STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G255	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI-SERVICES	[redacted] WASHINGTON, DC 20017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000		

A recertification survey was conducted from 05/15/19 through 05/16/19. Two clients were selected from a population of four women with various degrees of intellectual disabilities. This survey was conducted utilizing the focused fundamental survey process.

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

The survey findings determined that the facility was in substantial compliance with the requirements of 42 CFR 483, Subpart I, Requirements for Intermediate Care Facilities.

No deficiencies were cited.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Constance A. Reese	Program Director	6/11/19

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.

Health Regulation & Licensing Administration

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I 000	INITIAL COMMENTS A licensure survey was conducted from 05/15/19 to 05/16/19. A sample of two residents was selected from four women. The findings of the survey were based on observations, interviews and review of resident and administrative records. The following abbreviations will appear throughout the report: DSP - Direct Support Professional GHIID - Group Home for Individuals with Intellectual Disabilities QA - Quality Assurance Officer QIDP - Qualified Intellectual Disabilities Professional RN - Registered Nurse	I 000		
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. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHIID failed to ensure that each employee had a current health certificate on file, for three of 15 DSP personnel files reviewed (DSPs #2, 8 and 13), the registered nurse (RN), and the fitness instructor.	I 206		

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I 206	Continued From page 1 Findings included: 1. On 05/15/19 at 6:12 AM, DSP #2 greeted the surveyor at the facility door. Moments later, DSP #2 was observed assisting Resident #2 with putting on clothes. At 4:10 PM, DSP #13 was observed talking with DSP #3, who had worked the morning shift and was about to leave. At 4:30 PM, DSP #8 was observed preparing dinner in the kitchen and conversing with the QIDP. All three DSPs were observed interacting with the residents during their respective shifts on that day and on 05/16/19. On 05/16/19 beginning at 9:15 AM, review of the personnel files revealed the following: - DSP #2's health certificate was dated 03/23/18; - DSP #8's file did not show evidence of a health inventory that was certified by a physician. (There was, however, documentation showing that she had a negative test result when tested for tuberculosis on 10/20/18); - DSP #13's health certificate was dated 02/09/18. The findings were shared with the facility's quality assurance officer (QA) and the QIDP at 10:57 AM. On 05/16/19 at 10:58 AM, the QIDP and the QA stated that DSP #2 had a doctor's appointment scheduled for the next day (05/17/19). When asked if DSP #2 had been on the schedule in April and May (2019) and had worked with the residents, they replied "yes." At 11:07 AM, the QIDP stated that DSP #13 recently had received a complete physical exam; however, she had not obtained a health certificate from her physician. They said she was asked to return to the doctor to obtain the necessary clearance. No additional information regarding DSP# 8 was shared before	I 206	DSP#2 and #8 have obtained their health certificates. 5/17/19 DSP#13 obtained her health certificate on 1/11/19 and was filed on 5/17/19. QIDP/QA will monitor personnel records quarterly to ensure current health certificates for all staff. 5/17/19	

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I 206	Continued From page 2 the survey ended. 2. On 05/15/19 beginning at 2:39 PM, the RN was interviewed in the facility's nursing office on the top floor. She was observed engaged with staff and residents on both days of the survey. On 05/16/19 at 10:48 AM, review of the personnel file maintained for the RN revealed a health certificate 03/16/18. On 05/16/19 at 10:58 AM, the aforementioned finding was shared with the QA and QIDP. They confirmed that the RN had worked with the residents during the two-month period of 03/16/19 - 05/16/19. They stated they would check with the agency's human resources officer. No additional information was shared before the survey ended. 3. On 05/15/19 at 9:37 AM, the Fitness Instructor was observed working with Resident #1 performing physical exercises in the basement. Beginning at 10:08 AM, the Fitness Instructor was observed working with Resident #2 performing physical exercises. On 05/16/19 at 10:45 AM, review of the personnel file maintained for the Fitness Instructor revealed no evidence of a health inventory that was certified by a physician. On 05/16/19 at 11:09 AM, the QA stated that she would ask the agency's human resources officer about a health certificate. She also agreed to ask whether the written contract between the GHIID and the fitness company required them to submit a health certificate for any fitness instructor sent to work with the residents of this facility. No additional information was shared before the survey ended.	I 206	The fitness instructor will obtain his health certificate. QIDP/QA will monitor quarterly to ensure all credentials remain current.	6/30/19

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I 206	Continued From page 3 At the time of the survey, the facility failed to show evidence that they had implemented a system that ensures that every employee working with the residents obtained an annual health screening.	I 206		
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 maintained current certification in The Mandt System, for 10 of 14 one-to-one staff (DSPs #1, 2, 3, 4, 7, 9, 10, 12, 13 and 14). Findings included: On 05/15/19 at 8:02 AM, the QIDP stated that all four of the clients received one-to-one staffing supports during the day. Observations during the survey verified Residents #1, 2, 3 and 4 had one-to-one staffing supports. On 05/16/19 beginning at 9:15 AM, review of the personnel files revealed the following: - DSP #4 and 12's files did not show evidence of Mandt training; - DSP #1's Mandt training certificate showed it	I 229		

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I 229	Continued From page 4 expired on 01/31/18; - DSP #2's Mandt training certificate expired on 04/30/16; - DSP #3's Mandt training certificate expired on 11/30/17; - DSP #7's Mandt training certificate expired on 05/31/17; - DSP #9's Mandt training certificate expired on 02/28/19; - DSPs #10 and 13's Mandt training certificates expired on 06/30/18; and, - DSP #14's Mandt training certificate expired on 06/30/17. The one-to-one job descriptions listed Mandt training as a qualification for that position. The findings were shared with the facility's quality assurance officer (QA) and the QIDP at 10:57 AM. At 11:00 AM, the QIDP stated that DSPs were cross-trained to provide one-to-one supports for any of the four residents. She stated that Resident #4 was known to hit and kick staff. She further stated that all DSPs were expected to have current Mandt training; "they're all one-to-ones." The QA stated that she would follow-up with the human resources officer. No additional information was provided for review before the survey ended on 05/16/19. At the time of the survey, the facility failed to show evidence that they had implemented a system that ensures that every employee providing one-to-one supports for residents obtained and maintained current Mandt training.	I 229	DSP #2, #3, #7, #9, #10 and #14 will receive MANDT Training and receive their certificates of completion. QIDP/QA will monitor annually to ensure current MANDT Training.	6/14/19

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E 000	Initial Comments An emergency preparedness survey was conducted from 05/15/19 through 05/16/19. 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 QIDP - Qualified Intellectual Disabilities Professional QA - Quality Assurance	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	The facility's Program Director/ QIDP will review and revise its risk assessment to include potential hazards such as gas leaks specific to its geographic location. Staff will receive training on the Policy and Procedures for Handling and/or Responding to hazardous materials by the QIDP.	6/30/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gentanne A. Reese | TITLE: Program Director | (X6) DATE: 6/11/19

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E 006	Continued From page 1	E 006		

(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 observation, interview and record review, the facility failed to develop an all-hazard facility-based and community-based risk assessment to identify potential hazards (Gas Leak) essential to the facility's geographic location, for four of four clients residing in the facility (Clients #1, 2, 3 and 4).

Findings included.

On 05/15/19, at 6:27 AM, observation of the facility's location showed that a shell gas station was located directly across from the facility approximately one-hundred feet away or less.

On 05/15/19 beginning at 3:02 PM, the QIDP said during an interview that a gas leak, power outage, severe thunderstorms and snowstorm posed a high risk for this facility's location.

On 05/16/19 beginning at 10:28 PM, review of the facility's risk assessment verified the QIDP's interview that snowstorms, severe thunderstorms and power outage were assessed to be a high potential hazards for this facility's location.

At 1:25 PM, a follow-up interview was conducted

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E 006	Continued From page 2 with the facility's QIDP and QA regarding the risk assessments. When asked why gas leak was not added as part of their risk assessment, both the QIDP and QA stated that the team had a discussion about adding gas leak to the risk assessment when cited last year. The QA said that she would revisit the concern with the team. At the time of the survey, the facility failed to develop an all-hazard facility-based and community-based risk assessment to identify the potential hazards specific to their geographic location.	E 006		
E 009	Local, State, Tribal Collaboration Process CFR(s): 483.475(a)(4) [(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:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to	E 009	The facility's Program Director will provide additional information in the Communication Plans Policy/Procedure to include and enable the facility to collaborate with local/state/federal authorities during a disaster and emergency situation. An Emergency Preparedness contact list will be utilized in efforts to ensure an immediate and integrated response.	6/30/19

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E 009	Continued From page 3 contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This STANDARD is not met as evidenced by: Based on the review of documents and interview with facility staff, the facility failed to show documentation of efforts relevant to the process for ensuring cooperation and collaboration with local, regional, state and federal emergency preparedness officials' efforts to ensure an integrated response during a disaster or emergency situation, for four of four clients residing in the facility (Clients #1, 2, 3 and 4). Findings included: On 05/15/19, beginning at 3:02 PM, the QIDP said during an interview that she had not reached out to the local, regional, state and federal EP officials to ensure an integrated response during a disaster or an emergency situation. The QIDP stated that she was not certain if the facility's administrators reached out to the local, regional, state and federal EP officials to ensure an integrated response during a disaster or an emergency situation. The QIDP stated that she would follow up with her supervisor. On 05/16/19, at 12:00 PM, review of the facility's EPP updated on 02/27/19 showed no evidence that the facility collaborated with local, regional, state and federal EP officials to ensure an integrated response during a disaster or emergency situation. At 1:32 PM, the QIDP confirmed that the team had not reached out to	E 009		

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E 009	Continued From page 4 local, regional, state and federal officials regarding EP. At the time of the survey, there was no evidence that the facility developed policies and procedures that ensured cooperation and collaboration with local, regional, state and federal EP officials' efforts to ensure an integrated response during a disaster and/or emergency.	E 009		
E 024	Policies/Procedures-Volunteers and Staffing CFR(s): 483.475(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in	E 024	The Program Director will develop a policy and procedure for the use of volunteers during a disaster or emergency. The facility will utilize a Volunteer Emergency Contact Roster. 6/30/19	

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E 024	Continued From page 5 an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop policies and procedures that address the use of volunteers during an emergency, for four of four clients residing in the facility (Clients #1, 2, 3 and 4). Findings included: On 05/15/19 beginning at 3:02 PM, the QIDP said during an interview that the facility would not use volunteers during an emergency situation. On 05/16/19 beginning at 10:28 AM, review of the facility's EP, updated on 02/27/19 showed no evidence that policies and procedures had been developed to address how and if the facility would use volunteers during emergencies. At 1:45 PM, the QIDP and QA looked through the EP book and confirmed that there was no policy and procedure related to the use of volunteers during emergency situations. At the time of the survey, there was no evidence that the facility's EP addressed the use of volunteers during emergencies.	E 024		
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:	E 037		

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E 037	Continued From page 6 (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 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	E 037	DSP#4 and #15 received training on the EPP by the QIDP. QIDP will train all employees annually and review EPP Training Records quarterly to ensure training is completed for new and senior employees.	6/7/19

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 7	E 037		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G255	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI-SERVICES	[redacted] WASHINGTON, DC 20017

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E 037	Continued From page 8	E 037		

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.

*[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

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	09G255	A. BUILDING _____ B. WING _____	05/16/2019

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E 037	Continued From page 9	E 037		

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 show evidence that it trained all staff on initial emergency preparedness training, for two of fifteen newly hired staff employed by the facility (DSPs #4 and 15).

Findings included:

On 05/15/19, at 2:16 PM, DSP #15 was asked about the facility's EPP and tracking system during an emergency. DSP #15 said that she had not received initial training on the facility's EPP and that she just started working at the facility in February 2019. DSP #15 stated that she was the in-home day program teacher. When asked, DSP #15 stated that she works in the facility five days a week from 9:00 AM to 3:00 PM.

At 2:44 PM, DSP #4 was interviewed regarding the facility's tracking system during an emergency. DSP #4 said that she was unaware of the facility's tracking system. When asked, DSP #4 stated that she has not had initial training on the facility's EP since she started working at the facility in March 2019.

At 3:07 PM, the QIDP was asked about initial EP training for DSP #4 and DSP #15. The QIDP confirmed that DSP #4 and DSP #15 had not received initial training on the facility's EP. The QIDP said that a total of four DSPs needed to be

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E 037	Continued From page 10 trained on the EP. On 5/16/19 beginning at 10:28 AM, review of the EP in-service training documents showed no evidence that the facility had trained DSP #4 and DSP #15 on the EPP. At 1:50 PM, the QIDP said that training for the four newly hired DSPs is scheduled for 06/03/19. At the time of the survey, there was no documented evidence that newly hired staff received initial training on the facility's EPP.	E 037		

GOVERNMENT OF THE DISTRICT OF COLUMBIA

CRFMR
Rev. 9/02

DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING ADMINISTRATION

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Facility:	Street Address, City, State, ZIP Code:	Survey Date:
Community Multi-Services, Inc.	[redacted] Washington, DC 20018	5/15/19 - 5/16/19 Follow-up Dates(s):

Regulation Citation	Statement of Deficiencies	Ref. No.	Plan of Correction	Completion Date
000	A licensure survey was conducted from 05/15/19 through 05/16/19. A sample of two residents was selected from a population of four women. The findings of the survey were based on observations, interviews and review of resident and administrative records. Note: The following abbreviations will appear throughout the report: GHIID – Group Home for Individuals with Intellectual Disabilities QA – Quality Assurance Officer QIDP - Qualified Intellectual Disabilities Professional			

Name of Inspector — Date Issued: 5/28/19

Facility Director/Designee — Date: 6/11/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

	4701 **Background Check Requirement**				
4701.2	**Each facility…shall cause each prospective employee or contract worker who will have, or foreseeably may have direct patient, resident or client access, to undergo a criminal background check that shall reveal the criminal history, if any, in the District of Columbia and the fifty (50) states. Finger printing or live scan shall be performed in the District of Columbia utilizing the Metropolitan Police department (MPD) or a private agency. The criminal background check shall be performed, following finger printing or live scan, by the MPD and Federal Bureau of Investigation (FBI) in an FBI-approved environment. The results of the criminal background checks shall be forwarded to the Department of Health.** Based on review of personnel records and interview with management staff, there was no evidence that the facility obtained a finger print or live scan, for one of 19 employee files reviewed (a fitness instructor).				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

		Findings included: On 05/15/19 at 9:37 AM, the FI was observed working with Resident #1 performing physical exercises in the basement. Beginning at 10:08 AM, the fitness instructor was observed working with Resident #2 performing physical exercises. On 05/16/19 at 10:45 AM, review of the personnel file maintained for the fitness instructor revealed no evidence of a criminal background check. On 05/16/19 at 11:09 AM, the QA stated that she would ask the agency's human resources officer about a background check. She also agreed to ask whether the written contract between the GHIID and the fitness company required them to submit a criminal background check for any fitness instructor sent to work with the residents of this facility. No additional information was shared before the survey ended. At the time of the survey, the facility failed to show evidence that they had obtained a finger print or live scan for the fitness instructor.		The background check and finger print document was filed for the fitness instructor.	5/17/19