Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	034525	12/09/2020
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	The following deficiencies were found during the Emergency Preparedness survey conducted on December 09, 2020.
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, at least every 2 years as part of 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. Findings include: Facility record review on 12/09/2020 revealed the facility last community based risk assessment was conducted September 2018. A request was made for an updated community based risk assessment. None was provided. The Executive Director confirmed on 12/09/2020, the facility failed to perform a community based risk assessment, at least every 2 years as a part of the facility's EP. Failure to develop emergency plans based on community and facility risk assessments may cause harm to the patients during an emergency.
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 update the facility's process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials, at least every 2 years as part of the facility's emergency preparedness plan (EPP). 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 facility on 12/09/2020 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 information related to cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness, was last updated September 2018, according to facility documentation. The Executive Director confirmed on 12/09/2020, the facility failed update documentations regarding cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials , as required for the facility's EPP.
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 update at least every two years 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: Facility record review on 12/09/2020 revealed the last review of the facility's emergency communications plan that contained how the facility will coordinate patient care within the facility, across the healthcare providers and with state and local public health departments, and emergency management systems, was September 2018. A request was made for an updated plan. None was provided. The Executive Director confirmed on 12/09/2020, the facility failed to update their emergency communications plan that contained how the facility will coordinate patient care within the facility, across the healthcare providers and with state and local public health departments, and emergency management systems.
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 update their facility-based emergency planning, training and testing program, at least every two years. 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: Facility record review on 12/09/2020 revealed the last review of the facility-based emergency planning, training and testing program, was conducted on September 2018. The Executive Director confirmed on 12/09/2020, the facility failed to review their facility-based training and testing for staff based on their emergency preparedness 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 (EPP) and staff interview, it was determined the facility failed to have documentation of updated training for staff in their EPP. 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: Facility record review of the facility's EPP on 12/09/2020, revealed the last staff training was September 2018. A request was made for updated staff training based upon the facility's EPP. None was provided. The Executive Director confirmed on 12/09/2020, the facility failed to provide documentation of updated staff training based upon their established EPP.
I0000	The following deficiency was found at the time of the Centers for Medicare and Medicaid (CMS) Recertification survey conducted on 12/09/2020. The facility is compliant with 42 CFR Part 485, Subpart F, requirements for a Comprehensive Outpatient Rehabilitation Facilities.
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 record review and 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: Facility record review on 12/09/2020 revealed the facility last operational budget was updated by the governing board on August 2018. A request was made for an updated 2020 budget. None was provided. The Executive Director confirmed on 12/09/2020, the facility failed at least annually update the facility's intuitional budget for operations.