Understanding the Emergency Preparedness Inspection Process

Office of the State Fire Marshal

General Information

- Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers
- Published September 16, 2016
- Applies to all 17 provider and supplier types
- Implementation date November 15, 2017
- Compliance required for participation in Medicare
- Emergency Preparedness is one new of many already required

Facilities Impacted by EMP Rule

- Hospitals
- Religious Nonmedical Health Care Institutions (RNHCIs)
- Ambulatory Surgical Center (ASCs)
- Hospices
- Psychiatric Residential Treatment Facilities (PRTFs)
- All – Inclusive Care for the Elderly (PACE)
- Transplant Centers
- Long Term Care (LTC) Facilities
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
- Home Health Agencies (HHAs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Critical Access Hospital (CAHs)
- Clinics, Rehabilitation Agencies, & Public Health Agencies as providers of Outpatient PT and Speech Language Pathology Services
- Community Mental Health Centers (CMHCs)
- Organ Procurement Organization (OPOs)
- Rural Health Clinics (RHC & Federally Qualified Health Centers (FQHCs)
- Ed-Stage Renal Disease (ESRD) Facilities

What Will OSFM Staff Be Inspecting?

NURSING HOME

PRTF (Psychiatric Residential Treatment Facilities)

001 -Establishment of the Emergency Program (EP)

- Facilities are required to develop an emergency preparedness program that meets all of the standards specified within the condition/requirement.
- Program must describe a facility's comprehensive approach to meeting the health, safety, and security needs of their staff and patient population during an emergency or disaster situation.
- The program must also address how the facility would coordinate with other healthcare facilities, as well as the whole community during an emergency or disaster (natural, man-made, facility). The emergency preparedness program must be reviewed annually.

Survey Procedures

Understanding the Survey:

- Interview the facility leadership and ask him/her/them to describe the facility's emergency preparedness program.
- Ask to see the facility's written policy and documentation on the emergency preparedness program.
- For hospitals and CAHs only: Verify the hospital's or CAH's program was developed based on an all-hazards approach by asking their leadership to describe how the facility used an all-hazards approach when developing its program.

Understanding enforcement:

- Can this tag be waivered?

  No
- Can this tag have a FSES performed?

  No
- Can this tag qualify for Substandard quality of care?

  No

004-Develop and Maintain EP Program

- Develop and maintain an emergency preparedness plan
- Plan must be reviewed and updated at least annually
- Annual review must be documented to include the date of the review and any updates made to the emergency plan based on the review
  - **These include, but are not limited to:**
    - Natural disasters
    - Man-made disasters,
    - Facility-based disasters that include but are not limited to:
      - o Care-related emergencies;
      - o Equipment and utility failures, including but not limited to power, water, gas, etc.;
      - o Interruptions in communication, including cyber-attacks;
      - o Loss of all or portion of a facility; and
      - o Interruptions to the normal supply of essential resources, such as water, food, fuel (heating, cooking, and generators), and in some cases, medications and medical supplies (including medical gases, if applicable).

Survey Procedures

Understanding the Survey:

- • Verify the facility has an emergency preparedness plan by asking to see a copy of the plan.
- • Ask facility leadership to identify the hazards (e.g. natural, man-made, facility, geographic, etc.) that were identified in the facility's risk assessment and how the risk assessment was conducted.
- • Review the plan to verify it contains all of the required elements.
- • Verify that the plan is reviewed and updated annually by looking for documentation of the date of the review and updates that were made to the plan based on the review.

Understanding enforcement:

- Can this tag be waivered?

  No
- Can this tag have a FSES performed?

  No
- Can this tag qualify for Substandard quality of care?

  No

006-Maintain and Annual EP Updates

- Develop an emergency preparedness plan that is based on the facility-based and community-based risk assessment using an "all-hazards" approach.
- Facilities must document both risk assessments.
- Example consideration may include, but is not limited to:

  Natural disasters prevalent in a facility's geographic region such as wildfires, tornados, flooding, etc.

  An all-hazards approach is an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters.

  When developing an emergency preparedness plan, facilities are expected to consider, among other things, the following:

  - Identification of all business functions essential to the facility's operations that should be continued during an emergency;
  - Identification of all risks or emergencies that the facility may reasonably expect to confront;
  - Identification of all contingencies for which the facility should plan;
  - Consideration of the facility's location;
  - Assessment of the extent to which natural or man-made emergencies may cause the facility to cease or limit operations; and,
  - Determination of what arrangements may be necessary with other health care facilities, or other entities that might be needed to ensure that essential services could be provided during an emergency.

For LTC facilities and ICF/IIDs, written plans and the procedures are required to also include missing residents and clients, respectively, within their emergency plans.

Survey Procedures

Understanding the Survey:

- Ask to see the written documentation of the facility's risk assessments and associated strategies.
- Interview the facility leadership and ask which hazards (e.g. natural, man-made, facility, geographic) were included in the facility's risk assessment, why they were included and how the risk assessment was conducted.
- Verify the risk-assessment is based on an all-hazards approach specific to the geographic location of the facility and encompasses potential hazards.

Understanding enforcement:

- Can this tag be waivered?

  No
- Can this tag have a FSES performed?

  No
- Can this tag qualify for Substandard quality of care?

  No

007-EP Program Patient Population

- Emergency plan must specify the population served within the facility, such as inpatients and/or outpatients, and their unique vulnerabilities in the event of an emergency or disaster.
- A facility's emergency plan must also address persons at-risk, except for plans of ASCs, hospices, PACE organizations, HHAs, CORFs, CMHCs, RHCs, FQHCs and ESRD facilities
- Emergency plan must also address the types of services that the facility would be able to provide in an emergency.
- Emergency plan must identify which staff would assume specific roles in another's absence through succession planning and delegations of authority.
- During times of emergency, facilities must have employees who are capable of assuming various critical roles in the event that current staff and leadership are not available. At a minimum, there should be a qualified person who "is authorized in writing to act in the absence of the administrator or person legally responsible for the operations of the facility."

Survey Procedures

Understanding the Survey:

- Interview leadership and ask them to describe the following:
  - The facility's patient populations that would be at risk during an emergency event;
  - Strategies the facility (except for an ASC, hospice, PACE organization, HHA, CORF, CMHC, RHC, FQHC and ESRD facility) has put in place to address the needs of at-risk or vulnerable patient populations;
  - Services the facility would be able to provide during an emergency;• How the facility plans to continue operations during an emergency;
  - Delegations of authority and succession plans.
- Verify that all of the above are included in the written emergency plan.

Understanding enforcement:

- Can this tag be waivered?

  No
- Can this tag have a FSES performed?

  No
- Can this tag qualify for Substandard quality of care?

  No

009 – Process for EP Collaboration

- Responsibility for ensuring a coordinated disaster preparedness response lies upon the state and local emergency planning authorities, the facility must document its efforts to contact these officials to engage in collaborative planning for an integrated emergency response.

Survey Procedures

Understanding the Survey:

- Interview facility leadership and ask them to describe their process for ensuring cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to ensure an integrated response during a disaster or emergency situation.

- • Ask for documentation of the facility's efforts to contact such officials and, when applicable, its participation in collaborative and cooperative planning efforts.

- • For ESRD facilities, ask to see documentation that the ESRD facility contacted the local public health and emergency management agency public official at least annually to confirm that the agency is aware of the ESRD facility's needs in the event of an emergency and know how to contact the agencies in the event of an emergency.

Understanding enforcement:

- Can this tag be waivered?

  No

- Can this tag have a FSES performed?

  No

- Can this tag qualify for Substandard quality of care?

  No

0013 – Development of EP Policies and Procedures

- Facilities must develop and implement policies and procedures per the requirements of this standard
- The policies and procedures are expected to align with the identified hazards within the facility's risk assessment and the facility's overall emergency preparedness program.
- The facility must be able to demonstrate compliance upon survey, therefore we recommend that facilities have a central place to house the emergency preparedness program documents (to include all policies and procedures) to facilitate review.

Survey Procedures

Understanding the Survey:

- Review the written policies and procedures which address the facility's emergency plan and verify the following:
- • Policies and procedures were developed based on the facility- and community-based risk assessment and communication plan, utilizing an all-hazards approach.
- • Ask to see documentation that verifies the policies and procedures have been reviewed and updated on an annual basis.

Understanding enforcement:

- Can this tag be waivered?

  No
- Can this tag have a FSES performed?

  No
- Can this tag qualify for Substandard quality of care?

  No

0015 – Subsistence needs for staff and patients

- Facilities must be able to provide for adequate subsistence for all patients and staff for the duration of an emergency or until all its patients have been evacuated and its operations cease
- There are no set requirements or standards for the amount of provisions to be provided in facilities, Provisions include, but are not limited to, food, pharmaceuticals and medical supplies. Provisions should be stored in an area which is less likely to be affected by disaster, such as storing these resources above ground-level to protect from possible flooding
- This specific standard does not require facilities to have or install generators or any other specific type of energy source.
- Facilities must establish policies and procedures that determine how required heating and cooling of their facility will be maintained during an emergency situation, as necessary, if there were a loss of the primary power source.
- If a facility determines the best way to maintain temperatures, emergency lighting, fire detection and extinguishing systems and sewage and waste disposal would be through the use of a portable generator, then the Life Safety Code (LSC) provisions, such as generator testing and fuel storage, etc. outlined under the NFPA guidelines would not be applicable. Portable generators should be operated, tested, and maintained in accordance with manufacturer, local and/or State requirements. If a facility, however, chooses to utilize a permanent generator to maintain emergency power, LSC provisions such as generator testing and maintenance will apply and the facility may be subject to LSC surveys to ensure compliance is met.

0015 – Subsistence needs for staff and patients – Cont.

- Facilities are encouraged to confer with local health department and emergency management officials, as well as and healthcare coalitions, where available, to determine the types and duration of energy sources that could be available to assist them in providing care to their patient population during an emergency. As part of the risk assessment planning, facilities should determine the feasibility of relying on these sources and plan accordingly
- Facilities are not required to provide onsite treatment of sewage but must make provisions for maintaining necessary services. For example, LTC facilities are already required to meet Food Receiving and Storage provisions at §483.35(i) Sanitary Conditions, which contain requirements for keeping food off the floor and clear of ceiling sprinklers, sewer/waste disposal pipes, and vents can also help maintain food quality and prevent contamination
- Maintaining necessary services may include, but are not limited to, access to medical gases; treatment of soiled linens; disposal of bio-hazard materials for different infectious diseases; and may require additional assistance from transportation companies for safe and appropriate disposal in accordance with nationally accepted industry guidelines for emergency preparedness.

Survey Procedures

Understanding the Survey:

- Verify the emergency plan includes policies and procedures for the provision of subsistence needs including, but not limited to, food, water and pharmaceutical supplies for patients and staff by reviewing the plan.
- Verify the emergency plan includes policies and procedures to ensure adequate alternate energy sources necessary to maintain:
  - Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions;
  - Emergency lighting; and,
  - Fire detection, extinguishing, and alarm systems.
- Verify the emergency plan includes policies and procedures to provide for sewage and waste disposal.

Understanding enforcement:

- Can this tag be waivered?

  No
- Can this tag have a FSES performed?

  No
- Can this tag qualify for Substandard quality of care?

  No

0018- Procedures for Tracking of Staff and Patients

- Facilities must develop a means to track patients and on-duty staff in the facility's care during an emergency event. In the event staff and patients are relocated, the facility must document the specific name and location of the receiving facility or other location for sheltered patients and on-duty staff who leave the facility during the emergency.
- CMHCs, PRTF's, LTC facilities, ICF/IIDs, PACE organizations and ESRD Facilities are required to track the location of sheltered patients and staff during and after an emergency
- We are not specifying which type of tracking system should be used; rather, a facility has the flexibility to determine how best to track patients and staff, whether it uses an electronic database, hard copy documentation, or some other method. However, it is important that the information be readily available, accurate, and shareable among officials within and across the emergency response systems as needed in the interest of the patient. It is recommended that a facility that is using an electronic database consider backing up its computer system with a secondary source, such as hard copy documentation in the event of power outages.
- It is recommended that a facility that is using an electronic database consider backing up its computer system with a secondary source, such as hard copy documentation in the event of power outages
- Facilities are not required to track the location of patients who have voluntarily left on their own, or have been appropriately discharged, since they are no longer in the facility's care. However, this information must be documented in the patient's medical record should any questions later arise as to the patient's whereabouts.

Survey Procedures

Understanding the Survey:

- Ask staff to describe and/or demonstrate the tracking system used to document locations of patients and staff.
- Verify that the tracking system is documented as part of the facilities' emergency plan policies and procedures.

Understanding enforcement:

- Can this tag be waivered?

  No
- Can this tag have a FSES performed?

  No
- Can this tag qualify for Substandard quality of care?

  No

0020-Policies and Procedures including Evacuation

- Facilities must develop policies and procedures that provide for the safe evacuation of patients from the facility and include all of the requirements of this standard. RHCs and FQHCs must also place exit signs to guide patients and staff in the event of an evacuation from the facility.
- Facilities must have policies and procedures which address the needs of evacuees
- The policies and procedures must address staff responsibilities during evacuations
- Facilities must consider in their development of policies and procedures, the needs of their patient population and what designated transportation services would be most appropriate
- Facilities should consider their triaging system when coordinating the tracking and potential evacuation of patient/residents/clients. For instance, a triaging system for evacuation may consider the most critical patients first followed by those less critical and dependent on life-saving equipment
- For communicating this information, a facility could consider color coordination of triage level (i.e. green folder with this information is for less critical patients; red folders for critical and urgent evacuated patients, etc.). Additionally, this hard copy could include family member/representative contact information.

Survey Procedures

Understanding the Survey:

- Review the emergency plan to verify it includes policies and procedures for safe evacuation from the facility and that it includes all of the required elements.
- When surveying an RHC or FQHC, verify that exit signs are placed in the appropriate locations to facilitate a safe evacuation.

Understanding enforcement:

- Can this tag be waivered?

  No
- Can this tag have a FSES performed?

  No
- Can this tag qualify for Substandard quality of care?

  No

0022-Policies and Procedures for Sheltering

- Emergency plans must include a means for sheltering all patients, staff, and volunteers who remain in the facility in the event that an evacuation cannot be executed. . In certain disaster situations (such as tornadoes) , sheltering in place may be more appropriate as opposed to evacuation and would require a facility to have a means to shelter in place for such emergencies.
- Facilities are expected to include in their policies and procedures the criteria for determining which patients and staff that would be sheltered in place.
- When developing policies and procedures for sheltering in place, facilities should consider the ability of their building(s) to survive a disaster and what proactive steps they could take prior to an emergency to facilitate sheltering in place or transferring of patients to alternate settings if their facilities were affected by the emergency

Survey Procedures

Understanding the Survey:

- Verify the emergency plan includes policies and procedures for how it will provide a means to shelter in place for patients, staff and volunteers who remain in a facility.
- Review the policies and procedures for sheltering in place and evaluate if they aligned with the facility's emergency plan and risk assessment

Understanding enforcement:

- Can this tag be waivered?

  No
- Can this tag have a FSES performed?

  No
- Can this tag qualify for Substandard quality of care?

  No

0023-Policies and Procedures for Medical Docs

- In addition to any existing requirements for patient records found in existing laws, under this standard, facilities are required to ensure that patient records are secure and readily available to support continuity of care during emergency.

Survey Procedures

Understanding the Survey:

- Ask to see a copy of the policies and procedures that documents the medical record documentation system the facility has developed to preserves patient (or potential and actual donor for OPOs) information, protects confidentiality of patient (or potential and actual donor for OPOs) information, and secures and maintains availability of records.

Understanding enforcement:

- Can this tag be waivered?

  No
- Can this tag have a FSES performed?

  No
- Can this tag qualify for Substandard quality of care?

  No

0024-Policies and Procedures for Volunteers

- During an emergency, a facility may need to accept volunteer support from individuals with varying levels of skills and training. The facility must have policies and procedures in place to facilitate this support
- In order for volunteering healthcare professionals to be able to perform services within their scope of practice and training, facilities must include any necessary privileging and credentialing processes in its emergency preparedness plan policies and procedures
- Non-medical volunteers would perform non-medical tasks. Facilities have flexibility in determining how best to utilize volunteers during an emergency as long as such utilization is in accordance with State law, State scope of practice rules, and facility policy

Survey Procedures

Understanding the Survey:

- Verify the facility has included policies and procedures for the use of volunteers and other staffing strategies in its emergency plan.

Understanding enforcement:

- Can this tag be waivered?

  No
- Can this tag have a FSES performed?

  No
- Can this tag qualify for Substandard quality of care

  No

0025-Arrangement with other Facilities

- Facilities are required to have policies and procedures which include prearranged transfer agreements, which may include written agreements or contracted arrangements with other facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.
- Facilities should consider all needed arrangements for the transfer of patients during an evacuation.

Survey Procedures

Understanding the Survey:

- Ask to see copies of the arrangements and/or any agreements the facility has with other facilities to receive patients in the event the facility is not able to care for them during an emergency.
- Ask facility leadership to explain the arrangements in place for transportation in the event of an evacuation.

Understanding enforcement:

- Can this tag be waivered?

  No
- Can this tag have a FSES performed?

  No
- Can this tag qualify for Substandard quality of care?

  No

0026-Roles under a Waiver Declared by Secretary

- Facilities must develop and implement policies and procedures that describe its role in providing care at alternate care sites during emergencies
- It is expected that state or local emergency management officials might designate such alternate sites, and would plan jointly with local facilities on issues related to staffing, equipment and supplies at such alternate sites.
- Facility's policies and procedures must specifically address the facility's role in emergencies where the President declares a major disaster or emergency under the Stafford Act or an emergency under the National Emergencies Act, and the HHS Secretary declares a public health emergency
- Facilities policies and procedures should address what coordination efforts are required during a declared emergency in which a waiver of federal requirements under section 1135 of the Act has been granted by the Secretary.

Survey Procedures

Understanding the Survey:

- Verify the facility has included policies and procedures in its emergency plan describing the facility's role in providing care and treatment (except for RNHCI, for care only) at alternate care sites under an 1135 waiver.

Understanding enforcement:

- Can this tag be waivered?

  No
- Can this tag have a FSES performed?

  No
- Can this tag qualify for Substandard quality of care?

  No

0029-Development of Communication Plan

- Facilities must have a written emergency communication plan that contains how the facility coordinates patient care within the facility, across healthcare providers, and with state and local public health departments.
- The communication plan should include how the facility interacts and coordinates with emergency management agencies and systems to protect patient health and safety in the event of a disaster.
- The development of a communication plan will support the coordination of care
- The plan must be reviewed annually and updated as necessary. We are allowing facilities flexibility in
- How they formulate and operationalize the requirements of the communication plan.
- Facilities in rural or remote areas with limited connectivity to communication methodologies such as the Internet, World Wide Web, or cellular capabilities need to ensure their communication plan addresses how they would communicate and comply with this requirement in the absence of these communication methodologies.

Survey Procedures

Understanding the Survey:

- Verify that the facility has a written communication plan by asking to see the plan.
- Ask to see evidence that the plan has been reviewed (and updated as necessary) on an annual basis.

Understanding enforcement:

- Can this tag be waivered?

  No
- Can this tag have a FSES performed?

  No
- Can this tag qualify for Substandard quality of care?

  No

0030-Names and Contact Information

- A facility must have the contact information for those individuals and entities outlined within the standard.
- The requirement to have contact information for “other facilities” requires a provider or supplier to have the contact information for another provider or supplier of the same type as itself

Survey Procedures

Understanding the Survey:

- Verify that all required contacts are included in the communication plan by asking to see a list of the contacts with their contact information.
- Verify that all contact information has been reviewed and updated at least annually by asking to see evidence of the annual review.

Understanding enforcement:

- Can this tag be waivered?

  No
- Can this tag have a FSES performed?

  No
- Can this tag qualify for Substandard quality of care?

  No

0031-Emergency Officials Contact Information

- A facility must have the contact information for those individuals and entities outlined within the standard
- Facilities have discretion in the formatting of this information, however it should be readily available and accessible to leadership during an emergency event.
- Facilities are encouraged but not required to maintain these contact lists both in electronic format and hard-copy format in the event that network systems to retrieve electronic files are not accessible.
- All contact information must be reviewed and updated at least annually.

Survey Procedures

Understanding the Survey:

- Verify that all required contacts are included in the communication plan by asking to see a list of the contacts with their contact information.
- Verify that all contact information has been reviewed and updated at least annually by asking to see evidence of the annual review.

Understanding enforcement:

- Can this tag be waivered?

  No
- Can this tag have a FSES performed?

  No
- Can this tag qualify for Substandard quality of care?

  No

0032-Primary/Alternate Means for Communication

- Facilities are required to have primary and alternate means of communicating with staff, Federal, State, tribal, regional, and local emergency management agencies. Facilities have the discretion to utilize alternate communication systems that best meets their needs.
- We recognize that some facilities, especially in remote areas, may have difficulty using some communication systems, such as cellular phones, even in non-emergency situations, which should be outlined within their risk assessment and addressed within the communications plan. It is expected these facilities would address such challenges when establishing and maintaining a well-designed communication system that will function during an emergency.
- The communication plan should include procedures regarding when and how alternate communication methods are used, and who uses them. In addition the facility should ensure that its selected alternative means of communication is compatible with communication systems of other facilities, agencies and state and local officials it plans to communicate with during emergencies

Survey Procedures

Understanding the Survey:

- Verify the communication plan includes primary and alternate means for communicating with facility staff, Federal, State, tribal, regional and local emergency management agencies by reviewing the communication plan.
- Ask to see the communications equipment or communication systems listed in the plan.

Understanding enforcement:

- Can this tag be waivered?

  No
- Can this tag have a FSES performed?

  No
- Can this tag qualify for Substandard quality of care?

  No

0033-Methods for Sharing Information

- Facilities are required to develop a method for sharing information and medical (or for RNHCIs only, care) documentation for patients under the facility's care, as necessary, with other health care providers to maintain continuity of care
- Such a system must ensure that information necessary to provide patient care is sent with an evacuated patient to the next care provider and would also be readily available for patients being sheltered in place. While the regulation does not specify timelines for delivering patient care information, facilities are expected to provide patient care information to receiving facilities during an evacuation, within a timeframe that allows for effective patient treatment and continuity of care.
- Facilities (with the exception of HHAs, RHCs, FQHCs, and CORFs) are also required to have a means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510 and 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).

Survey Procedures

Understanding the Survey:

- Verify the communication plan includes a method for sharing information and medical (or for RNHCIs only, care) documentation for patients under the facility's care, as necessary, with other health (or care for RNHCIs) providers to maintain the continuity of care by reviewing the communication plan.
  - For RNCHIs, verify that the method for sharing patient information is based on a requirement for the written election statement made by the patient or his or her legal representative.
- Verify the facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients, by reviewing the communication plan

Understanding enforcement:

- Can this tag be waivered?

  No
- Can this tag have a FSES performed?

  No
- Can this tag qualify for Substandard quality of care?

  No

0034-Sharing Information on Occupancy/Needs

- Facilities, except for transplant centers, must have a means of providing information about the facility's needs and its ability to provide assistance to the authority having jurisdiction (local and State emergency management agencies, local and state public health departments, the Incident Command Center, the Emergency Operations Center, or designee).
- For hospitals, CAHs, RNHCIs, inpatient hospices, PRTFs, LTC facilities, and ICF/IIDs, they must also have a means for providing information about their occupancy.
- Occupancy reporting is considered, but not limited to, reporting the number of patients currently at the facility receiving treatment and care or the facility's occupancy percentage. The facility should consider how its occupancy affects its ability to provide assistance.

Survey Procedures

Understanding the Survey:

- Verify the communication plan includes a means of providing information about the facility's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee by reviewing the communication plan.
- For hospitals, CAHs, RNHCIs, inpatient hospices, PRTFs, LTC facilities, and ICF/IIDs, also verify if the communication plan includes a means of providing information about their occupancy.

Understanding enforcement:

- Can this tag be waivered?

  No
- Can this tag have a FSES performed?

  No
- Can this tag qualify for Substandard quality of care?

  No

0035-LTC and ICF/IID Family Notifications

- LTC facilities and ICF/IIDs are required to share emergency preparedness plans and policies with family members and resident representative s or client representatives, respectively.
- Facilities have flexibility in deciding what information from the emergency plan should be shared, as well as the timing and manner in which it should be disseminated. While we are not requiring facilities take specific steps or utilize specific strategies to share this information with residents or clients and their families or representatives, we would recommend that facilities provide a quick "Fact Sheet" or informational brochure to the family members and resident or client representatives which may highlight the major sections of the emergency plan and policies and procedures deemed appropriate by the facility
- Other options include providing instructions on how to contact the facility in the event of an emergency on the public website or to include the information as part of the facility's check-in procedures. The facility may provide this information to the surveyor during the survey to demonstrate compliance with the requirement.

Survey Procedures

Understanding the Survey:

- Ask staff to demonstrate the method the facility has developed for sharing the emergency plan with residents or clients and their families or representatives.
- Interview residents or clients and their families or representatives and ask them if they have been given information regarding the facility's emergency plan.
- Verify the communication plan includes a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with residents or clients and their families or representatives by reviewing the plan.

Understanding enforcement:

- Can this tag be waivered?

  No
- Can this tag have a FSES performed?

  No
- Can this tag qualify for Substandard quality of care?

  No

0036-Emergency Prep Training and Testing

- An emergency preparedness training and testing program as specified in this requirement must be documented and reviewed and updated on at least an annual basis.
- The training and testing program must reflect the risks identified in the facility's risk assessment and be included in their emergency plan. For example, a facility that identifies flooding as a risk should also include policies and procedures in their emergency plan for closing or evacuating their facility and include these in their training and testing program
- This would include, but is not limited to, training and testing on how the facility will communicate the facility closure to required individuals and agencies, testing patient tracking systems and testing transportation procedures for safely moving patients to other facilities.
- Additionally, for facilities with multiple locations, such as multi-campus or multi-location hospitals, the facility's training and testing program must reflect the facility's risk assessment for each specific location.

Survey Procedures

Understanding the Survey:

- Verify that the facility has a written training and testing (and for ESRD facilities, a patient orientation) program that meets the requirements of the regulation.
- Verify the program has been reviewed and updated on, at least, an annual basis by asking for documentation of the annual review as well as any updates made.
- Verify that ICF/IID emergency plans also meet the requirements for evacuation drills and training at §483.470(i).

Understanding enforcement:

- Can this tag be waivered?

  No
- Can this tag have a FSES performed?

  No
- Can this tag qualify for Substandard quality of care?

  No

0037-Emergency Prep Training Program

- Facilities are required to provide initial training in emergency preparedness policies and procedures that are consistent with their roles in an emergency to all new and existing staff, individuals providing services under arrangement, and volunteers
- This includes individuals who provide services on a per diem basis such as agency nursing staff and any other individuals who provide services on an intermittent basis and would be expected to assist during an emergency.
- Facilities should provide initial emergency training during orientation (or shortly thereafter) to ensure initial training is not delayed. With the exception of CORFs which must complete initial training within the first two weeks of employment, we recommend initial training be completed by the time the staff has completed the facility's new hire orientation program.
- Additionally, in the case of facilities with multiple locations, such as multi-campus hospitals, staff, individuals providing services under arrangement, or volunteers should be provided initial training at their specific location and when they are assigned to a new location.
- Facilities have the flexibility to determine the focus of their annual training, as long as it aligns with the emergency plan and risk assessment. Ideally, annual training should be modified each year, incorporating any lessons learned from the most recent exercises, real-life emergencies that occurred in the last year and during the annual review of the facility's emergency program.
- While facilities are required to provide annual training to all staff, it is up to the facility to decide what level of training each staff member will be required to complete each year based on an individual's involvement or expected role during an emergency

0037-Emergency Prep Training Program – Cont.

- Facilities must maintain documentation of the annual training for all staff. The documentation must include the specific training completed as well as the methods used for demonstrating knowledge of the training program.

Survey Procedures

Understanding the Survey:

- Ask for copies of the facility's initial emergency preparedness training and annual emergency preparedness training offerings.
- Interview various staff and ask questions regarding the facility's initial and annual training course, to verify staff knowledge of emergency procedures.
- Review a sample of staff training files to verify staff have received initial and annual emergency preparedness training.

Understanding enforcement:

- Can this tag be waivered?

  No
- Can this tag have a FSES performed?

  No
- Can this tag qualify for Substandard quality of care?

  No

0039-Emergency Prep Testing Requirements

- Facilities must on an annual basis conduct exercises to test the emergency plan, which for LTC facilities also includes unannounced staff drills using the emergency procedures
- Specifically, facilities are required to conduct a tabletop exercise and participate in a full-scale community-based exercise or conduct an individual facility exercise if a community-based exercise is not available
- As the term full-scale exercise may vary by sector, facilities are not required to conduct a full-scale exercise as defined by FEMA or DHS's Homeland Security Exercise and Evaluation Program (HSEEP). For the purposes of this requirement, a full scale exercise is defined and accepted as any operations-based exercise (drill, functional, or full-scale exercise) that assesses a facility's functional capabilities by simulating a response to an emergency that would impact the facility's operations and their given community.
- Facilities are expected to contact their local and state agencies and healthcare coalitions, where appropriate, to determine if an opportunity exists and determine if their participation would fulfill this requirement.
- Facilities are encouraged to engage with their area Health Care Coalitions (HCC) (partnerships between healthcare, public health, EMS, and emergency management) to explore integrated opportunities
- Facilities that are not able to identify a full-scale community-based exercise, can instead fulfill this part of their requirement by either conducting an individual facility-based exercise, documenting an emergency that required them to fully activate their emergency plan, or by conducting a smaller community-based exercise with other nearby facilities.
- Facilities that conduct an individual facility-based exercise will need to demonstrate how it addresses any risk(s) identified in its risk assessment.

Survey Procedures

Understanding the Survey:

- Ask to see documentation of the annual tabletop and full scale exercises (which may include, but is not limited to, the exercise plan, the AAR, and any additional documentation used by the facility to support the exercise.
- Ask to see the documentation of the facility's efforts to identify a full-scale community based exercise if they did not participate in one (i.e. date and personnel and agencies contacted and the reasons for the inability to participate in a community based exercise).
- Request documentation of the facility's analysis and response and how the facility updated its emergency program based on this analysis.

Understanding enforcement:

- Can this tag be waivered?

  No
- Can this tag have a FSES performed?

  No
- Can this tag qualify for Substandard quality of care?
- No

0041-Hospital CAH and LTC Emergency Power

- Note: This provision for hospitals, CAHs and LTC facilities requires these facility types to base their emergency power and stand-by systems on their emergency plan, risk assessment and policies and procedures. The determination for a generator should be made through the development of the facility's risk assessment and policies and procedures. If these facilities determine that no generator is required to meet the emergency power and stand-by systems requirements, then §§482.15(e)(1) and (2), §483.73(e)(1) and (2), §485.625(e)(1) and (2), would not apply.
- However, these facility types are must continue to meet the existing provisions and requirements for their provider/supplier types under physical environment CoPs or any existing LSC guidance.

Emergency and standby power systems

- CMS requires Hospitals, CAHs and LTC facilities to comply with the 2012 edition of the National Fire Protection Association (NFPA) 101 – Life Safety Code (LSC) and the 2012 edition of the NFPA 99 – Health Care Facilities Code in accordance with the Final Rule (CMS–3277–F). NFPA 99 requires Hospitals, CAHs and certain LTC facilities to install, maintain, inspect and test an Essential Electric System (EES) in areas of a building where the failure of equipment or systems is likely to cause the injury or death of patients or caregivers. An EES is a system which includes an alternate source of power, distribution system, and associated equipment that is designed to ensure continuity of electricity to elected areas and functions during the interruption of normal electrical service.
- In addition to the LSC, NFPA 99 and NFPA 110 requirements, the Emergency Preparedness regulation requires all Hospitals, CAHs, and LTC facilities to implement emergency and standby power systems based upon a facility's established emergency plan, policies, and procedures

0041-Hospital CAH and LTC Emergency Power

- Emergency preparedness policies and procedures (substandard (b) of the emergency preparedness requirements) are required to address the subsistence needs of staff and residents, whether the facility decides to evacuate or shelter in place.

Emergency generator location

NFPA 110 contains minimum requirements and considerations for the installation and environmental conditions that may have an effect on Emergency Power Supply System (EPSS) equipment, including, building type, classification of occupancy, hazard of contents, and geographic location.

Under emergency preparedness, the regulations require that the generator and its associated equipment be located in accordance with the LSC, NFPA 99, and NFPA 110 when a new structure is built or an existing structure or building is renovated. Therefore, new structures or building renovations that occur after November 15, 2016, the effective date of the Emergency Preparedness Final Rule must consider NFPA requirements to ensure that the EPSS equipment is in a location to minimize damage.

Emergency generator inspection and testing

NFPA 110 contains routine maintenance and operational testing requirements for emergency and standby power systems, including generators. Emergency generators required by NFPA 99 and the Emergency Preparedness Final Rule must be maintained and tested in accordance with NFPA 110 requirements, which are based on manufacture recommendations, instruction manuals, and the minimum requirements of NFPA 110, Chapter 8.

0041-Hospital CAH and LTC Emergency Power

Emergency generator fuel

NFPA 110 permits fuel sources for generators to be liquid petroleum products (e.g., gas, diesel), liquefied petroleum gas (e.g., propane) and natural or synthetic gas (e.g., natural gas).

Generators required by NFPA 99 are designated by Class, which defines the minimum time, in hours, that an EES is designed to operate at its rated load without having to be refueled. Generators required by NFPA 99 for Hospitals, CAHs and LTC facilities are designated Class X, which defines the minimum run time as being "other time, in hours, as required by application, code or user." However, NFPA 110 does require facilities considering seismic events to maintain a minimum 96 hour fuel supply.

However, NFPA 110 does require facilities considering seismic events to maintain a minimum 96 hour fuel supply. NFPA 110 also requires that generator installations in locations where the probability of interruption of off-site (e.g., natural gas) fuel supplies is high to maintain onsite storage of an alternate fuel source sufficient to allow full output of the ESS for the specified class.

Survey Procedures

Understanding the Survey:

- Verify that the hospital, CAH and LTC facility has the required emergency and standby power systems to meet the requirements of the facility's emergency plan and corresponding policies and procedures
- Review the emergency plan for "shelter in place" and evacuation plans. Based on those plans, does the facility have emergency power systems or plans in place to maintain safe operations while sheltering in place?
- For hospitals, CAHs and LTC facilities which are under construction or have existing buildings being renovated, verify the facility has a written plan to relocate the EPSS by the time construction is completed
- For hospitals, CAHs and LTC facilities with generators:
- For new construction that takes place between November 15, 2016 and is completed by November 15, 2017, verify the generator is located and installed in accordance with NFPA 110 and NFPA 99 when a new structure is built or when an existing structure or building is renovated. The applicability of both NFPA 110 and NFPA 99 addresses only new, altered, renovated or modified generator locations.
- Verify that the hospitals, CAHs and LTC facilities with an onsite fuel source maintains it in accordance with NFPA 110 for their generator, and have a plan for how to keep the generator operational during an emergency, unless they plan to evacuate.

Understanding enforcement:

- Can this tag be waivered?

  No
- Can this tag have a FSES performed?

  No
- Can this tag qualify for Substandard quality of care?

  No

0042-Integrated Health Systems

- Healthcare systems that include multiple facilities that are each separately certified as a Medicare-participating provider or supplier have the option of developing a unified and integrated emergency preparedness program that includes all of the facilities within the healthcare system instead of each facility developing a separate emergency preparedness program.
- If an integrated healthcare system chooses this option, each certified facility in the system may elect to participate in the system's unified and integrated emergency program or develop its own separate emergency preparedness program. It is important to understand that healthcare systems are not required to develop a unified and integrated emergency program. Rather it is a permissible option.
- the separately certified facilities within the healthcare system are not required to participate in the unified and integrated emergency preparedness program.
- If a healthcare system elects to have a unified emergency preparedness program, the integrated program must demonstrate that each separately certified facility within the system that elected to participate in the system's integrated program actively participated in the development of the program.
- each facility should designate personnel who will collaborate with the healthcare system to develop the plan
- This could include the names of personnel at each facility who assisted in the development of the plan and the minutes from planning meetings
- A unified program must be developed and maintained in a manner that takes into account the unique circumstances, patient populations, and services offered at each facility participating in the integrated program.

0042-Integrated Health Systems

- Each separately certified facility must be capable of demonstrating during a survey that it can effectively implement the emergency preparedness program and demonstrate compliance with all emergency preparedness requirements at the individual facility level. Compliance with the emergency preparedness requirements is the individual responsibility of each separately certified facility.
- The unified emergency preparedness program must include a documented community–based risk assessment and an individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach. This is especially important if the facilities in a healthcare system are located across a large geographic area with differing weather conditions.
- The unified program must have a coordinated communication plan and training and testing program. For example, if the unified emergency program incorporates a central point of contact at the "system" level who assists in coordination and communication, such as during an evacuation, each facility must have this information outlined within its individual plan.
- This type of integrated healthcare system emergency program should focus the training and exercises to ensure communication plans and reporting mechanisms are seamless to the emergency management officials at state and local levels to avoid potential miscommunications between the system and the multiple facilities under its control.

Survey Procedures

Understanding the Survey:

- Verify whether or not the facility has opted to be part of its healthcare system's unified and integrated emergency preparedness program. Verify that they are by asking to see documentation of its inclusion in the program.
- Ask to see documentation that verifies the facility within the system was actively involved in the development of the unified emergency preparedness program.
- Ask to see documentation that verifies the facility was actively involved in the annual reviews of the program requirements and any program updates.
- Ask to see a copy of the entire integrated and unified emergency preparedness program and all required components (emergency plan, policies and procedures, communication plan, training and testing program).
- Ask facility leadership to describe how the unified and integrated emergency preparedness program is updated based on changes within the healthcare system such as when facilities enter or leave the system.

Understanding enforcement:

- Can this tag be waivered?

  No
- Can this tag have a FSES performed?

  No
- Can this tag qualify for Substandard quality of care?

  No


QUESTIONS