Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	034523	08/27/2018
Name of Provider or Supplier	**Street Address, City, State**	
Advanced Medical Therapy, Llc	15640 North 7th Street, Suite 6, Phoenix, 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	42 CFR 485.51 Comprehensive Outpatient Rehabilitation Facilities (CORF) 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 8/27/18. The following Condition level 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, an interview with the facility administrator it was determined, the facility failed to

(E-0004) ensure that this CORF had developed, documented and implemented an Emergency Plan that was to be reviewed and updated at least annually. Failure to have an established Emergency plan poses the high potential risk that the health and safety of patients and staff will be compromised in the event an Emergency situation occurs if staff are not knowledgeable of what to do during an emergency situation;

(E-0006) perform community and facility risk assessments as part of developing the facility's emergency plan;

(E-0007) ensure within an Emergency Preparedness plan that they incorporated documentation to include the needs of the patient population they serve or a delegation of authority as part of the continuity of operations. Failure to develop a continuity plan involving the patient population which includes delegation of authority and succession plans may cause disruption of services to patients/clients during an emergency which could lead to harm;

(E-0011) develop and maintain a EP plan with assistance from fire, safety, and other appropriate experts that must be reviewed and updated at least annually. Failure to develop and maintain an emergency preparedness plan could lead to harm to both patients and staff.

(E-0013) develop Emergency Preparedness policies and procedures based on an established EP plan, community risk assessment and communication plan, and the policies and procedures were not reviewed and updated at least annually;

(E-0020) have policies and procedures for safe evacuation from the facility including consideration of care needs of evacuees, staff responsibilities, transportation, identification of evacuation location(s), and primary and alternate means of communication with external sources of assistance. Failure to include a process for cooperation and collaboration could lead to harm to both patients and staff;

(E-0022) develop and implement a policy and procedure for sheltering in place during an emergency. Failure to adequately shelter in place during an emergency could lead to harm to both patients and staff;

(E-0023) develop and implement EP plan policy and procedures for the use of volunteers in an emergency. Failure to address the use of volunteers in an emergency could adversely impact patient care during an emergency.

(E-0024) develop and implement a policy and procedure for the use of volunteers in an emergency. Failure to address the use of volunteers in an emergency could

	adversely impact patient care during an emergency; (E-0029) develop a written emergency communications plan that contained how the facility coordinates patient care within the facility, across the healthcare providers and with state and local public health departments, and emergency management systems. Failure to develop a written emergency communications plan poses the high potential risk that all staff working in the facility will not be aware of their role expectations during any type of emergency that is encountered at the facility, which is a health and safety risk for their patients, as needed information may not be able to be transmitted or received; (E-0030) develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. Failure to have an emergency preparedness communication plan could lead to harm to both patients and staff. (E-0031) develop an emergency official's contact list. Failure to have an emergency official's contact list during an emergency could lead to harm to both patients and staff. (E-0032) have a primary and alternate means of communication during an emergency. Failure to have a primary and alternate means of communication during an emergency could lead to harm to both patients and staff; (E-0033) develop and implement a method for sharing information and medical documentation for patients under the CORF'S care, as necessary, with other health care providers to maintain the continuity of care. (E-0034) develop a means to sharing information on occupancy, needs, and its ability to provide assistance to the authority having jurisdiction. Failure to develop a means to report occupancy levels and/or needs may result in resident's not receiving care and services as needed. (E-0036) develop a facility based emergency planning, training and testing program. Failure to provide facility based training and testing tailored to the Emergency Plan may lead to untrained staff in an emergency situation and may result in harm to the patients during an emergency; and (E-0039) conduct exercises to test an emergency plan at least annually. Failure to conduct exercises to test the emergency plan could lead to harm to both patients and staff. The cumulative effect of these systematic deficient practices resulted in the facility's failure to meet the requirement for the Condition of Participation for Establishment of the Development of an Emergency Preparedness Plan, which poses a high 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 documents, an interview with the facility administrator it was determined, the facility failed to ensure that this CORF had developed, documented and implemented an Emergency Plan that was to be reviewed and updated at least annually. Failure to have an established Emergency plan poses the high potential risk that the health and safety of patients and staff will be compromised in the event an Emergency situation occurs if staff are not knowledgeable of what to do during an emergency situation. Findings include: Surveyors requested a copy of the facility Emergency Plan. Administrator stated: "They do not have an emergency plan developed with local fire department ." The Officer Coordinator/Acting Administrator confirmed during an exit conference on 8/27/18, that the facility failed to develop an Emergency Plan that was to be reviewed and updated annually.
E0006	Plan Based on All Hazards Risk Assessment CFR(s): 485.68(a)(1)-(2) 403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 460.84(a)(1)-(2), 482.15(a)(1)-(2), 483.73(a)(1)-(2), 483.475(a)(1)-(2), 484.102(a)(1)-(2), 485.68(a)(1)-(2), 485.542(a)(1)-(2), 485.625(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) [(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 the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at 418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. 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. (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. *[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. 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, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at 483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. 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, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This STANDARD is not met as evidenced by: Based on review of the facility Emergency Plan, record review and staff interview, it was determined, the facility failed to develop a community-based risk assessment utilizing an all-hazards approach prior to developing the facility's emergency plan. Failure to develop emergency plans based on community-based risk assessment may cause harm to the patients and staff during an emergency if the needs of the community are not assessed and identified in the plan. Findings include: The surveyor and the Office Coordinator/Acting Administrator reviewed the facility's Emergency Plan on August 27, 2018. The plan did not include a community-based risk assessment in the development of the facility's plan. The Office Coordinator/Acting Administrator confirmed during an exit conference on August 27, 2018, the Emergency Plan did not include a community-based risk assessment.
E0007	EP Program Patient Population CFR(s): 485.68(a)(3) 403.748(a)(3), 416.54(a)(3), 418.113(a)(3), 441.184(a)(3), 460.84(a)(3), 482.15(a)(3), 483.73(a)(3), 483.475(a)(3), 484.102(a)(3), 485.68(a)(3), 485.542(a)(3), 485.625(a)(3), 485.727(a)(3), 485.920(a)(3), 491.12(a)(3), 494.62(a)(3). [(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 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.** *[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. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC 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 record review and staff interview, it was determined the facility failed to ensure within their Emergency Preparedness plan that they incorporated documentation to include the needs of the patient population they serve or a delegation of authority as part of the continuity of operations. Failure to develop a continuity plan involving the patient population which includes delegation of authority and succession plans may cause disruption of services to patients/clients during an emergency which could lead to harm. Findings include: The Office Coordinator/Acting Administrator reviewed the facility's Emergency Preparedness Plan with the surveyor on August 27, 2018. The facility was unable to locate any documentation addressing the needs of the patient population or a delegation of authority within the current written plan . The Office Coordinator/Acting Administrator confirmed during an interview on August 27, 2018, the facility did not have documentation addressing the needs of the patient population or a delegation of authority within the current written plan.
E0011	CORF/Clinic Development and Fire Safety CFR(s): 485.68(a)(5) 485.68(a)(5) Condition for Participation: [(a) Emergency Plan. The Comprehensive Outpatient Rehabilitation Facility (CORF) must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (a)(5) Be developed and maintained with assistance from fire, safety, and other appropriate experts. 485.727(a)(6) Condition for Participation: [(a) Emergency Plan. The Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services ("Organizations") must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (a)(6) Be developed and maintained with assistance from fire, safety, and other appropriate experts. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined, the facility failed to ensure their emergency preparedness plan be developed and maintained with assistance from fire, safety, and other appropriate experts that must be reviewed and updated at least annually. Failure to include develop and maintain an emergency preparedness plan with assistance from fire, safety, and other appropriate experts could lead to harm to both patients and staff if appropriate input from the experts is not included. Findings include: The surveyors requested documentation from the Office Coordinator on 8/27/18, that demonstrated their emergency preparedness plan was developed and maintained with assistance from fire, safety, and other appropriate experts.

	The Office Coordinator acknowledged on August 27, 2018, that they did not have documentation to show an emergency preparedness plan was developed and maintained with assistance from fire, safety, and other appropriate experts.
E0013	Development of EP Policies and Procedures CFR(s): 485.68(b) 403.748(b), 416.54(b), 418.113(b), 441.184(b), 460.84(b), 482.15(b), 483.73(b), 483.475(b), 484.102(b), 485.68(b), 485.542(b), 485.625(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b). (b) Policies and procedures. [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 every 2 years. *[For LTC facilities at 483.73(b):] Policies and procedures. The LTC facility 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. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at 460.84(b):] Policies and procedures. The PACE organization 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 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at 494.62(b):] Policies and procedures. The dialysis facility 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 every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This STANDARD is not met as evidenced by: Based on review of the facility Emergency plan, record review and staff interview, it was determined the facility failed to develop and implement emergency preparedness policies and procedures, based on the Emergency Plan. Failure to develop policies and procedures during an emergency could cause harm to staff and patients if staff are not informed of what is required by them during an emergency. Findings include: The Officer Coordinator/Acting Administrator and the surveyor reviewed the Emergency Plan on August 27, 2018. The plan did not include emergency preparedness policies and procedures, based on the Emergency Plan.

	The Officer Coordinator/Acting Administrator confirmed during an exit conference on August 27, 2018, that the Emergency Plan did not include emergency preparedness policies and procedures, based on the Emergency Plan.
E0020	Policies for Evac. and Primary/Alt. Comm. CFR(s): 485.68(b)(1) 403.748(b)(3), 416.54(b)(2), 418.113(b)(6)(ii), 441.184(b)(3), 460.84(b)(3), 482.15(b)(3), 483.73(b)(3), 483.475(b)(3), 485.68(b)(1), 485.542(b)(3), 485.625(b)(3), 485.727(b)(1), 485.920(b)(2), 491.12(b)(1), 494.62(b)(2) [(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 every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCIs at 403.748(b)(3) and ASCs at 416.54(b)(2) and REHs at 485.542(b)(3):] Safe evacuation from the [RNHCI or ASC or REHs] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at 485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at 485.727(b)(1), and ESRD Facilities at 494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at 491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This STANDARD is not met as evidenced by: Based on review of the facility Emergency plan, record review and staff interview, it was determined the facility failed to have policies and procedures for safe evacuation from the facility including consideration of care needs of evacuees, staff responsibilities, transportation, identification of evacuation location(s), and primary and alternate means of communication with external sources of assistance. Failure to include a process for cooperation and collaboration could lead to harm to both patients and staff. Findings include: The surveyor and the Officer Coordinator/Acting Administrator and reviewed the Emergency Plan on August 27, 2018. The plan did not include policies and procedures for safe evacuation from the facility including consideration of care needs of evacuees, staff responsibilities, transportation, identification of evacuation location (s), and primary and alternate means of communication with external sources of assistance. The Officer Coordinator/Acting Administrator confirmed during an exit conference on August 08, 2018, that the Emergency Plan did not include policies and procedures

	for safe evacuation from the facility including consideration of care needs of evacuees, staff responsibilities, transportation, identification of evacuation location(s), and primary and alternate means of communication with external sources of assistance.
E0022	Policies/Procedures for Sheltering in Place CFR(s): 485.68(b)(2) 403.748(b)(4), 416.54(b)(3), 418.113(b)(6)(i), 441.184(b)(4), 460.84(b)(5), 482.15(b)(4), 483.73(b)(4), 483.475(b)(4), 485.68(b)(2), 485.542(b)(4), 485.625(b)(4), 485.727(b)(2), 485.920(b)(3), 491.12(b)(2), 494.62(b)(3). (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 every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at 418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This STANDARD is not met as evidenced by: Based on review of the facility emergency plan, record review and staff interview, it was determined the facility failed to develop and implement a policy and procedure for sheltering in place during an emergency. Failure to adequately shelter in place during an emergency could lead to harm to both patients and staff. Findings include: The surveyor and the Officer Coordinator/Acting Administrator reviewed the facility's Emergency Plan on August 27, 2018. The Emergency Plan did not identify a process for sheltering patients and staff during an emergency. The facility verbally indicated they had processes's they could use, but did not have a process outlined in the Emergency Plan. The Officer Coordinator/Acting Administrator confirmed during an exit conference on August 27, 2018, the emergency plan at the facility did not identify a process for sheltering patients and staff during an emergency.
E0023	Policies/Procedures for Medical Documentation CFR(s): 485.68(b)(3) 403.748(b)(5), 416.54(b)(4), 418.113(b)(3), 441.184(b)(5), 460.84(b)(6), 482.15(b)(5), 483.73(b)(5), 483.475(b)(5), 484.102(b)(4), 485.68(b)(3), 485.542(b)(5), 485.625(b)(5), 485.727(b)(3), 485.920(b)(4), 486.360(b)(2), 491.12(b)(3), 494.62(b)(4). [(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 every 2 years [annually for LTC facilities]. At a

	minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at 403.748(b) and REHs at 485.542(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This STANDARD is not met as evidenced by: Based on review of the facility Emergency Plan and staff interview, it was determined the facility failed to develop and implement policy and procedures that address a system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. The policies and procedures failed to be reviewed and updated at least annually Findings include: The surveyor and the Officer Coordinator/Acting Administrator reviewed the facility's Emergency Plan on August 27, 2018. The plan did not include policies and procedures to address a system of medical documentation that preserved patient information, protected confidentiality of patient information, and secured and maintained availability of records. The Officer Coordinator/Acting Administrator confirmed on August 27, 2018, the facility Emergency Plan did not include policies and procedures to address a system of medical documentation.
E0024	Policies/Procedures-Volunteers and Staffing CFR(s): 485.68(b)(4) 403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 460.84(b)(7), 482.15(b)(6), 483.73(b)(6), 483.475(b)(6), 484.102(b)(5), 485.68(b)(4), 485.542(b)(6), 485.625(b)(6), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5). [(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 every 2 years [annually for LTC facilities]. 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 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 review of the facility Emergency Plan, and staff interview, it was determined the facility failed to develop and implement policies and procedures for the use of volunteers in an emergency. Failure to address the use of volunteers in an emergency could adversely impact patient care during an emergency. Findings include: The Office Coordinator reviewed the facility's Emergency Plan with the surveyor on August 27, 2018. The plan did not include policies and procedures to address the use of volunteers in an emergency. The Office Coordinator confirmed on August 27, 2018, the facility Emergency Plan did not include policies and procedures to address the use of volunteers in an emergency.
E0029	Development of Communication Plan CFR(s): 485.68(c) 403.748(c), 416.54(c), 418.113(c), 441.184(c), 460.84(c), 482.15(c), 483.73(c), 483.475(c), 484.102(c), 485.68(c), 485.542(c), 485.625(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c). (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]. This STANDARD is not met as evidenced by: Based on review of the facility Emergency Plan, facility record review, and interview, it was determined the facility failed to develop and implement emergency preparedness Communication Plan that complies with Federal, Sate, and local laws and must be reviewed and updated at least annually. Failure to develop a Communication Plan could delay the process for treatment of patients and staff during an emergency. Findings include: The Officer Coordinator/Acting Administrator and the surveyor reviewed the facility's Emergency Plan on August 27, 2018. The plan did not include emergency preparedness Communication Plan that complies with Federal, Sate, and local laws and must be reviewed and updated at least annually. The Officer Coordinator/Acting Administrator confirmed during the exit conference on August 27, 2018, the facility Emergency Plan did not include emergency preparedness Communication Plan that complies with Federal, Sate, and local laws and must be reviewed and updated at least annually.
E0030	Names and Contact Information CFR(s): 485.68(c)(1) 403.748(c)(1), 416.54(c)(1), 418.113(c)(1), 441.184(c)(1), 460.84(c)(1), 482.15(c)(1),

483.73(c)(1), 483.475(c)(1), 484.102(c)(1), 485.68(c)(1), 485.542(c)(1), 485.625(c)(1), 485.727(c)(1), 485.920(c)(1), 486.360(c)(1), 491.12(c)(1), 494.62(c)(1). [(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:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at 482.15(c) and CAHs at 485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at 403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at 416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at 418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at 484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at 486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).

This STANDARD is not met as evidenced by:
Based on review of the facility Emergency Plan (EP) record review, and staff interview, it was determined the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must include contact information related to staff, entities providing services under arrangement, next of kin, guardian or custodian, other facilities and volunteers be reviewed and updated at least annually. Failure to have an emergency preparedness communication plan that includes specific information could lead to harm to both patients and staff.

Findings include:

The surveyor, the Office Coordinator reviewed the facility's Emergency Plan. The Emergency Plan did not emergency preparedness communication plan that included contact information related to staff, entities providing services under arrangement, next of kin, guardian or custodian, other facilities and volunteers is reviewed and at least update annually.

The Office Coordinator confirmed on August 27, 2018, the EP plan did not identify an emergency preparedness communication plan that included contact information related to staff, entities providing services under arrangement, next of kin, guardian or custodian, other facilities and volunteers, and was not reviewed annually.

E0031	Emergency Officials Contact Information CFR(s): 485.68(c)(2) 403.748(c)(2), 416.54(c)(2), 418.113(c)(2), 441.184(c)(2), 460.84(c)(2), 482.15(c)(2), 483.73(c)(2), 483.475(c)(2), 484.102(c)(2), 485.68(c)(2), 485.542(c)(2), 485.625(c)(2), 485.727(c)(2), 485.920(c)(2), 486.360(c)(2), 491.12(c)(2), 494.62(c)(2). [(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: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at 483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at 483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This STANDARD is not met as evidenced by: Based on review of the facility Emergency Plan (EP) record review, and staff interview, it was determined the facility failed to develop a emergency officials contact list. Failure to have an emergency official's contact list during an emergency could lead to harm to both patients and staff if staff do not know who to contact if the need arises. Findings include: The surveyor and the Office Coordinator reviewed the facility's Emergency Plan. The Emergency Plan did not identify an emergency official's contact list. The Office Coordinator confirmed on August 27, 2018, the EP plan did not identify an emergency official's contact list.
E0032	Primary/Alternate Means for Communication CFR(s): 485.68(c)(3) 403.748(c)(3), 416.54(c)(3), 418.113(c)(3), 441.184(c)(3), 460.84(c)(3), 482.15(c)(3), 483.73(c)(3), 483.475(c)(3), 484.102(c)(3), 485.68(c)(3), 485.542(c)(3), 485.625(c)(3), 485.727(c)(3), 485.920(c)(3), 486.360(c)(3), 491.12(c)(3), 494.62(c)(3). [(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: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at 483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This STANDARD is not met as evidenced by: Based on review of the facility Emergency Plan (EP), record review, and staff

	interview, it was determined the facility failed to have a primary and alternate means of communication during an emergency. Failure to have a primary and alternate means of communication during an emergency could lead to harm to both patients and staff. Findings include: The surveyor and the Officer Coordinator/Acting Administrator reviewed the facility's Emergency Plan on August 27, 2018. The Emergency Plan did not identify a primary and alternate means of communicating with the CORF staff or Federal, State, tribal, regional, and local emergency management agencies during an emergency. The facility indicated in the communication plan to have a primary and alternate means of communication, but no documentation of the actual items outlined in the Emergency Plan. The Officer Coordinator/Acting Administrator confirmed during the exit conference on August 27, 2018, the facility EP did not identify a primary and alternate means of communicating with the CORF staff or Federal, State, tribal, regional, and local emergency management agencies during an emergency.
E0033	Methods for Sharing Information CFR(s): 485.68(c)(4) 403.748(c)(4)-(6), 416.54(c)(4)-(6), 418.113(c)(4)-(6), 441.184(c)(4)-(6), 460.84(c)(4)-(6), 441.184(c)(4)-(6), 460.84(c)(4)-(6), 482.15(c)(4)-(6), 483.73(c)(4)-(6), 483.475(c)(4)-(6), 484.102(c)(4)-(5), 485.68(c)(4), 485.542(c)(4)-(6), 485.625(c)(4)-(6), 485.727(c)(4), 485.920(c)(4)-(6), 491.12(c)(4), 494.62(c)(4)-(6). [(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: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under 484.102(c), CORFs under 485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at 403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at 491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This STANDARD is not met as evidenced by: Based on review of the facility Emergency Plan, facility record review, and interview, it was determined the facility failed to develop and implement a method for sharing information and medical documentation for patients under the CORF'S care, as necessary, with other health care providers to maintain the continuity of care. Findings include:

	The Office Coordinator/Acting Administrator and the surveyor reviewed the facility's Emergency Plan on August 27, 2018. The plan did not include a method for sharing information and medical documentation for patients under the CORF'S care, as necessary, with other health care providers to maintain the continuity of care. The Office Coordinator/Acting Administrator confirmed on August 27, 2018, the facility Emergency Plan did not include a method for sharing information and medical documentation for patients under the CORF'S care, as necessary, with other health care providers to maintain the continuity of care.
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 the Emergency Plan (EP), record review, and staff interview, it was determined the facility failed to develop a means to sharing information on occupancy, needs, and it's ability to provide assistance to the authority having jurisdiction. Failure to develop a means to report occupancy levels and/or needs may result in residents not receiving care and services as needed. Findings include: The Officer Coordinator/Acting Administrator and the surveyor reviewed the facility's Emergency Plan on August 27, 2018. The Emergency Plan did not include a method to share occupancy levels and/or facility needs to other facilities or to the authority having jurisdiction or the Incident Command Center. The Officer Coordinator/Acting Administrator confirmed during the exit interview on August 27, 2018 the EP plan for the facility did not include a method to share occupancy levels and/or facility needs to other facilities or to the authority having jurisdiction or the Incident Command Center.
E0036	EP Training and Testing CFR(s): 485.68(d) 403.748(d), 416.54(d), 418.113(d), 441.184(d), 460.84(d), 482.15(d), 483.73(d), 483.

	475(d), 484.102(d), 485.68(d), 485.542(d), 485.625(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d). *[For RNCHIs at 403.748, ASCs at 416.54, Hospice at 418.113, PRTFs at 441.184, PACE at 460.84, Hospitals at 482.15, HHAs at 484.102, CORFs at 485.68, REHs at 485.542, CAHs at 486.625, "Organizations" under 485.727, CMHCs at 485.920, OPOs at 486.360, and RHC/FHQs at 491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at 483.73 (d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at 483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at 483.470(i). *[For ESRD Facilities at 494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This STANDARD is not met as evidenced by: Based on review of the facility Emergency Preparedness Plan, and staff interview, it was determined the facility failed to develop a facility based emergency planning, training and testing program. Failure to provide facility based training and testing tailored to the Emergency Plan may lead to untrained staff in an emergency situation and may result in harm to the patients during an emergency. Finding include: The surveyor and the Officer Coordinator/Acting Administrator reviewed the facility's Emergency Plan (EP) on August 27, 2018. The plan did not include facility based training and testing for staff based on the Emergency Plan, facility risk assessment and the communications plan. The Officer Coordinator/Acting Administrator confirmed during an interview on August 27, 2018, the EP plan did not include facility based training and testing for staff based on the Emergency Plan, facility risk assessment and the communications plan.
E0039	EP Testing Requirements

CFR(s): 485.68(d)(2)

416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 460.84(d)(2), 482.15(d)(2), 483.73(d)(2), 483.475(d)(2), 484.102(d)(2), 485.68(d)(2), 485.542(d)(2), 485.625(d)(2), 485.727(d)(2), 485.920(d)(2), 491.12(d)(2), 494.62(d)(2). *[For ASCs at 416.54, CORFs at 485.68, REHs at 485.542, OPO, "Organizations" under 485.727, CMHCs at 485.920, RHCs/FQHCs at 491.12, and ESRD Facilities at 494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) 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 its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion 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 Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion 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 hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at 441.184(d), Hospitals at 482.15(d), CAHs at 485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 PACE at 460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at 483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, 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 [LTC facility] facility's response to and maintain

documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at 483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at 484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at 486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the 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. *[RNCHIs at 403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI 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 response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.

	This STANDARD is not met as evidenced by: Based on review of the facility Emergency Preparedness Plan, and staff interview, it was determined the facility failed to perform a Community-Based full scale exercise and conduct exercises to test the emergency plan at least annually. Failure to conduct exercises to test the emergency plan and failure to provide facility based training and testing tailored to the Emergency Plan may lead to untrained staff in an emergency situation and may result in harm to the patients during an emergency. Finding include: The surveyor and the Officer Coordinator/Acting Administrator reviewed the facility's Emergency Plan (EP) on August 27, 2018. The plan did not have a documented Community-Based full scale exercise for staff based on the Emergency Plan. The Officer Coordinator/Acting Administrator confirmed during an interview on August 27, 2018, the EP plan did not include annual facility based training and testing for staff based on the Emergency Plan.
I0000	The following deficiencies were found at the time of the Centers for Medicare and Medicaid (CMS) Recertification survey conducted on 08/27/18. The facility is non-compliant with 42 CFR Part 485 Subpart B, requirements for a Comprehensive Outpatient Rehabilitation Facility (CORF) due to the Condition Level citation related to Appendix Z.
I0503	LICENSURE OF PERSONNEL CFR(s): 485.54(b) Personnel that provide service must be licensed, certified, or registered in accordance with applicable state and local laws. This STANDARD is not met as evidenced by: Based on review of facility personnel records, and staff interviews, it was determined the facility failed to ensure that the behavioral health professional (BHP) was an employee or contracted employees of the facility. Failure to ensure the (BHP) providing clinical oversight is licensed per state and local laws presents a danger to patients and staff if personnel are not qualified to perform their job duties and to ensure proper care to patients. Findings include: Surveyor requested the personnel record for the BHP, who has been providing clinical oversight to a behavioral health technician (BHT). Surveyor requested a copy of a written contract for the BHP to be providing clinical oversight at this facility. The facility staff did not have a personnel record or contract for the BHP. The Office Coordinator/Acting Administrator confirmed during an interview on 08/27 /18, that the BHP was not employed or under contract with the facility.
I0585	MAINTENANCE

CFR(s): 485.62(c)(1)

The facility must establish a written preventive maintenance program to ensure that all equipment is properly maintained and equipment needing periodic calibration is calibrated consistent with the manufacturer's recommendations.

This STANDARD is not met as evidenced by:
Based on direct observation, review of policy and procedures, documents, and interviews, it was determined the facility failed to ensure the equipment and supplies within the CORF is safe for patient use; which poses a high potential risk that patients will receive care with unsafe equipment which could cause physical injury.

Findings include:

Direct observation during the tour on 08/27/18, revealed the following:

Review of policy and procedure titled "Hydrocollator" revealed: "The use of a hydrocollator is a heat modality for physical and occupational therapy treatment... Preparation of hydrocollator: 7. Once a month the units will be cleaned as follows: c. Pour or drain water completely...."

Review of the online Hydrocollator Heating Units Service and User Manual - Chattanooga Group (http://www.ersbiomedical.com/Manuals/chatt/Hydroc_svc_manu.pdf) recommended: "...1. Maintain 1 of 1 hydrocollator: Regularly clean and drain the tank (every two weeks)...."

Review of document titled "Hydrocollator Temperature Log - Cervical" for Chattanooga E-2 Hydrocollator located in the Physical Therapy Gym revealed the cleaning was not completed/documented every 2 weeks per manufactures guidelines. Equipment was cleaned April 4, 2018, June 08, 2018 and June 25, 2018, July 20, 2018, August 10, 2018 and August 24, 2018. There was no documented cleaning for May 2018 and February 2018, and not every two weeks as required

Review of the online Hydrocollator Heating Units Service and User Manual - Chattanooga Group (http://www.ersbiomedical.com/Manuals/chatt/Hydroc_svc_manu.pdf) recommended: "...1. Maintain 1 of 1 hydrocollator: Regularly clean and drain the tank (every two weeks)...."

Review of document titled "Hydrocollator Temperature Log - Lumbar" for Chattanooga M-2 Hydrocollator located in the Physical Therapy Gym revealed that the cleaning was not completed/documented every 2 weeks per manufactures guidelines. Equipment was cleaned on April 4, 2018, June 08, 2018 and June 25, 2018, July 20, 2018, August 10, 2018 and August 24, 2018 with no documented cleaning in May 2018. Cleaning was not completed/documented in February 2018.

The Office Coordinator /Acting Administrator confirmed during an interview on 08/27/18, the facility was not following manufactures guidelines for Hydroculator's cleaning every 2 weeks as required.