Iowa Center for Home Care
HHA Survey Review G-Tags
3rd Quarter 2019

Total # of reports: 22
Recertification surveys: 13 (4 deficiency free)
Complaint: 9 (2 deficiency free)
Extended: 1 (1 deficiency free)
Revisits: 6 (6 deficiency free)
Inability to competize = 7
Validation survey = 3

Old CMS description of G-tags

New G tags

G406

- Failed to keep patients free of injury while providing direct care.
- Patient Rights: Agency failed to keep patient safe and free of injury while providing direct care services.

G430

- Agency failed to ensure the patient remained free from injury while staff provided direct care for a patient. Staff left marks on patient's arm while restraining patient during GT reinsertion. Patient was combative and fighting staff.
- Injury to patient while staff was performing passive ROM.

G440

- Consent form didn't indicate who was being billed for services and how much out of pocket the patient would pay.
- Consent form failed to say who was being billed for services, what services were being provided, and how much agency planned to bill the responsible party; Another client received PT/OT but not on consent.
- Agency didn't inform patient of which insurance payer would be billed for services and the amount the patient could expect to pay out of pocket. The patient' s copy of the service agreement in the home was blank. This was true of multiple patients.

G510

- Agency failed to ensure start of care comprehensive assessments were completed by the 5th day. Failed to ensure accurate and thorough completion of all pertinent components of the comprehensive assessment and failed to complete significant change in condition comprehensive assessments were completed in 48 hours.
- SOC comprehensive assessment not completed by the 5th day following SOC; DRR not completed with the comprehensive SOC; Recerts not completed between day 56-60; ROCs not completed within 48 hours of agency's knowledge of DC from input facility; DC comprehensive assessments were not completed within 48 hours of the agency's knowledge of the need to DC.

G514

- Failure to provide an initial assessment visit within 48-hrs. Exceeding the required time allowed puts agency patients at risk for not having immediate care.

G520

- Agency failed to ensure completion of all pertinent components of the comprehensive assessment by the 5th day following the start of care.
- All pertinent components of the comprehensive assessment must be completed by the 5th day.

G528

- Failed to ensure accurate/thorough completion of pertinent components of comprehensive assessment. Mobility assessment questions on OASIS contained entry "Not Attempted". Resumption of care assessment failed to include assessment of pressure ulcer including measurement, drainage, appearance of wound bed and surrounding tissue. Height and weight not assessed.
- No policy regarding wound care assessments; OASIS stated no surgical wound, but narrative noted removing staples that visit from surgical incision; Assessment of wound lacked any measurements and no physical assessment of the wound;

G536

- Failure to accurately complete a drug regimen for multiple patients or indicate patients' medication side effects, nurse's notes lacked documentation of outcomes of med changes.
- Failure to complete a drug regimen review. Failure to ensure meds were reviewed at time of each comprehensive assessment.
- DRR failed to identify patient took duplicate medications to treat high blood pressure. Failed to identify potential for low blood sugar levels related to interactions between multiple medications.
- DRR lacked documentation of significant side effects, ineffective drug therapy, no compliance, and duplicate drug therapy. Specially ordered duplicates were not noted as being present on the DRR.
- No DRR at discharge. No documentation of duplicate drugs. No DRR at recertification.
- DRR wasn't completed with the comprehensive assessment. The agency did as a separate document that didn't "attach" to the comprehensive assessment.

G544

- Agency failed to ensure accurate and thorough completion of other follow up (significant change in condition) comprehensive assessment in a timely manner.

- Failure to ensure completion of other follow up comprehensive assessment at time of change in patient status/condition.

G546

- agency failed to ensure timely completion of the recertification comprehensive assessments between day 56-60 of each 60-day recertification period.
- Failure to complete updated assessments at recertification in a timely manner.
- Recert assessments were completed outside the 5-day window.

G548

- Agency failed to ensure accurate completion of all pertinent components of the resumption of care comprehensive assessments within in 48 hours of the agency's knowledge of return home.
- Failure to ensure accurate completion of all pertinent components of the update to the comprehensive assessment within 48-hrs of the agency's knowledge of return home from an inpatient facility.
- Failure to complete ROC in 48 hours.
- ROC assessments were not completed within 48-hour timeframe based on when the professional signed the document as complete.

G550

- Failure to ensure completion of discharge assessment within two calendar days of identification of the need to discharge a patient.
- Failed to ensure completion of the discharge comprehensive assessment within two calendar days of identification of the need to discharge a patient.
- Failure to complete updated comprehensive assessments at discharge within two calendar days of identification of the need to discharge a patient.
- Failure to complete DC OASIS in two calendar days in charts reviewed.
- Completion of the DC comprehensive assessment within two calendar days of identification of the need to DC the patient.
- The DC assessment was signed not dated as having been completed.

G570

- Failure to ensure the agency met patients' assessed needs for therapy services; failed to follow physician ordered POC/or failed to notify the physician of the need to vary from the plan; failed to ensure the agency skilled staff completed an individualized POC that contained accurate information; failed to provide medications, treatments and services only as ordered by a physician; failed to integrate all services provided both directly and under arrangement to assure identification of patient needs. The agency did not have a policy for how quickly therapy services were initiated.
- Failure to complete individualized POC that contains accurate information. Failure to revise the plan in the interim. Failure to provide medications, treatments and services ordered by the physician. Failure to alert physician to patient changes. Failure to coordinate patient care in a way that meets the needs of the patient.
- Agency failed to complete an individualized POC that contains accurate information. Agency failed to revise POC with all interim and verbal orders allowing clinicians to work from an updated POC.
  Care planning, coordination, quality of care. Failed to ensure skilled staff promptly alerted physician to changes that may suggest need to alter POC.

G572

- Failure to notify the physician of changes in visit history for a patient.
- Failed to follow POC and lacked documentation of skilled nurse's visits.
- Failed to follow POC/notify physician of need to vary from physician ordered POC.
- Agency failed to follow a Plan of Care or notify the physician of the need to vary from the physician ordered Plan of Care; Weight ordered every visit; nurse failed to weigh patient or notify physician that no weight was obtained. Failed to perform services as ordered.
- Failed to follow a POC established and periodically reviewed by a MD, DO, or Doctor of Podiatry, or notify the physician of the need to vary from the orders. Physician was not notified of missed visits. Ordered weights were lacking documentation as to why. Patient had order for pulse ox and clinical record lacked documentation that they were done.

G574

- POC failed to include orders to accurately reflect the medications the patient was taking.
- Failure to ensure accurate completion of the POC.
- Failure to maintain an accurate POC. POC didn't identify when Albuterol should be used.
- Failure to maintain accurate POC; Medication orders were not updated and accurate.
- Agency failed to ensure the accurate completion of all components of the Plan of Care including all supplies/equipment used by the patient and accurate medication orders for multiple patients. POC listed medications that were not found in the home and reportedly the patient was no longer taking. An expired bottle of medication was found in the home and when questioned the patient's caregiver reported the patient had not been taking the medication for years. Patient did not have a reason listed on the POC for why a medication would be taken PRN. Service orders did not accurately reflect what the patient was receiving or patient needs, also lacked a planned frequency or duration.
- Agency did not include all required elements in POC including all supplies/equipment and medications, risk of emergency room and hospital readmission. In all clients reviewed-missing risk for emergency department visits and hospital readmission and necessary interventions to address the underlying risks. Failure to identify a dosage for a cream. Failed to list a medication on the POC. Failed to list the Lifeline as equipment. Failed to list TED hose. Failed to list dose for oral medication. Docusate Sodium-Senna - failed to list dose for each component of tablet. Did not list handheld shower or tub transfer bench. Note stated patient used laxatives but no laxatives listed in POC. Discontinued medications not removed from POC. Wrong doses of medications listed. No listing of mg/tsp for Tylenol or Advil. Missing a "dressing aide device" in DME.
- Agency failed to ensure the accurate completion of all components of the POC and/or failed to ensure the POC contained current, accurate information for patients sampled. POC identified different amounts of water to flush the GT with before and after feedings.
- Agency failed to ensure accurate completion of all components comprising the POC including all supplies/equipment used by the patient to meet patient needs, medications taken by patient and patient risk for emergent care/hospitalization risk. POC documented patient's risk for emergent care and acute care hospitalization as "moderate" but lacked any description of patient's risk for emergency room visits and hospital re-admissions or any interventions to address the underlying risk factors.
- Failure to maintain complete and accurate POCs with current orders.
- POC failed to identify correct dose of medication or a BIPAP machine. POC failed to document long handled sponge as equipment. POC revealed no wounds but wound supplies were listed under supplies. Failed to list a Roho cushion.

- Failure to ensure all components of POC: lack of medication dose, lack of supplies (incontinence brief, long handled sponge, compression stockings, scale). One chart lacked duration for aide.
- Patient's POC didn't have bathroom scale listed for DME. Walker listed as DME, but patient wasn't using walker. MOM (med) listed as cont. on 485 but patient taking PRN Oxygen liter flow in home didn't match the liter flow on the 485 Calcium and Vit D over the counter- patient had picked up different dose of Calcium/Vit D but wasn't updated on med list. DME had cane- but patient wasn't using. Patient had long handled shower brush and handheld shower- not listed as DME on documentation. Medplanner was listed but patient's meds administered by AL staff had been DC but still listed on med profile. Heating pad were not listed, PRN meds didn't include reason to be taken.
- POC didn't identify pill-splitter and bed cane as equipment used to meet patient's needs. Failure to administer medications as ordered by the physician. Order failed to identify specific locations of wounds. Failure to specify how many days or doses the patient should take an antibiotic.
- POC failed to list all DME used by the client (ERS button); incorrect cert dates on 485; missing DME (doppler machine, scooter, dressing supplies, incontinence supplies, diabetic supplies, oxygen equipment; Oxygen in use and O2 not listed as a med and failed to mention dosage and frequency of use for O2

G576

- Failure to update POC with additional nurse visits and tapering off med for patient.
- Failure to update the POC; Verbal orders present but not added to the Plan of Care.
- Failure to update the POC increased potential for errors in delivery of treatments.
- Agency failed to update POC with all new orders for multiple patients.
- All orders recorded on POC; No update to POC for lab draw order and removal of PICC, no update to POC for PT orders, no update to POC that PT was on hold.
- Failure to update POC with all new physician orders on multiple patients. Agency did not document PT orders on a working care plan as required by regulation. New orders for physician notification of symptoms and new med orders were not added to the POC.

G580

- Agency failed to provide medications, treatments or services only as ordered by the physician. The clinical record lacked verbal order changing dose of Vitamin D. Clinical record lacked a physician order for diuretic.
- Failure to ensure staff follow physician's orders for medication administration and treatments provided by agency and staff placed patients at risk for inconsistent care/treatment and possible harm. Clinical record lacked documentation of a physician interim or verbal order for Tramadol.
- Agency failed to provide treatments/medications only as ordered by a physician for multiple patients. Orders received by an ARNP for wound vac placement and to be changed 3 times per week - no documentation of communication with a MD or DO to obtain approval prior to placing the wound vac. Physician ordered a change in medication, RN made an extra visit to change med in the home but did not obtain an order for an extra visit from physician. RN documented she was unable to perform wound care as directed by physician as AquaCell was not yet in the home; she cleansed the wound with NS and applied Medihoney and covered with foam dressing - no documentation that the physician was contacted for new orders. POC lacked orders for medications used in the home.

- Failure to provide medications, services and treatments only as ordered by a physician in several patients. Some charts failed to continued OT after physician sent orders to continue. Lack of physician orders for dressing changes. Physician order to flush 50ml of acetic acid to suprapubic catheter but nurses documented flush of 20ml and 15 ml.
- At a home visit med planner errors reported by patient, confirmed and corrected by the nurse. The nurse then set up meds for the next week- patient had switched from Docusate with Senna to just Docusate - nurse didn't identify that change which wasn't consistent with the current med profile order.

- Failure to obtain physician's orders for administration of medications, treatments, and services provided by agency staff. Lack of order for PT evaluation for a patient, recommendations for wound cultures, for a digoxin level, weight checks.

G590

- Agency failed to report changes in clinical findings or patients' needs to physician for several residents. Notes lacked documentation of physician notifications for blood sugar issues, increased urination at night, etc.
- Record lacked documentation of physician notification of patient's continued noncompliance with diabetic regimen or high blood sugars. BS parameters ordered on POC - no documentation of physician notification of blood sugars out of the parameters. POC directed RN to notify physician of unusual weight gain or loss, yet weights were not assessed.
- Failure to communicate changes in patient's status with the physician.
- Must promptly alert the relevant physician of changes in the patient's condition. PICC line was covered with plastic for shower. Staff cut the plastic off with scissors and one of the elements was missing as later identified by parent of patient. Nurse indicated to parent the physician would be notified in two days.

G606

- Agency failed to coordinate care and integrate services to assure patient needs are being met. Clinical record lacked documentation of coordination/care conferences between nursing and physical therapy to integrate services,

G608

- Agency initiated occupational therapy services to assist with bathing over two weeks after the patient requested additional assistance.
- Failure to coordinate care - Client not able to contact RN via the answering service. Client made call to the physician after no contact for hours and was told to be taken to ER. Agency discharged client from services without first setting up therapy services for outpatient.
- Agency failed to ensure patient care delivery was coordinated in a way to meet patient individualized needs.

G616

- Agency failed to provide patient medication lists written in plain language that included the medication name, dosage, frequency, administration times and which medications will be administered by agency personnel and administration.

G640

- QA/PI: Agency failed to develop a QAPI program

G642

- Program scope: Agency policy said there was a QAPI committee and noted what areas they would identify areas of improvement but according to governing body meeting minutes all that was done was review of OASIS; no info regarding tracking of other QI or selection of QAPI project; Administrator later revealed she was only person involved in governing body and for QAPI she reviewed OASIS data at least twice per year

G644

- Program data: Administrator reported that she is only one on governing body and sole person involved in QAPI; she reported she had done nothing else with OASIS data except review it and had not chosen a QAPI project. Had not monitored effectiveness and safety of services, quality of care, and identify opportunities for improvement

G648

- High risk, high volume or problem prone: Administrator stated he/she was tracking infections of patients but only had documentation of one patient infection for the last year and no staff documented infections.

G650

- Incidence, prevalence, severity of problems: Administrator reported that he/she had not done anything with OASIS data except review it; Had not considered incidence, prevalence, and severity of problems in any areas

G652

- Activities lead to immediate correction: No immediate correction of any identified problem that directly or potentially threaten the health and safety of clients

G654

- Track adverse patient events: Agency did not track adverse patient events, analyze their causes, and implement preventive actions

G656

- Improvements are sustained: Agency had no data to show success with QAPI and that its performance was tracked to ensure that improvement is sustained.

G658

- PI projects: No PI projects completed

G660

- Executive responsibilities for QAPI: No evidence of QI measures tracked

G 700

- Skilled professional services: Failure to perform ongoing interdisciplinary assessment on patient; Failure to ensure agency staff provided services ordered by physician and as indicated on POC; Failure to ensure staff communicated with physician involved in POC or current POC. Failed to ensure RNs supervised LPN staff per policy every 30 days.

G706

- Interdisciplinary Assessment of the Patient: Failed to assess/measure wounds. Measurements when performed, did not contain depth measurements. Did not perform wound assessments as ordered in the Plan of Care. Orders to weigh patient each visit - no weights performed.
- Wound assessments not completed weekly.
- LPN working as HHA did "skin care". Visit note did not specify what the LPN did in order to provide skin care, lacked documentation the LPN identified concerns/changes in patient condition and reported changes to client's RN; skilled note by LPN assessed patient who had no skin issues; in narrative portion of note it said client fell after SNV and went to ER via ambulance and also saw doctor for low blood sugars. LPN noted patient to have several stitches in RLE and noted gauze to be clean and intact. No further assessment of the wound and no measurements; no note that LPN Notified RN of patient's change in condition, did not contact physician to see if physician wanted wound care or any other changes to POC. Another SNV note says patient had bruising and cool skin but did not say where bruising was; client also had wound where sutures had been removed but no documentation of assessment of wound; another SNV with no wound measurements; patient reported going to doctor for wound infection and LPN had assessed wound as red and swollen but RN case manager was unaware, had not seen the patient in last five weeks. Agency LPNs not communicating with RN Case manager

G710

- Provide services in the POC: Nothing in notes that nurse assessed for depression as was noted on POC to do; agency staff failed to provide wound care prior to providing wound care

G718

- Communication with physician: Clinical note documented that patient believed LVAD was infected and nurse would contact LVAD nurses and get instructions on changing dressings and report concerns; clinical record lacked documentation of any communication with physician or LVAD nurses; no documentation of communication with physician of presence of new skin tear after a patient fall; orders for PT/OT eval but no OT eval ever done, no documentation as to why; ROC documented there was no indicated need for therapy but a completed initial PT visit note indicated further PT visits would occur then after one more visit by PT it was noted that PT would be placed on hold until patient's MCO/CM obtained a new wc for patient; patient and his caregiver did not feel his needs were being met.

G726

- No supervision of LPN every 30 days as policy stated would be done.

G764

- Records did not document that HHA was competent in skills for applying condom catheter.
- Records did not document how it was determined that HHA was competent in obtaining BP; no documentation of competency training on PEG tube care or weight;

G768

- Agency's documentation showed HHA demonstrated competency in shampooing and bathing a patient in the shower, sponge, or tub, but didn't specify which shampoo/bath types the aide failed to complete.

- Competency Evaluation: no documented evidence of competency for tasks the HHA was performing in the home (applying orthotic braces, compression stockings).
- HHA Competency: No documentation of competency for extended skills.
- Competency training: Failed to show competency in basic skills; determined HHA was competent in VS assessment but failed to identify what VS assessment included.
- Aide's personnel file lacked documentation of competency of bed bath, sponge bath, tub bath, shampoo in bed, sink or tub. No documentation of aide competency in applying a leg brace, applying topical med.

G772

- Failure to ensure HHAs have documented evidence of competency by an RN in the assigned task area prior to independently performing the task with a patient.
- Agency failed to ensure home health aides assigned to perform tasks requiring extra skills exceeding the level of basic home health aide services had documented evidence of competency evaluation by a RN in the assigned task area prior to being assigned to provide care independently/and or performing the task with an agency patient.

G796

- HHA assignments and duties: POC failed to specify what skin care meant.

G798

- Failure of RNs to provide specific written instructions directing the care provided by the aides for each patient; Specifically, the type of wound dressing and where to put it.

G800

- Failure to ensure HHAs provided care to patients as directed by skilled professional.
- Failure to provide services per the written Care Plan.
- Failed to ensure HHAs performed tasks only as ordered by physician and/or as directed by skilled professional assigning the HHA to patient. Applied compression stockings without a physician order. HHA did not perform assigned tasks or identify a reason why the task was not performed as assigned.
- Services provided by HH aide: Aide did not document performed tasks as on POC and no reason why they were not completed; HHA documentation did not show completion of any of the assigned tasks; HHA documented NA for some of assigned tasks but no reason as to why not done; This occurred on many HHA notes and assigned tasks.

G808

- RN did not supervise an aide at least every 14 days for patients receiving hands on personal care.
- On site supervisory visit every 14 days- visits not occurring. Patient was initially HHA only case and SN visits for injection were added. Agency did not increase the frequency of Supervisory Visits with the addition of SN to the services.
- On site supervisory visit every 14 days: visits not occurring.
- Failure to supervise HH aide services at least every 14-days.
- HHA Supervision every 14 days.

G814

- RN did not conduct onsite visit at least every 60 days to observe HHAs performing cares.

- Non-skilled direct observation of HHA every 60 days: RN did not make onsite visit at least every 60 days to observe ALL HHAs performing cares.
- Agency failed to ensure a RN completed home health aide supervision at least every 60 days while observing each HH aide present and providing direct patient care for patients.
- HHA supervision at least every 60 days.

G818

- Failure to ensure supervision of HHAs by RNs maintained documentation of a review of all supervisory elements; put patients' personal care needs at risk.
- Failure to complete HH aide supervision every 60 days with no skilled services.
- Failure to complete all components of home health aide supervision every 14 days with skilled services and 60 days with no skilled services. Failed to assess infection control, honoring patient rights, open communication, ability to report changes in patient skin.

G848

- Compliance with Federal, State, and Local Law: Background check done three days after staff's hire date; Some background checks done up to ten days after hire date.
- Agency allowed multiple employees to work without completing the required dependent adult abuse and child abuse background check.

G1008

- Agency failed to maintain all patient documentation in agency's primary home health office ant to maintain accurate, complete clinical records, failed to include all interventions, including medication administration, treatments, and services and responses to those interventions, failed to complete transfer summaries and send to the physician caring for the patient at the inpatient facility within two business days, failed to complete discharge summaries and send to the physician and any other health care professional caring for the patient upon the patient's home health discharge.

G1014

- Failed to ensure clinical record contained complete wound assessments. Skilled visit notes not locked within agency policy window. Agency failed to complete a thorough assessment of patient wound.
- Documentation of wound by LPN that RN was unaware of; no orders from physician for care; no communication notes; no documentation of patient's wound being infected

G1022

- Failure to send a discharge summary to the physician and other HC professionals.
- Discharge and Transfer Summaries- failed to send to physician within required time frame (17 days late).
- Agency failed to complete and send a transfer summary to the physician caring for the patient at the inpatient facility after transfer within two business days.
- Failure to complete and send a transfer summary to physician caring for the patient at the inpatient facility after transfer within two business days of the patient's transfer. No evidence of transfer summary sent to hospital physician.
- Discharge and transfer summaries: Transfer summary lacked components of date of client's admit, services being provided, and meds. Date of DC summary was prior to actual DC date and lacked components such as admit date, services provided, meds; clinical record lacked documentation of when the dc summary was sent to provider

- Agency did not send transfer summaries to other facilities when transferred only to physician office. No documentation to support DC summary was sent to physician.
- Failure to send physician and other facilities summary of patients care.

G1024

- Agency policy states documentation will be completed on site during the visit whenever safe, if unable the clinician will complete the documentation within five days. Several charts were electronically signed past the five days. PT/OT notes provided signature of therapist but lacked time of signature. DRR had signature of author but lacked time of signature. Aide care plan was stored electronically without signature, credentials, or time of the author.
- Agency failed to ensure authentication of handwritten entries made in each patient's clinical record included the employee's signature, title, date and time of the signature.
- No time with signatures; All visit notes both for SN and HHA services lacked a time of completion with electronic signature. Therapy notes without time of completion; physician order with handwritten signature lacked time of signature; MV note lacked time of signature.
- No authentication of medical record.

E 009

- Emergency preparedness plan lacked policy and procedures for cooperation and collaboration with local, tribal, regional, state, and federal emergency.

E 017

- Failed to ensure each patient received a copy of the Emergency Preparedness Plan.
- Failed to ensure each patient received a copy of the Emergency Preparedness Plan included as part of the comprehensive assessment.
- Agency Comprehensive Assessment in Disaster: Failed to assess emergency preparedness needs of the patient with each comprehensive assessment.
- Agency failed to ensure the clinical record included an assessment of the emergency plan as part of all comprehensive assessments
- Agency completed emergency preparedness plan, left yellow copy at patient's home, the white copy was placed in the patient's clinical record and the plan was documented in the comprehensive assessment. Plan lacked policy/procedure for individualized emergency.
- Patient didn't have completed patient individualized emergency plan in the home- it was blank. Recert comprehensive assessment had a place to document on Emergency Preparedness but was blank; assessment lacked documentation of review of emergency plan home folder; blank patient emergency plans- the agency had in electronic version but not in hard copy in patient's home. Also not documenting the review of the plan with the patient at time of comprehensive assessment.

E 019

- Homebound HHA/Hospice inform EP Officials: No written P & P for notification of appropriate agencies and officials of homebound patients in need of evac due to an emergency.
- Homebound HHA/Hospice Inform EP Officials (must inform state and local emergency preparedness officials about patients in need of evacuation…based on patient's medical and psychiatric condition and home environment. agency policy and procedure lacked specific reference to homebound patients.

E 021

- Agency failed to have procedures in place to inform State/local officials of any on duty staff/patients that they are unable to contact in the event of an interruption of services related to an emergency.
- Failure to have procedures in place to inform state/local officials of any on duty staff and patients they are unable to contact in the event of an emergency.
- Need to specify f/u with on-duty staff and pts that are unable to be contacted. Also cited that the agency policy didn't include surrounding hospitals or nursing homes the agency has an arrangement with to ensure continuity of care.

E 023

- Policies and Procedures for Medical Documentation: Agency failed to identify the process for protection of patient documentation and process to keep information from unauthorized access should an emergent situation occur.

E 024

- Agency's emergency preparedness plan didn't include policies and procedures to address use of volunteers or other emergency staffing strategies during an emergency. Placed patients at risk for not having help to meet safety and health care needs in the event of a natural or manmade disaster. Administrator reported not having any volunteers.

E 031

- Emergency Officials contact info: No P & P for cooperation and collaboration with tribal regional, state, and federal emergency preparedness officials

E 037

- EP Training Program: Agency failed to ensure initial/annual training to all staff.
- Agency failed to ensure training in emergency preparedness for all staff, including individuals providing services under arrangement. Two hired staff and one OT under contract had not completed the training.
- Failure to ensure emergency preparedness training to all existing staff consistent with their expected roles for directed hired and contracted staff for a period of one year.
- EP training program- all staff trained on hire/annually. Failure to train contracted staff.
- EP Training Program. All agency staff (existing, staff employed under arrangement of contract) didn't have evidence of annual training on EP.

E 039

- Testing requirements: No analysis of agency's response was completed with the drills that were performed
- Facilities must conduct exercises to test EP at least annually. Failure to document any training exercises in 2018.
- EP Testing Requirements. Must have documented an annual full-scale testing and one additional exercise that may be full-scale or a tabletop. Agency only had 1 event documented per year.