Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	034523	08/10/2021
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	The following deficiencies were found at the time of the unannounced on-site Medicare Recertification survey conducted August 10, 2021.
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:

REPECT CITATION

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-0009) include a documented process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials. Failure to include a process for cooperation and collaboration 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 sheltering in place during an emergency could lead to harm to both patients and staff;

(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-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-0034) 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. (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; (E-0037) have documentation of new and existing staff trained in an Emergency Preparedness Plan. 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.
I0000	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 8/10/2021. The following Condition level and Standard level deficiencies were found during the survey.
I0510	ADMINISTRATOR CFR(s): 485.56(b)(3) The governing body must appoint an administrator who designates, in writing, an individual who, in the absence of the administrator, acts on behalf of the administrator. This STANDARD is not met as evidenced by: Based on a review of facility policy and procedure, and staff interview, it was determined the facility failed to appoint in writing the individual who is the Administrator for the licensed facility, which increases the potential risk of the

	facility, failing to have overall management of the facility under the authority delegated by the governing body. Findings include: Review of facility policy "Comprehensive Outpatient Rehabilitation Facility: Policy and Procedure Manual" revealed: "...Designates, in writing, an individual who is the Administrator ...." A review of facility documentation revealed the facility failed to appoint in writing the individual who is the Administrator of the licensed facility. Employee #6, verified in interview on 08/10/2021, the facility failed to designate in writing the appointed Administrator for the licensed facility.
I0517	INSTITUTIONAL BUDGET PLAN CFR(s): 485.56(d)(2) The institutional budget plan must provide for an annual operating budget prepared according to generally accepted accounting principles; a 3-year capital expenditure plan if expenditures in excess of $100,000 are anticipated, for that period, for the acquisition of land; the improvement of land, buildings and equipment; and the replacement, modernization, and expansion of buildings and equipment; and annual review and updating by the governing body. This STANDARD is not met as evidenced by: Based on facility policy and procedures, facility documentation review and staff interview and it was determined the facility failed to update at least annually the facility's intuitional budget for operation of the facility. Failure to at least annually prepare an operational budget may affect the operation of the facility, which could affect the treatment of patients. Findings include: Review of the policy "Financial Policy" revealed: " ...there shall be an annual operating budget that shall include all anticipated income and expenses ...." Facility documentation review revealed the facility last operational budget was updated by the governing board on August 2018. A request was made for an updated budget. None was provided. Employee #6 confirmed on 08/10/2021, the facility failed at least annually update the facility's intuitional budget for operations.
I0532	COMPREHENSIVE REHABILITATION PROGRAM CFR(s): 485.58 The facility must provide a coordinated rehabilitation program that includes, at a minimum, physicians' services, physical therapy services and social or psychological services. The services must be furnished by personnel that meet the qualifications set forth in 485.70 and must be consistent with the plan of treatment and the results of comprehensive patient assessments.

	This CONDITION is not met as evidenced by: Based on review of facility documents and interview with staff, it was determined that the Governing Body failed to ensure the facility provides a coordinated rehabilitation program that includes social or psychological services, which has the potential risk of patients not receiving needed services in a timely manner. This is cited at a Condition Level. Finding include: Review of the facility's personnel records revealed, the facility does not employee or contract a professional that provides social or psychological. An interview on 08/10/2021, with Employee #6 revealed the licensed facility has not had a professional that provides social or psychological services since June 2021. Employee #6, verified on 08/10/2021, the facility failed to ensure the condition of participation regarding the licensed facility employing or contracting with a professional that provides social or psychological services.