Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	883920	03/17/2026
Name of Provider or Supplier	**Street Address, City, State**	
Pediatric Place Of Union City, Llc	1345 Edwards Street, Union City, TN	

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	An Emergency Preparedness (EP) survey was conducted on 3/17/2026 during a recertification survey. The Rural Health Clinic (RHC) was found to have condition level deficiencies for non-compliance with the EP regulations that govern RHCs.
E0001	Establishment of the Emergency Program (EP) 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 the rural health clinic's (rhc's) policies and procedures, document review, observations, and interviews, the RHC failed to develop and implement an Emergency Preparedness (EP) plan that was reviewed and updated at least every 2 years with all the essential elements. The findings included: 1. The RHC failed to maintain an Emergency Preparedness (EP) plan to be reviewed and updated every two years. Refer to E-0004 2. The RHC failed to develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years; as well as be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. Refer to E-0006 3. The RHC failed to review and update their Emergency Preparedness (EP) plan every two years to address population, including, but not limited to, persons at-risk; the type of services the RHC has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. Refer to E-0007 4. the RHC failed to maintain an Emergency Preparedness (EP) plan that was reviewed and updated every two years and include a process for cooperation and collaboration with local, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. Refer to E-0009 5. The RHC failed to review and update their EP policies and procedures at least every two years based on the emergency plan, risk assessment, and the communication plan. Refer to E-0013 6. The RHC failed to maintain and update every two years emergency preparedness policies and procedures to address safe evacuation from the facility, staff responsibilities, transportation, and alternate means of communication. Refer to E-0020 7. The RHC failed to maintain and update every two years emergency preparedness policies and procedures to address a means to shelter in place for patients, staff, and volunteers who remain in the facility. Refer to E-0022 8. The RHC failed to maintain and update every two years policies and procedures for maintaining confidentiality of records during an emergency. Refer to E-0023 9. The RHC failed to maintain and update every two years policies and procedures for the use of volunteers and other staffing strategies in case of an emergency or disaster. Refer to E-0024 10. The RHC failed to maintain and update every two years EP communication plan. Refer to E- 0029 11. The RHC failed to maintain and update every 2 years contact information for staff, physicians, volunteers and other health facilities as part of the written communication plan. Refer to E-0030 12. The RHC failed to maintain and update every 2 years contact information for Federal, State, regional and local emergency preparedness officials as part of the written communication plan. Refer to E 0031 13. The RHC failed to maintain and update every 2 years a communication plan that included primary and alternate means for communication with facility staff, Federal, State and local emergency management agencies. Refer to E 0032 14. The RHC failed to maintain and update a communication plan every 2 years for sharing medical information. Refer to E-0033 15. The RHC failed to maintain and update a communication plan every 2 years that provided information about the RHC's occupancy, needs and its ability to provide assistance. Refer to E-0034 16. The RHC failed to maintain and update every 2 years an EP training and testing program. Refer to E-0036 17. The RHC failed to educate all employees on the EP program upon hire and at least every two years. Refer to E-0037 18. The RHC failed to document they had conducted exercises to test the emergency plan annually and participate in a full-scale exercise, facility-based functional exercise or community-based every 2 years. Refer to E-0039
E0004	Develop EP Plan, Review and Update Annually 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 the Rural Health Clinic's (RHCs) documentation and interview, the RHC failed to maintain an Emergency Preparedness (EP) plan to be reviewed and updated every two years. The findings included: Review of the RHC's documentation revealed that the facility did not have an EP plan that was reviewed and updated EP every two years. During an interview on 3/17/2026 at 11:00 AM, the Office Manager (OM) stated that the EP manual had not been updated since the initial survey in 2022. During an interview, on 3/17/2026 at 12:00 PM, the Administrator stated that the EP manual had not been updated since the initial survey.
E0006	Plan Based on All Hazards Risk Assessment 403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 460.84(a)(1)-(2), 482.15(a)(1)-(2), 483.73(a)(1)-(2), 483.475(a)(1)-(2), 484.102(a)(1)-(2), 485.68(a)(1)-(2), 485.542(a)(1)-(2), 485.625(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at 418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at 483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at 483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be

	reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This STANDARD is not met as evidenced by: Based on review of the Rural Health Clinic's (RHC's) documentation and interview, the RHC failed to develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years; as well as be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. The findings included: Review of the RHC's documentation revealed that the RHC did not have a documented risk assessment since 2022 available for review. During an interview on 3/17/2026 at 11:00 AM, the Office Manager (OM) stated the RHC did not have documentation of updates available for review. The OM confirmed the last update was in 2022. During an interview on 3/17/2026 at 12:00 PM, the Administrator stated the RHC did not have documentation of updates available for review.
E0007	EP Program Patient Population 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 the Rural Health Clinic's (RHC's) documentation and interview, the RHC failed to review and update their Emergency Preparedness (EP) plan every two years to address population, including, but not limited to, persons at-risk; the type of services the RHC has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. The findings included: Review of the RHC's documentation revealed the RHC had not reviewed and updated an EP plan to address the population and continuity of operations since the initial survey in 2022. During an interview, on 3/17/2026, at 11:00 AM, the Office Manager (OM) stated the RHC did not have documentation of updates available for review. During an interview, on 3/17/2026, at 12:00 PM, the Administrator stated the RHC did not have documentation of updates available for review.
E0009	Local, State, Tribal Collaboration Process

	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 the Rural Health Clinic's (RHC's) documentation review and interview, the RHC failed to maintain an Emergency Preparedness (EP) plan that was reviewed and updated every two years and include a process for cooperation and collaboration with local, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The findings included: Review of the RHC's documentation revealed that the RHC did not have updated processes to maintain integrated responses with EP officials since 2022. During an interview on 3/17/2026 at 11:00 AM, the Office Manager (OM) stated the RHC did not have documentation of updates available for review. During an interview on 3/17/2026 at 12:00 PM, the Administrator stated the RHC did not have documentation of updates available for review.
E0013	Development of EP Policies and Procedures 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 the Rural Health Clinic's (RHC's) policy review and interview, the RHC failed to review and update their EP policies and procedures at least every two years based on the emergency plan, risk assessment, and the communication plan. The findings included: Review of the RHC's policy, "[named RHC] Policy and Procedures," revised 8/28/2022, revealed that the RHC did not have documentation of EP policies and procedures that had been updated every 2 years. During an interview on 3/17/2026 at 11:00 AM, the Office Manager (OM) stated the RHC did not have documentation of updates available for review. During an interview on 3/17/2026 at 12:00 PM, the Administrator stated the RHC did not have documentation of updates available for review.
E0020	Policies for Evac. and Primary/Alt. Comm. 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 Rural Health Clinic's (RHC's) policy review, observations, and interview, the RHC failed to maintain and update every two years emergency preparedness

	policies and procedures to address safe evacuation from the facility, staff responsibilities, transportation, and alternate means of communication. The findings included: Review of the RHC's policy, "[named RHC] Policy and Procedures," revised 8/28/2022, revealed the RHC did not maintain and update every two years emergency preparedness policies and procedures to address safe evacuation from the facility, staff responsibilities, transportation, and alternate means of communication. Observations on 3/17/2026 at 1:45 PM revealed no evacuation routes posted throughout the rural health clinic. During an interview on 3/17/2026 at 11:00 AM, the Office Manager (OM) stated the RHC did not have documentation of updates available for review. During an interview on 3/17/2026 at 12:00 PM, the Administrator stated the RHC did not have documentation of updates available for review.
E0022	Policies/Procedures for Sheltering in Place 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 Rural Health Clinic's (RHC's) policy review and interview, the RHC failed to maintain and update every two years emergency preparedness policies and procedures to address a means to shelter in place for patients, staff, and volunteers who remain in the facility. The findings included: Review of the RHC's policy, "[named RHC] Policy and Procedures," revised 8/28/2022, revealed that the RHC did not maintain and update every two years emergency preparedness policies and procedures to address a means to shelter in place for patients, staff, and volunteers who remain in the facility. During an interview on 3/17/2026 at 11:00 AM, the Office Manager (OM) stated the RHC did not have documentation of updates available for review. During an interview on 3/17/2026 at 12:00 PM, the Administrator stated the RHC did not have documentation of updates available for review.
E0023	Policies/Procedures for Medical Documentation 403.748(b)(5), 416.54(b)(4), 418.113(b)(3), 441.184(b)(5), 460.84(b)(6), 482.15(b)(5), 483.73(b)(5), 483.475(b)(5), 484.102(b)(4), 485.68(b)(3), 485.542(b)(5), 485.625(b)(5), 485.727(b)(3), 485.920(b)(4), 486.360(b)(2), 491.12(b)(3), 494.62(b)(4). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures

	must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at 403.748(b) and REHs at 485.542(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This STANDARD is not met as evidenced by: Based on Rural Health Clinic's (RHC's) policy review and interview, the RHC failed to maintain and update every two years policies and procedures for maintaining confidentiality of records during an emergency. The findings included: Review of the RHC's policy, "[named RHC] Policy and Procedures," revised 8/28/2022, revealed the RHC failed to maintain and update every two years policies and procedures for maintaining confidentiality of records during an emergency. During an interview on 3/17/2026 at 11:00 AM, the Office Manager (OM) stated the RHC did not have documentation of updates available for review. During an interview on 3/17/2026 at 12:00 PM, the Administrator stated the RHC did not have documentation of updates available for review.
E0024	Policies/Procedures-Volunteers and Staffing 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 Rural Health Clinic's (RHC's) policy review and interview, the RHC failed to maintain and update every two years policies and procedures for the use of volunteers and other staffing strategies in case of an emergency or disaster. The findings included: Review of the RHC's policy, "[named RHC] Policy and Procedures," revised 8/28/2022, revealed that the RHC did not have documentation of

	updates available for review. During an interview on 3/17/2026 at 11:00 AM, the Office Manager (OM) stated the RHC did not have documentation of updates available for review. During an interview on 3/17/2026 at 12:00 PM, the Administrator stated the RHC did not have documentation of updates available for review.
E0029	Development of Communication Plan 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 Rural Health Clinic's (RHC's) documentation and interview, the RHC failed to maintain and update every two years EP communication plan. The findings included: Review of the RHC's documentation revealed that the RHC failed to maintain and update every two years EP communication plan. During an interview on 3/17/2026 at 11:00 AM, the Office Manager (OM) stated the RHC did not have documentation of updates available for review. During an interview on 3/17/2026 at 12:00 PM, the Administrator stated the RHC did not have documentation of updates available for review.
E0030	Names and Contact Information 403.748(c)(1), 416.54(c)(1), 418.113(c)(1), 441.184(c)(1), 460.84(c)(1), 482.15(c)(1), 483.73(c)(1), 483.475(c)(1), 484.102(c)(1), 485.68(c)(1), 485.542(c)(1), 485.625(c)(1), 485.727(c)(1), 485.920(c)(1), 486.360(c)(1), 491.12(c)(1), 494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at 482.15(c) and CAHs at 485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at 403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at 416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at 418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at 484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at 486.360(c):]

	The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is not met as evidenced by: Based on Rural Health Clinic's (RHC's) documentation review and interview, the RHC failed to maintain and update every 2 years contact information for staff, physicians, volunteers and other health facilities as part of the written communication plan. The findings included: Review of the RHC's documentation revealed that the RHC did not maintain and update every 2 years contact information for staff, physicians, volunteers and other health facilities as part of the written communication plan. During an interview on 3/17/2026 at 11:00 AM, the Office Manager (OM) stated the RHC did not have documentation of updates available for review. During an interview on 3/17/2026 at 12:00 PM, the Administrator stated the RHC did not have documentation of updates available for review.
E0031	Emergency Officials Contact Information 403.748(c)(2), 416.54(c)(2), 418.113(c)(2), 441.184(c)(2), 460.84(c)(2), 482.15(c)(2), 483.73(c)(2), 483.475(c)(2), 484.102(c)(2), 485.68(c)(2), 485.542(c)(2), 485.625(c)(2), 485.727(c)(2), 485.920(c)(2), 486.360(c)(2), 491.12(c)(2), 494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at 483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at 483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This STANDARD is not met as evidenced by: Based on the Rural Health Clinic's (RHC's) documentation and interview, the RHC failed to maintain and update every 2 years contact information for Federal, State, regional and local emergency preparedness officials as part of the written communication plan. The findings included: Review of the RHC's documentation revealed that the RHC did not update every 2 years contact information for Federal, State, regional and local emergency preparedness officials as part of the written communication plan. During an interview on 3/17/2026 at 11:00 AM, the Office Manager (OM) stated the RHC did not have documentation of updates available for review. During an interview on 3/17/2026 at 12:00 PM, the Administrator stated the RHC did not have documentation of updates available for review.
E0032	Primary/Alternate Means for Communication 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 the Rural Health Clinic's (RHC's) documentation and interview, the RHC failed to maintain and update every 2 years a communication plan that included primary and alternate means for communication with facility staff, Federal, State and local emergency management agencies. The findings included: Review of the RHC's documentation revealed that the RHC did not update every 2 years a communication plan that included primary and alternate means for communication with facility staff, Federal, State and local emergency management agencies. During an interview on 3/17/2026 at 11:00 AM, the Office Manager (OM) stated the RHC did not have documentation of updates available for review. During an interview on 3/17/2026 at 12:00 PM, the Administrator stated the RHC did not have documentation of updates available for review.
E0033	Methods for Sharing Information 403.748(c)(4)-(6), 416.54(c)(4)-(6), 418.113(c)(4)-(6), 441.184(c)(4)-(6), 460.84(c)(4)-(6), 441.184(c)(4)-(6), 460.84(c)(4)-(6), 482.15(c)(4)-(6), 483.73(c)(4)-(6), 483.475(c)(4)-(6), 484.102(c)(4)-(5), 485.68(c)(4), 485.542(c)(4)-(6), 485.625(c)(4)-(6), 485.727(c)(4), 485.920(c)(4)-(6), 491.12(c)(4), 494.62(c)(4)-(6). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under 484.102(c), CORFs under 485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at 403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at 491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This STANDARD is not met as evidenced by: Based on the Rural Health Clinic's (RHC's) documentation and interview, the RHC failed to maintain and update a communication plan every 2 years for sharing medical information. The findings included: Review of the RHC's documentation revealed that the RHC did not maintain and update a communication plan every 2 years for sharing

	medical information. During an interview on 3/17/2026 at 11:00 AM, the Office Manager (OM) stated the RHC did not have documentation of updates available for review. During an interview on 3/17/2026 at 12:00 PM, the Administrator stated the RHC did not have documentation of updates available for review.
E0034	Information on Occupancy/Needs 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 the Rural Health Clinic's (RHC's) documentation and interview, the RHC failed to maintain and update a communication plan every 2 years that provided information about the RHC's occupancy, needs and its ability to provide assistance. The findings included: Review of the RHC's documentation revealed that the RHC failed to maintain and update a communication plan every 2 years that provided information about the RHC's occupancy, needs and its ability to provide assistance. During an interview on 3/17/2026 at 11:00 AM, the Office Manager (OM) stated the RHC did not have documentation of updates available for review. During an interview on 3/17/2026 at 12:00 PM, the Administrator stated the RHC did not have documentation of updates available for review.
E0036	EP Training and Testing 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 the Rural Health Clinic's (RHC's) policy review and interview, the RHC failed to maintain and update every 2 years an EP training and testing program. The findings included: Review of the RHC's policy, "[named RHC] Policy and Procedures," revised 8/28/2022, revealed that "... Emergency Preparedness training should be conducted at least ever 2 years. Documentation of the training on the EOP [Emergency Operations Plan] and all emergency preparedness training should be maintained by the administrator..." During an interview on 3/17/2026 at 11:00 AM, the Office Manager (OM) stated the RHC did not have documentation of updates available for review. During an interview on 3/17/2026 at 12:00 PM, the Administrator stated the RHC did not have documentation of updates available for review.
E0037	EP Training Program 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 the Rural Health Clinic's (RHC's) policy review, review of Emergency Preparedness (EP) manual and interview, the RHC failed to educate all employees on the EP program upon hire and at least every two years. The findings included: Review of the RHC's policy, "[named RHC] Policy and Procedures," revised 8/28/2022, revealed that, "The current staff should be trained on the new or updated EOP [Emergency Operations Plan] at the time of its publication. All new staff should be trained on the EOP in orientation..." During an interview on 3/17/2026 at 11:00 AM, the Office Manager (OM) stated the RHC did not have documentation of updates available for review. During an interview on 3/17/2026 at 12:00 PM, the Administrator stated the RHC did not have documentation of updates available for review.
E0039	EP Testing Requirements 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 the Rural Health Clinic's (RHC's) policy review, documentation review and interview, the RHC failed to document they had conducted exercises to test the emergency plan annually and participate in a full-scale exercise, facility-based functional exercise or community-based every 2 years. The findings included: Review of the RHC's policy, "[named RHC] Policy and Procedures," revised 8/28/2022, revealed, "...The facility must conduct exercises to test the emergency plan at least annually. The facility should participate in a full-scale exercise that is community-based every 2 years or when a community-based exercised is not accessible, conduct a facility-based functional exercise every 2 years...After full scale exercises, tabletops or actual events, the facility should analyze the response, identify areas for improvement and updated the EOP [Emergency Operations Plan]..." There was no documentation the rural health clinic had conducted exercises to test the emergency plan annually and participate in a full-scale exercise, facility-based functional exercise or community-based every 2 years. During an interview on 3/17/2026 at 11:00 AM, the Office Manager (OM) stated the RHC did not have documentation of updates available for review. During an interview on 3/17/2026 at 12:00 PM, the Administrator stated the RHC did not have documentation of updates available for review.
J0000	A Recertification survey was conducted on 3/17/2026. The Rural Health Clinic (RHC) was found to have Condition level deficiencies for non-compliance identified under Program Evaluation.
J0011	COMPLIANCE WITH FED., STATE & LOCAL LAWS Standard-level Tag 491.4 Compliance with Federal, State and local laws The rural health clinic . . . and its staff are in compliance with applicable Federal, State and local laws and regulations. This STANDARD is not met as evidenced by: Based on Rural Health Clinic's (RHC) personnel file review and interview, the RHC failed to ensure 5 out of 9 (Advanced Practice Registered Nurse (APRN #1),

	Registered Nurse (RN #1, RN #2, RN #3 and RN #4)) personnel were in compliance with applicable Federal, State and local laws and regulations. The findings included: Review of the RHC's personnel documentation revealed there was documentation APRN #1, RN #1, RN #3 and RN #4 had was currently certified in Basic Life Support (BLS) or Advanced Cardiac Life Support (ACLS). During an interview on 3/17/2026 at 11:00 AM, Office Manager (OM) stated that the certifications expired in 2025 and had not been renewed.
J0042	PHYSICAL PLANT AND ENVIRONMENT 491.6(b) Maintenance: The clinic . . . has a preventive maintenance program to ensure that: (1) All essential mechanical, electrical and patient-care equipment is maintained in safe operating condition; This STANDARD is not met as evidenced by: Based on the Rural Health Clinic's (RHC's) documentation review, the facility failed to develop and implement a system for preventive maintenance program to ensure all mechanical and electrical equipment were safe and functioning properly. The findings included: There was no documentation provided for surveyor review of preventative maintenance program to ensure all essential mechanical, electrical and patient-care equipment is maintained in safe operating condition.
J0043	PHYSICAL PLANT AND ENVIRONMENT The clinic . . . has a preventive maintenance program to ensure that: 491.6(b)(2) Drugs and biologicals are appropriately stored; and This STANDARD is not met as evidenced by: Based on observations and interview, the rural health clinic failed to label the opened medication container with the date opened before it was stored. The findings included: Observations on 3/17/2026 at 1:45 PM stored in the medication cabinet revealed an 8-ounce bottle of ibuprofen oral suspension 100 milligram/5 milliliters. The medication had been opened; however, an open date was not documented on the container. During an interview on 3/17/2026 at 1:45 PM the Office Manager stated the facility did not place "open dates" on the multi-dose medications.
J0100	STAFFING AND STAFF RESPONSIBILITIES 491.8(b) Physician responsibilities. The physician performs the following: (1) . . . provides medical direction for the clinic's . . . health care activities and consultation for, and medical supervision of, the health care staff. (3) . . . provides medical orders, and provides medical care services to the patients of the clinic or center. This STANDARD is not met as evidenced by: Based on documentation review and interview, the Rural Health Clinic (RHC) failed to ensure the physician provided collaboration and supervision for the non-physician practitioner. The findings included: Review of the RHC's documentation revealed that neither collaborative agreement, supervisory agreement, nor practice protocols were

	available for review. Durng an interview on 3/17/2026 at 1:45 PM, the Administrator stated was unable to provide the documentation of supervision and collaboration upon request.
J0123	STAFFING AND STAFF RESPONSIBILITIES 491.8(b) Physician responsibilities. The physician performs the following: (2) In conjunction with the physician assistant and/or nurse practitioner member(s), participates in developing, executing, and periodically reviewing the clinic's . . . written policies and the services provided to Federal program patients. 491.8(c) Physician assistant and nurse practitioner responsibilities. (1) The physician assistant and the nurse practitioner members of the clinic's . . . staff: (i) Participate in the development, execution and periodic review of the written policies governing the services the clinic . . . furnishes; 491.9(b) Patient care policies . . . (1) The clinic's health care services are furnished in accordance with appropriate written policies which are consistent with applicable State law. (2) The policies are developed with the advice of a group of professional personnel that includes one or more physicians and one or more physician assistants or nurse practitioners. At least one member is not a member of the clinic . . . staff. (4) These policies are reviewed at least biennially by the group of professional personnel required under paragraph (b)(2) of this section and reviewed as necessary by the clinic... This STANDARD is not met as evidenced by: Based on the Rural Health Clinic's (RHC's) policy and interview, the physician failed to, in conjunction with the nurse practitioner, participate in developing and executing and periodically reviewing at least biennially the clinic's written policies and the services provided to Federal program patients. The findings included: Review of the RHC's policy, "[named clinic] Policy and Procedures," revised 8/28/2022, revealed for compliance with rural health clinic guidelines, "...An annual review of clinic policies and procedures as well as medical practices will be performed..." During an interview on 3/17/2026 at 11:00 AM, the Office Manager (OM) stated the RHC did not have documentation of an annual/biennial evaluation available for review. During an interview on 3/17/2026 at 12:00 PM, the Administrator stated the RHC did not have documentation an annual/biennial evaluation available for review.
J0160	PROGRAM EVALUATION 491.11 Program evaluation. This CONDITION is not met as evidenced by: Based on review of Rural Health Clinic's (RHC's) policy and interview, the RHC failed to perform a program evaluation, at least biennially. The findings included: 1. The Administrator/Medical Director failed to complete or arrange for a biennial evaluation of the total program that included a review of policies and procedures and a sample review of active and closed clinical records. Refer to J-0161 2. The Rural Health Clinic was unable to provide documentation of any action taken based on a completed biennial evaluation. Refer to J-0162
J0161	PROGRAM EVALUATION 491.11 Program evaluation. (a) The clinic or center carries out, or arranges for, a

	biennial evaluation of its total program. (b) The evaluation includes review of: (1) The utilization of clinic or center services, including at least the number of patients served and the volume of services; (2) A representative sample of both active and closed clinical records; and (3) The clinic's or center's health care policies. (c) The purpose of the evaluation is to determine whether: (1) The utilization of services was appropriate; (2) The established policies were followed; and (3) Any changes are needed. This STANDARD is not met as evidenced by: Based on review of Rural Health Clinic's (RHC's) policy, documentation and interview, the Administrator/Medical Director failed to complete or arrange for a biennial evaluation of the total program that included a review of policies and procedures and a sample review of active and closed clinical records. The findings included: Review of Rural Health Clinic's (RHC's) policy, "[named clinic] Policy and Procedures," revised 8/28/2022, revealed, "... Upon completion of the annual review, the findings will be reviewed and appropriate corrective actions, if necessary, will be taken. Whenever possible the RHC annual evaluation will be performed in conjunction with the annual evaluation committee ..." Review of the RHC's documentation revealed no documentation of completion of biennial evaluations of the total program. During an interview on 3/17/2026 at 11:00 AM, the Office Manager (OM) stated the RHC did not have documentation of an annual/biennial evaluation available for review. During an interview on 3/17/2026 at 12:00 PM, the Administrator stated the RHC did not have documentation of an annual/biennial evaluation available for review.
J0162	PROGRAM EVALUATION 491.11(d) The clinic or center staff considers the findings of the evaluation and takes corrective action if necessary. This STANDARD is not met as evidenced by: Based on review of the Rural Health Clinic's (RHC's) policy, document review and interview, the RHC failed to provide documentation of any actions taken based on completed biennial evaluations. The findings included: Review of Rural Health Clinic's (RHC's) policy, "[named clinic] Policy and Procedures," revised 8/28/2022, revealed, "...Upon completion of the annual review, the findings will be reviewed and appropriate corrective actions, if necessary, will be taken. Whenever possible the RHC annual evaluation will be performed in conjunction with the annual evaluation committee ..." Review of the RHC's documentation revealed no documentation of changes that resulted from the completion of biennial evaluations of the total program. During an interview on 3/17/2026 at 11:00 AM, the Office Manager (OM) stated the RHC did not have documentation of an annual/biennial evaluation available for review. During an interview on 3/17/2026 at 12:00 PM, the Administrator stated the RHC did not have documentation of an annual/biennial evaluation available for review.