the area shortly thereafter. At 8:50 AM, Client #6 was observed eating breakfast in the dining room, with DSP #5 seated next to him. On 02/06/19 at 10:28 AM, review of Client #6's current POS and MARs (February 2019) showed the following: "Metoclopramide 10 mg tablet. Take one tablet by mouth twice daily - 30 minutes prior to breakfast and dinner for vomiting." The POS	W 368	The TME/DSP will be retrained by RN on the importance of following instructions to wait 30 minutes prior to feeding Client #6 after receiving metoclopramide. The RN will monitor weekly for compliance.	3/8/19

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W 368	Continued From page 5 and MAR also showed the Metoclopramide was scheduled to be administered at 7:30 AM, with other medications scheduled for 8:00 AM. On 02/06/19 at 3:30 PM, DSP #8 was asked about Client #6's Metoclopramide. He stated that the client should receive the medication before meals. When asked if the facility RN had discussed the Metoclopramide during in-service training, DSP #8 replied "they're supposed to wait 30 minutes." On 02/06/19 at 4:06 PM, DSP #5 was asked about Client #6's Metoclopramide. She stated that she (the one-to-one staff) was supposed to wait for 30 minutes before giving him breakfast. She confirmed that it had been discussed during in-service training, adding that the medication was prescribed to reduce vomiting. DSP #5 further explained that it took her "some time to warm and puree" the client's food; however, she acknowledged that she had not timed the process to ensure that 30 minutes passed before Client #6 started breakfast. 2. On 02/06/19 at 8:47 AM, DSP #8 was observed administering three drops of Debrox 6.5% ear drops in Client #2's right ear and three drops in the left ear. DSP #8 then placed the bottle of ear drops back into its box and handed the ear drops to the surveyor. Immediate review of the label on the box showed the following: "Ear drops 6.5%. Instill 5 drops in each ear first 7 days every month for cerumen management." When asked if he was through administering the ear drops, DSP #8 replied "yes." The surveyor then showed him the pharmacy label. After DSP #8 examined the label and the MAR, he administered two more drops in each ear.	W 368	The TME will be retrained by RN on the correct medication administration procedure to include reading the physician order sheet, the MAR and the pharmacy label for consistency. The RN will monitor TME once a week for compliance.	3/8/19

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W 368	Continued From page 6 On 02/06/19 at 10:57 AM, review of Client #2's current POS and MARs (February 2019) showed the following: "Ear drops 6.5%. Instill 5 drops in each ear first 7 days every month for cerumen management." On 02/06/19 at 3:40 PM, DSP #8 stated that the facility's RN usually administered the morning medications. Shortly after he left, however, review of Client #2's MAR revealed DSP #8's initials were in the boxes used to document administration of the ear drops on the mornings of 02/02/19, 02/03/19, 02/04/19, 02/05/19 and 02/06/19. At the time of the survey, the facility failed to ensure that Client #2's ear drops and Client #6's Metoclopramide were administered in accordance with the POS.	W 368		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that all medications were administered without error, for one of five clients residing in the facility (Client #2). Findings included: [Cross-refer to W368] On 02/06/19 at 8:47 AM,	W 369		

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W 369	Continued From page 7 DSP #8 was observed administering three drops of Debrox 6.5% ear drops in Client #2's right ear and three drops in the left ear. The label on the box showed the following: "Ear drops 6.5%. Instill 5 drops in each ear first 7 days every month for cerumen management." When the surveyor showed him the pharmacy label, DSP #8 examined the label and the MAR and then administered two more drops in each ear. On 02/06/19 at 10:57 AM, review of Client #2's current POS and MARs (February 2019) showed the following: "Ear drops 6.5%. Instill 5 drops in each ear first 7 days every month for cerumen management." At the time of the survey, the facility failed to ensure that Client #2's ear drops were administered without error.	W 369	The TME will be retrained on the correct medication administration procedure to include reading the physician order sheet, the MAR and the pharmacy label for consistency. The RN will monitor the TME once a week for compliance.	3/8/19

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I 000	INITIAL COMMENTS A licensure survey was conducted from 02/06/19 through 02/08/19. Three residents were selected from a population of six men with intellectual disabilities. A fourth person, Resident #5, was added for a focused review of the resident's nutritional needs. 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. % - Percent DSP - Direct Support Professional GHIID - Group Home for Individuals with Intellectual Disabilities IPP - Individual Program Plan QIDP - Qualified Intellectual Disabilities Professional RN - Registered Nurse	I 000		
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure that each resident's mealtime protocol was implemented consistently for one of three residents in the sample (Resident #2). Findings included: On 02/06/19 at 3:45 PM, Resident #2 was observed drinking Ensure as he sat in the living	I 222	QIDP has provided training for DSP# 16 on Client #2 feeding protocol. All DSPs will receive training on Client #2 feeding protocol. QIDP/Nursing Staff will continue to monitor documentation and implementation of feeding protocol.	2/28/19

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I 222	Continued From page 1 room. At 5:32 PM, Resident #2 was served fish, macaroni salad, broccoli and a muffin. Resident #2 refused to eat his meal and walked back to the living room at 5:36 PM. On 02/07/19 at 11:27 AM review of Resident #2's mealtime protocol dated 07/03/18 revealed revealed staff should offer ensure two hours after breakfast and dinner. On 02/07/19 at 11:46 AM, review of the staff in-service training records showed that all staff received training on Resident #2's mealtime protocol on 01/09/19. During an interview on 02/08/19 at 4:15 PM, DSP #16 confirmed that Resident #2 has a feeding protocol. DSP #16 stated that Resident #2 receives his Ensure two hours after his meal. At the time of the survey, observations revealed that the training on Resident #2's mealtime protocol had not been effective.	I 222		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, interview and record review, the GHIID failed to ensure that each DSP who was assigned to provide one-to-one supports	I 229		

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I 229	Continued From page 2 maintained current certification in The Mandt System, for six of eight one-to-one staff (DSPs #3, 4, 5, 6, 10 and 13). Findings included: On 02/06/19 at 7:30 AM, DSP #3 stated that she was Resident #3's assigned one-to-one staff during the overnight shift. She replied "yes" when asked if the resident received one-to-one staffing supports 24 hours, 7 days per week. Further observations during the survey showed Residents #2 and 6 also had one-to-one staffing assignments. On 02/07/19 beginning at 11:48 AM, review of personnel files revealed that most DSPs had received Mandt training; however, most certificates showed expiration dates that had since passed. At 1:00 PM, when asked about Mandt training, the QIDP stated that Mandt training was required for any staff assigned to provide one-to-one supports. She identified eight DSPs (DSPs #3, 4, 5, 6, 8, 10, 13 and 14) as being one-to-ones and offered to seek current information from the main office. On 02/07/19 beginning at 2:10 PM, review of the eight aforementioned DSP files: 1) Confirmed that their one-to-one job descriptions listed Mandt training as a qualification for the position; and, 2) There was no evidence that DSPs #3, 4, 5, 6, 10 and 13 had obtained and/or maintained certification in the Mandt System. No additional information was provided for review before the survey ended on 02/08/19. At the time of the survey, the GHIID failed to ensure that every staff who was assigned to	I 229	All 1:1 DSP staff will be required to renew their Mandt certification prior to expiration. QIDP and QA will review personnel/ training records quarterly. The QIDP will ensure that DSP# 3, 4, 5,6, 10 and 13 will be retrained in the next scheduled Mandt class.	3/30/19 3/30/19

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I 229	Continued From page 3 provide residents with one-to-one supports had maintained current certification in The Mandt System, as required in their job descriptions.	I 229		
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 GHIID staff failed to ensure that each resident's physical fitness and exercise program was implemented at the recommended frequency, for one of three residents in the core sample (Resident #1). Findings included: On 02/06/19 at 7:30 AM, observations showed Resident #1 sitting in the living room while the television was on the news channel. The resident extended his hand when greeted by the surveyor. Resident #1 appeared to be non-verbal. The resident, who stayed home from his day program that day, was observed leaving the facility at 10:35 AM with a staff, who said they were going for a walk in the community. At 3:20 PM, the QIDP provided the surveyor with the residents' IPPs. Resident #1 had an exercise objective (IPP dated 12/06/18) that stated: "[Resident's name] will participate in an exercise activity with a Direct Support Professional independently for 30 minutes 5 days a week." Further review revealed the following: "Direct Support Professionals will encourage [resident's name] to use the exercise bike/treadmill, do	I 422	The QIDP will review the active treatment goals for both day program and residential for clients in home to ensure implementation as stated in the ISPs receptive to each. QIDP will monitor for accurate and proper documentation for Client #1. All DSP staff will be retrained on Client #1 active treatment goals.	3/15/19

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I 422	Continued From page 4 jumping jacks, and/or community walks." [Note: The resident had similar exercise objectives in both his day program IPP as well as his residential IPP.] Continued observations showed at 4:15 PM, DSP #11 tapped on Resident #1's shoulder and said they were going for a walk. The resident immediately turned off his radio, grabbed his coat and went out the front door with DSP #11. Resident #1 was observed reentering the facility with others at 5:05 PM. On 02/06/19 beginning at 4:20 PM, review of Resident #1's performance data sheets for his exercise program revealed staff had documented the following: - 01/2019: ball toss, dancing, bike riding, walking or some other form of exercise on 10 of 31 days; and, - 12/2018: jumping jacks or other exercises on 8 of 31 days. The data showed Resident #1 did not meet the criteria of 20 days per month. On 02/07/19 at 9:48 AM, the QIDP and RN were asked about Resident #1's exercise program. The RN stated that it had been recommended by the nutritionist for good health and weight management. The QIDP concurred, adding that the resident would benefit from staying fit because he (Resident #1) enjoyed assisting staff with chores around the house. Immediate review of Resident #1's nutrition assessment (dated 12/05/18) confirmed the nutritionist's recommendation for the exercise program. The QIDP stated that Resident #1 readily participated in exercise and guessed that perhaps he had not met the criteria due to cold weather outdoors during the winter months. When this was again	I 422		

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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) COMPLETE DATE
I 422	Continued From page 5 discussed during the exit conference on 02/08/19 at approximately 5:00 PM, it was pointed out that staff had documented indoor exercises, such as riding the stationary bike and/or dancing to music. At the time of the survey, the facility failed to ensure that Resident #1's exercise objective was implemented at the recommended frequency.	I 422		

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	09G037	A. BUILDING _____ B. WING _____	02/08/2019

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E 000	Initial Comments An emergency preparedness survey was conducted from 02/06/19 through 02/08/19. 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. EPP - Emergency Preparedness Program PEP - Personal Emergency Plan QIDP - Qualified Intellectual Disabilities Professional RA - Risk Assessment	E 000		
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.	E 006		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese | TITLE: Program Director | (X6) DATE: 3/6/19

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 006	Continued From page 1 (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to establish emergency plans to address each hazard identified in the RA, for six of six clients residing in the facility (Client #1, 2, 3, 4, 5 and 6). Findings Included: During an interview with the QIDP on 02/07/19, beginning at 3:20 PM, the QIDP stated that the facility's RA had identified snow storm, flood and severe thunderstorm as the greatest potential hazards. On 02/08/19 beginning at 11:22 AM, review of the facility's RA (not dated), showed "Civil disturbance" was determined to be one of the highest overall risk (at 41%). On 02/08/19, beginning at 11:30 AM, review of the facility's EPP dated August 2018, showed no evidence that the facility had established a plan on how to address Civil disturbance. During a follow-up interview on 02/08/19 at 3:14 PM, the QIDP acknowledged that there were no plans developed to address the aforementioned identified risk.	E 006	CMS Program Director will develop and implement a policy on Civil Disturbance. QIDP will train staff on the Civil Disturbance Policy for the residential location area and develop a scenario for staff to respond. An analysis will be completed and documented.	3/15/19 3/20/19

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E 007	EP Program Patient Population CFR(s): 483.475(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This STANDARD is not met as evidenced by: Based on interview and record review, the facility emergency plan failed to address the most vulnerable client at risk assessment for two of six clients residing in the facility (Clients #2 and 3). Findings included: During an interview on 02/07/19 at 3:38 PM, the QIDP stated they had determined that Client #2 was one of the clients that would be "especially at risk" during an emergency due to the client's need for a one-to-one staff, gait belt, and risk for falling. Client #3 was also at risk due to his need for a one-to-one staff for elopement. On 02/08/19 beginning at 10:43 AM, review of the EPP and the client's PEP (not dated), revealed the plan failed to address the aforementioned risks for Client #2 and 3. On 02/08/19 at 3:30 PM, the QIDP acknowledged	E 007	QIDP will update the PEEP for high risk Client #2 and #3 to include their personal and special needs during and after an evacuation. Staff will receive training on Client #2 and #3 revised PEEP.	3/15/19

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E 007	Continued From page 3 that the client's plan failed to address Clients #2 and 3 most vulnerable risks. At the time of the survey, the facility failed to ensure that the EPP and/or PEP included the identified risk to ensure client's health and safety during and after an emergency.	E 007		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group	E 039	QIDP will coordinate with CMS Program Director to organize and plan a facility based exercise to include a tabletop/drills and complete an analysis of the facility's response to the exercise.	3/29/19

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E 039	Continued From page 4 discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to conduct a full-scale community-based exercise with outside sources or a facility-based exercise, for six of six clients residing in the facility (Clients #1, 2, 3, 4, 5 and 6). Findings included: On 02/08/19 beginning at 9:45 AM, review of the facility's EPP (not dated) showed no evidence	E 039		

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E 039	Continued From page 5 that the facility had participated in a full-scale community based exercise or a facility-based exercise. Drill reports indicated however, that facility staff had engaged in a "tabletop activity" on 07/02/2018. On 02/08/19 at 3:03 PM, the QIDP confirmed that the facility had not participated in a full-scale community based exercise or a facility-based exercise. She stated that the director had reached out to several outside sources (i.e. fire department, recreation centers and other group homes) about coordinating a full-scale exercise with the facility and there was one such exercise being planned for 04/2019. The QIDP said that on 07/02/18, staff watched a video on how to respond to an Active Shooter scenario and discussed the topic afterwards. The QIDP acknowledged that the training session on Active Shooter did not constitute a facility-based exercise. At the time of the survey, the facility failed to conduct emergency exercises to test the emergency plan.	E 039		