Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number** 034509	**(X3) Date Survey Completed** 05/23/2019
Name of Provider or Supplier Vital Care Rehabilitation, Llc	**Street Address, City, State** 14545 West Grand Avenue, Suite 108, Surprise, AZ	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	**Summary Statement of Deficiencies** (Each deficiency should be preceded by full regulatory or LSC identifying information)
E0000	The facility must meet all applicable Federal, State, and local emergency preparedness requirements as outlined in the Medicare and Medicaid Programs: Emergency Preparedness Requirements of Medicare and Medicaid Participating Providers and Suppliers Final Rule (81 FR 63860) September 16, 2016. This is a Recertification Survey for Medicare, and was surveyed on 5/23/19. The facility meets the Standards, based upon compliance with acceptance of a plan of correction. The following Condition and Standard level deficiencies were found during the survey.
E0001	Establishment of the Emergency Program (EP) CFR(s): 485.68 403.748, 416.54, 418.113, 441.184, 460.84, 482.15, 483.73, 483.475, 484.102, 485. 68, 485.542, 485.625, 485.727, 485.920, 486.360, 491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) * [For hospitals at 482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the

	requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: * [For CAHs at 485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This CONDITION is not met as evidenced by: Based on review of facility documents/ policy and procedure and staff interview, it was determined the facility failed to (E004) ensure the Emergency Preparedness plan was updated and reviewed annually, which increases the potential risk that staff are not adequately prepared to respond to an emergency effectively and safely in the event of an emergency. The cumulative effect of this systematic deficient practice resulted in the agency's failure to meet the requirement for the Condition of Participation for Establishment of the Development of an Emergency Preparedness Plan, which poses a potential risk to the health and safety of patients and staff related to potential harm if staff and patients are not aware of what to do during an emergency situation.
E0004	Develop EP Plan, Review and Update Annually CFR(s): 485.68(a) 403.748(a), 416.54(a), 418.113(a), 441.184(a), 460.84(a), 482.15(a), 483.73(a), 483.475(a), 484.102(a), 485.68(a), 485.542(a), 485.625(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at 482.15 and CAHs at 485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at 483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at 494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is not met as evidenced by: Based on review of facility policy/procedure and staff interview, it was determined the facility failed to ensure the Emergency Preparedness plan was updated and reviewed annually, which is a CORE requirement with EP and increases the potential risk that staff are not adequately prepared to respond to an emergency effectively and safely in the event of an emergency.

	Findings incude: Facility policy, "Emergencies and Disasters - #803 Disaster Plan" revealed: "... Analysis/Review/Evaluation...The Administrator will evaluate the Plan annually for its performance, scope and effectiveness with the assistance of qualified fired [sic], safety and other appropriate experts. The results of this evaluation will be provided to the Governing Body...." Policy #803 was signed by Employee #2. There was no date of signature on the document. The policy was last reviewed 08/01/2016. The Facility Administrator confirmed on 5/23/19, the Governing Body did not review the Emergency Plan on an annual basis.
E0009	Local, State, Tribal Collaboration Process CFR(s): 485.68(a)(4) 403.748(a)(4), 416.54(a)(4), 418.113(a)(4), 441.184(a)(4), 460.84(a)(4), 482.15(a)(4), 483.73(a)(4), 483.475(a)(4), 484.102(a)(4), 485.68(a)(4), 485.542(a)(4), 485.625(a)(4), 485.727(a)(5), 485.920(a)(4), 486.360(a)(4), 491.12(a)(4), 494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. 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. * * [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. 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 review of facility documents, EP plan and staff interview, it was determined the facility failed to require staff collaborate with local, tribal, regional, State and Federal EP officials to ensure that the facility has the appropriate resources during an emergency. Findings include: The EP plan given to the surveyor to review on 5/23/19, did not address the requirement to collaborate with the appropriate EP officials. The Facility Administrator confirmed on 5/23/19, their EP plan did not address the requirement to collaborate with the appropriate EP officials.
E0034	Information on Occupancy/Needs CFR(s): 485.68(c)(5) 403.748(c)(7), 416.54(c)(7), 418.113(c)(7) 441.184(c)(7), 482.15(c)(7), 460.84(c)(7), 483.73(c)(7), 483.475(c)(7), 484.102(c)(6), 485.68(c)(5), 485.68(c)(5), 485.727(c)(5), 485.542(c)(7), 485.625(c)(7), 485.920(c)(7), 491.12(c)(5), 494.62(c)(7). [(c) The

	[facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54 (c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at 418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This STANDARD is not met as evidenced by: Based on review of facility policy/procedure and staff interview, it was determined the facility failed to provide information about the facility's occupancy needs and its ability to provide assistance in the event of an emergency. Failure to disclose information about the facility to the appropriate agencies increases the potential risk that patients are at risk of harm if the facility does not have the resources to execute a safe emergency response. Findings include: The surveyor reviewed the facilities EP plan which did not include the requirement for the facility to disclose their occupancy needs as well as their ability to provide assistance to other facilities in the event of an emergency. The Facility Administrator confirmed during an interview on 5/23/19, that the facility failed to implement occupancy needs as required per the Conditions for Coverage.
I0000	No deficiencies were found during the unannounced, on-site Medicare Recertification Survey conducted on 5/23/19.