Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	034525	08/07/2018
Name of Provider or Supplier	**Street Address, City, State**	
Saguaro Rehabilitation And Aquatic Therapy, Llc	305 North Plaza Drive, Apache Junction, 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 08/01/18 and 08 /02/18, with a telephone exit on 8/7/18. 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-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 situtation.
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: " The fire department has the emergency plan for the facility." Surveyors met with local fire department officials at the facility, and it was determined that they did not have the facility's Emergency Plan. The Executive Director confirmed during an exit conference on 8/7/18, that the facility failed to develop an Emergency Plan that is 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 facility record review, and interview and it was determined the facility failed to perform a community based risk assessments as part of developing the facility's emergency plan (EP). Failure to develop emergency plans based on a community-based risk assessment may cause harm to the patients and staff during an emergency if . Findings include: On 8/1/18 the surveyors, along with the Executive Director reviewed the EP tag requirements to be included in an EP plan. Since the facility did not have a documented EP, the surveyors could not determine if risk assessments for the community or the facility were completed. The Executive Director confirmed on 8/1 and 8/2/18 that there was no EP plan developed that included a risk assessment for the community or for the facility. Failure to develop emergency plans based on community and facility risk assessments may cause harm to the patients during an emergency.
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 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. Findings include: The Executive Director was unable to locate any documentation addressing the needs of the patient population or a delegation of authority when the surveyors requested all documentation related to the facility EP plan on 8/1/18 and 8/2/18. The Executive Director confirmed during an interview on 8/1/18 and 8/2/18, the facility did not have documentation addressing the needs of the patient population or a delegation of authority within the current written plan.
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 record review and staff interview, it was determined, the facility failed to 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. Findings include: The surveyors requested documentation from the Executive Director on 8/1/18 and 8./2/18 related to cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials as part of the requirements for an EP plan. The Executive Director acknowledged on August 02, 2018, that the requirement include documentation for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials was not initiated to be part of their Emergency Plan.
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 observation, interview and facility record review it was determined the facility failed to 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. Findings include: The surveyors, requested from the Executive Director on 8/1/18 and 8/2/18, copies of all policies and procedures that were developed and implemented as related to their EP plan. No polices and procedures were provided. The Executive Director confirmed on 8/1/18 and 8/2/18, that the facility did not have EP policies and procedures developed and implemented. Failure to develop emergency plans based on community risk assessments may cause harm to the residents during an emergency.
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 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 State surveyors requested documentation that the facility had 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 as part of their EP plan on 8/1/18 and 8/2/18. No policy was provided related to safe evacuation during an emergency situation. The Executive Director acknowledged on August 02, 2018, that they did not 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.
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 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 sheltering in place during an emergency could lead to harm to both patients and staff. Findings include: Surveyors requested a policy and procedure for sheltering in place during an emergency on 8/1/18 and 8/2/18. The facility did not identify a process for sheltering patients and staff during an emergency. The Executive Director acknowledged during an interview on August 02, 2018, the facility did not identify a process for sheltering patients and staff during an emergency.
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 record review and staff interview, it was determined the facility failed to 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. Findings include: On 8/1/18 and 8/2/18 the surveyors requested the facility's policies and procedures to address the use of volunteers in an emergency. No policy was provided. The Executive Director acknowledged during an interview on August 02, 2018, the facility did not have 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 facility documents, and interview, it was determined the facility failed to 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. Findings include: The surveyors, along with the Executive Director reviewed the facility's Emergency Plan on 08/01/18 and 08/02/18. The facility did not have documentation of a written emergency communications plan. Executive Director stated: "The fire department has the documents of a plan and training of staff." Surveyors upon speaking with local fire officials learned that they did not have any documentation of a emergency plan or training done with facility staff. The Executive Director confirmed during an exit conference on 8/7/18, that the facility failed to develop an emergency communications plan that is to be reviewed and updated annually.
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 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 requested documentation to demonstrate how the facility identified a primary and alternate means of communicating between staff and Federal, State, tribal, regional, and local emergency management agencies during an emergency during interviews conducted on 8/1/18 and 8/2/18. No documentation of theses required items in the Emergency Plan were provided. The Executive Director confirmed on August 02, 2018, the facility did not identify a primary and alternate means of communicating between staff and/or Federal, State, tribal, regional, and local emergency management agencies during an emergency.
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 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 State surveyors requested documentation from the facility on 8/1/18 and 8/2/18, that included a method to share occupancy levels and/or facility needs to other facilities or to the authority having jurisdiction or the Incident Command Center, during an emergency situation. The Executive DIrector acknowledged during an interview on August 02, 2018, the facility did not have available documentation related to a method to share occupancy levels and/or facility needs to other facilities or to the authority having jurisdiction or the Incident Command Center if an emergency situation warranted this requirement.
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 record review 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 State surveyors requested documentation on August 02, 2018, of a facility based training and testing for staff based on the facility Emergency Plan, facility risk assessment and the communications plan. The Executive Director confirmed during an interview on August 02, 2018, they did not have an Emergency Plan to include facility based training and testing for staff based on the Emergency Plan, facility risk assessment and the communications plan.
E0037	EP Training Program CFR(s): 485.68(d)(1) 403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 460.84(d)(1), 482.15(d)(1), 483.73(d)(1), 483.475(d)(1), 484.102(d)(1), 485.68(d)(1), 485.542(d)(1), 485.625(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1). *[For RNCHIs at 403.748, ASCs at 416.54, Hospitals at 482.15, ICF/IIDs at 483.475, HHAs at 484.102, REHs at 485.542, "Organizations" under 485.727, OPOs at 486.360, RHC/FQHCs at 491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at 418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at 441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at 460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency

preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at 483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at 485.68 (d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at 485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at 485. 920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.

This STANDARD is not met as evidenced by:
Based on record review of the facility Emergency Preparedness Plan, and staff interview, it was determined the facility failed to 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.

Finding include:

The State surveyor requested on August 02, 2018, documentation to demonstrate the

	facility's Emergency Plan included annual facility based training and testing for staff based on an established Emergency Plan. No documentation related to annual facility based training and testing for staff based on an established Emergency Plan was provided. The Executive Director confirmed during an interview on August 02, 2018, the facility did not have an EP plan to include annual facility based training and testing for staff based on an Emergency 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 record review and staff interview, it was determined the facility failed to 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. Findings include: The State surveyors requested the facility's Emergency Preparedness Testing Requirements during an interview on 8/2/18. The facility was unable to provide documentation for Emergency Preparedness Testing Requirements to include the following: 1. Participate in a full-scale exercise (FSE) that is community-based. 2. Conduct an additional exercise that may include, but is not limited to the following: (A) A second FSE that is individual, facility-based. (B) A tabletop exercise. The Executive Director confirmed during the exit conference on August 02, 2018, the facility did not participate in the required Emergency Preparedness Testing Requirements to participate in a full-scale exercise that is community-based and the additional required exercise.
I0000	The following deficiencies were found at the time of the Centers for Medicare and Medicaid (CMS) Recertification survey conducted on 08/01/18, 08/02/18 and a telephonic interview on 8/07/18.
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 facilty failed to ensure that the medical license for the medical director (MD) and contract for the MD to provide services at this facility were not expired. Failure to have personnel licensed per state and local laws presents a danger to patient's and staff that personnel are not qualified to perform their job duties and to ensure proper care to patients.

	Findings include: A review of the medical director personnel record, who is a contracted employee of the facility, revealed that the most current contract for this medical director to work at this location was dated February 19, 2013, with an expiration date of February 19, 2014. No current contract was provided by facility personnel to surveyors at the time of this survey. The MD license on file at the facility expired April 17, 2018. The Executive Director confirmed during an interview on 08/02/18, that the current medical director for the facility contact had expired February 19, 2014, and their medical (MD) license was not current.
I0509	ADMINISTRATOR CFR(s): 485.56(b)(2) The governing body must appoint an administrator who implements and enforces the facility's policies and procedures. This STANDARD is not met as evidenced by: Based on review of facility policies/procedures, and staff interviews, it was determined that the facility failed to follow their own facility policy and ensure that all their policies and procedures were reviewed and updated at least once per year. This deficient practice poses a high potential risk for staff and patients, if staff providing the care are not aware of the facility's policies and procedures for daily operations. Findings include: Administrative Policies 1-F) 1513: Advisory Board Review of Policies: Review Date: 5/27/2015, requires: "... Policy: Its is the policy of Saguaro that the Board of Directors and Professional Advisory Board, will review all policies and procedures, including Budget Review at least once per year, or more often as needed...." The Executive Director confirmed during an interview conducted on 08/02/18, that the policies and procedures have not been reviewed or updated per facility's polices and procedures.
I0535	PLAN OF TREATMENT CFR(s): 485.58(b) For each patient, a physician must establish a plan of treatment before the facility initiates treatment. The plan of treatment must meet certain specified requirements. This STANDARD is not met as evidenced by: Based on a review of patients' medical records, and staff interviews, it was determined the CORF failed to require physicians review patient treatment plans every 60 days, for 10 of 10 patients on service for greater than 60 days (Patient #'s 1 thru 10). This deficient practice failed to ensure the comprehensive reassessment of the patient's condition/progress was evaluated and revised.

	Findings include: Review of 10 of 10 medical records for patients #1 thru 10 revealed physicians do not conduct 60 day treatment plan reviews. Facility administrator provided treatment plan reviews by the medical director on half slip papers dated for 2015. The Administrator and Physical Therapist (PT) confirmed during interviews conducted on 08/02/18, and telephonic interview 8/07/18, that the physicians perform 60-day treatment plan reviews.
I0568	PROTECTION OF CLINICAL RECORD INFORMATION CFR(s): 485.60(b) The facility must safeguard clinical record information against loss, destruction, or unauthorized use. The facility must have procedures that govern the use and removal of records and the conditions for release of information. The facility must obtain the patient's written consent before releasing information not required to be released by law. This STANDARD is not met as evidenced by: Based on observations during tour, and staff interviews, it was determined the CORF failed to safeguard clinical record information against loss, destruction, or unauthorized use. This deficient practice posed a potential fire safety hazard and potential loss of past or current patient clinical records when medical records were stored unsecured in cardboard boxes. Findings include: Observation on tour of the facility revealed discharged (closed out) clinical records were stored unsecured within the second floor loft, (an unlicensed area of the facility building, and the records were stacked in "Banker" boxes and subjected to potential environmental damage, loss, or unauthorized use. The Administrator confirmed during an interview conducted on 08/01/18 and 08/02 /18, that the facility did not safeguard clinical records in a secure location or cabinet to protect records from damage, loss or unauthorized use.
I0574	SAFETY AND COMFORT OF PATIENTS CFR(s): 485.62(a)(3) A fire alarm system with local (in-house) capability must be functional, and where power is generated by electricity, an alternate power source with automatic triggering must be present. This STANDARD is not met as evidenced by: Based on observations during tour, and staff interviews, it was determined the CORF failed to require that their fire alarm system (Smoke detectors) mounted in various areas of the facility were completely assembled and completely functional within the facility. Failing to ensure that the smoke detectors were intact and completely

	functional, poses a high potential risk to the health and safety of patients in preventing harm from the spread of fire, if patients and staff cannot be warned of smoke created from an unwarranted situation. Findings include: Observation on tour on both 8/1/18 and 8/2/18, revealed that three smoke detectors were located in various locations within the facility that were only the outer shell of the smoke detector. There were no covers, no batteries attached and or a visible hardwiring smoke detector mechanism present. The Executive Director confirmed on 8/1/18 and 8/2/18 both that the items identified above were missing for each smoke detector.
I0579	SANITARY ENVIRONMENT CFR(s): 485.62(b) The facility must maintain a sanitary environment and establish a program to identify, investigate, prevent, and control the cause of patient infections. This STANDARD is not met as evidenced by: Based on review of facility policies/procedures, observations during tour, and staff interviews, it was determined that the CORF failed to 1. maintain a sanitary environment and 2. ensure that patient supplies were not outdated. These deficient practices pose a high potential risk for breach in infection control. Findings include: 1. The surveyors observed the following during a tour conducted on 08/01/18 and 08 /02/18: Dust covered air vents in men's and women's locker rooms. Extensive water damage/marks traveling down the corner wall from the ceiling located in the corner of the room of the front lobby close to the physical therapy room used by patients. The Executive Director indicated that the building was old, during an interview conducted on 08/01/18 and 08/02/18, and confirmed the above mentioned environmental findings. 2. The facility's First Aid kit located in pool area contained the following outdated patient supplies: Antibiotic ointment 1/2 oz (1) expired 08/2011. "Cavicide" hospital grade disinfectant mixed with water in spray bottles. Unknown expiration date for the mixed product. Unknown mixture blend in the spray bottle. -Pool test chemicals outdated, 2013, and 2017. The Executive Director confirmed during an interview conducted on 08/07/18, the

	above mentioned dust covered vents, water damage marks on the wall (which the Executive Director relayed they have the insurance money to repair, however, no document confirmation was given to surveyors); and outdated supplies.
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 observations during tour, review of policies and procedures, manufacturer recommendations documents, and staff interviews, it was determined that the facility failed to follow manufacturer recommendations to ensure that the facility hydrocollator equipment was drained and cleaned every two weeks as per manufacturer's recommendations. This deficient practice poses the high potential risk for the spread of infection and cross contamination between patients, which will affect patient safety, Findings Include: The surveyors observed during a observation on tour conducted on 08/01/18, a [brand name] hydrocollator in use. 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)...." The surveyors requested the facility copy of the manufacturer recommendations for maintenance and care of the hydrocollator ? No manufacturer recommendations were provided. for the Facility document titled "Daily Temperature Record" revealed the following: Heading "Equipment Name" Hydrocollator. Documentation showed that the hydrocollator was cleaned the following dates: 3/27/17 and 12/19/17 Surveyors requested documentation for the maintenance of the hydrocollator. The facility failed to document the draining of the hydrocollator tank every two weeks. Physical Therapist Aide indicated during an interview conducted on 08/01/18, that s /he thought the hydroculator had to be drained once a month, and confirmed that the facility did not have the manufacturer's manual for reference.