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	34G255	A. BUILDING _____ B. WING _____	02/07/2019

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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 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.	E 037		

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

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 (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 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.	E 037		

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E 037	Continued From page 2 *[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. *[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	E 037		

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E 037	Continued From page 3	E 037		

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:
The facility failed to assure staff training on its emergency preparedness policies and procedures formally occurred for direct care staff of the group home and was documented as required as evidenced by interview and record verification. The finding is:

Review of the facility's emergency plan (EP) on 2/5/19 revealed the facility to have a system in place to prepare and aid staff in the event of emergencies. Further review of the EP, however revealed no documentation of staff training on the EP was included with the plan. Interview with staff at the group home revealed limited knowledge of what was contained in the EP but knew where the EP notebook was located in the home.

Interview with the home manager and the program director on 2/6/19 revealed the agency conducts EP training for administrative staff on a regular basis but it is left to the managers for each home to train staff. Further interview with the home manager revealed training of the EP with staff if usually conducted during staff meetings but no documentation of exact information covered or which staff have been

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E 037	Continued From page 4 trained is documented. Continued interviews with the home manager and program director revealed the facility does not have a formal training program for new staff or annually for existing staff to assure they are trained on all of the facility's EP.	E 037		
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 discussion led by a facilitator, using a narrated,	E 039		

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E 039	Continued From page 5 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: The facility failed to assure testing on its emergency preparedness policies and procedures formally occurred for direct care staff of the group home and was documented as required as evidenced by interview and record verification. The finding is: Review of the facility's emergency plan (EP) on 2/5/19 revealed the facility to have a system in place to prepare and aid staff in the event of emergencies. Further review of the EP, however revealed no documentation of testing of the EP	E 039		

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E 039	Continued From page 6 was included with the plan. Interview with the home manager and the program director on 2/6/19 revealed the agency conducts EP informal testing for administrative staff on a regular basis but testing the EP with direct care staff does not occur. Further review of the EP revealed no documentation of the facility's testing exercises on a community level, facility full scale exercise or a table top exercise was available for review during the 2/5-6/19 survey.	E 039		
W 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: The facility failed to provided sufficient direct care staff to manage and supervise clients appropriately as evidenced by observations, interviews and record verification. The finding is: Morning observations on 2/6/19 at 6:20 AM revealed one staff present in the home with 5 clients up and ready in the living room and dining room area. The staff person was observed to work alone until 6:50 AM when the home manager entered the group home and 7:00 AM when 1st staff started work. Observations during the 30 minutes while staff was working alone in the house revealed client #1, client #2, client #4	W 186		

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W 186	Continued From page 7	W 186		

and client #6 to sit at the table unengaged waiting for breakfast to be served. Client #2 was observed to mouth his hand and occasionally hit his head with his other hand while client #6 was observed to exhibit self-stim behaviors.

Further observations during the 30 minutes revealed client #5 to move about the group home between the dining room, living room, kitchen and bedroom making loud vocalizations and talking closely with staff and surveyor. Staff was observed to start making breakfast at 6:35 AM but had to stop, cut the stove off and leave 4 clients sitting at the table unsupervised for 5 minutes to assist client #1 in the bathroom with his shower. Continued observations revealed staff to restart breakfast and make breakfast without including any of the clients although client #4 and client #5 were passively asked to help in the kitchen and refused. Staff completed making eggs and toast and started serving the clients as other staff arrived.

Interview with staff revealed 3rd shift staff work alone until 7:00 AM when 1st shift staff arrives. Further interview with staff revealed 3rd shift staff are responsible for getting client #2 and client #6 up and ready in the morning before 1st shift arrives but sometimes other clients in the home wake up early too.

Review of client #5's individual support plan (ISP) dated 2/8/18 revealed client #5 should have "line of sight"supervision. Further review of the ISP revealed a behavior plan dated 12/8/15 to address non-compliance, self-injury, property destruction and physical aggression and noted the client is more likely to engage in these challenging behaviors for several reasons

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W 186	Continued From page 8 including when their is a lack of structured activity. The facility failed to assure enough staff were available during early morning observations on 2/6/19 to assure clients were appropriately engaged and supervised as required.	W 186		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: The facility failed to assure medications for 1 of 6 clients in the group home (#6) were kept locked except when being prepared for administration as evidenced by observation, interview and record verification. The finding is: Morning observations in the group home on 2/6/19 at 6:30 AM from the living room revealed topical medications to be sitting on the desk in the medication room. Interview with staff passing morning medications at 7:10 AM revealed often 3rd shift staff will leave topical medications on the desk to be put back in the closet by first shift. Further interview with staff, substantiated by observations, revealed the topical medications that were left out on the desk belonged to client #6 and included Head and Shoulders shampoo, Gold Bond powder, Absorbase and Clobetasol Ointment. Review of client #6's physician's orders dated 11/4/18 verified client #6 is prescribed these topical medications. Interview with the home manager and program coordinator revealed these	W 382		

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W 382	Continued From page 9 topical medications should not be left out unattended and should be placed back in the medication closet when not being used as they are prescribed medications for client #6.	W 382		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: The facility failed to assure fire evacuation drills were conducted at least quarterly for each shift of personnel as evidenced by interview and record verification. The finding is: Review on 2/5/19 of the facility's fire drill evacuation reports for the past year revealed the facility failed to run several drills during the past 6 months as required. For example: Interview with the home manager and program coordinator on 2/6/19 revealed the facility conducts a drill on each shift per quarter with yearly quarters being January-March, April-June, July-September and October-December. Further interviews revealed the facility will often schedule the drills during the first 2 months each quarter to allow any needed make-up drills to occur during the 3rd month of the quarter. However, review of the most recent 6 months of fire drills, substantiated by continued interviews, revealed only a 11/28/18 2nd shift fire drill was conducted during the October-December 2018 quarter failing to meet the required 1st shift and 3rd shift drills for the quarter. In addition, further	W 440		

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W 440	Continued From page 10 review of the fire drill reports revealed no fire drills had been conducted in 2019 until 3rd shift staff conducted one on 2/6/19 during the survey.	W 440		