STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G169	A. BUILDING _____ B. WING _____	04/17/2018

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E 000	Initial Comments THIS FACILITY IS IN COMPLIANCE WITH THE CONDITIONS OF PARTICIPATION FOR INTERMEDIATE CARE FACILITIES FOR PERSONS WITH MENTAL RETARDATION FOUND AT 42 CFR 483.400 THRU 483.460 AND 42 CFR 483.480 (GENERAL/HEALTH REQUIREMENTS)."	E 000		
E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(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.] * [For hospitals at §482.15 and CAHs at §485.625(a):] 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. 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 annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that	E 004		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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E 004	Continued From page 1 must be [evaluated], and updated at least annually. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure an acceptable risk assessment was performed to address and identify hazards (e.g. natural, man-made, facility, geographic, etc.) in the facility's emergency plan (EP). The finding is: The EP risk assessment was not performed. Review on 4/16/18 of facility documents revealed the following: There was no risk assessment completed to address and identify hazards (e.g. natural, man-made, facility, geographic, etc.) for the facility. Interviews on 4/16/18 with the qualified intellectual disabilities professional (QIDP) revealed he was not aware of the need to perform a risk assessment. Additional interview via telephone with the facility administrator revealed the agency was not aware of what the actual structure of the EP or how it was to be developed.	E 004		
E 007	EP Program Patient Population CFR(s): 483.475(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. 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	E 007		

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E 007	Continued From page 2 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 interview and record review, the facility failed to ensure an acceptable risk assessment was performed to address the needs of the population served in the facility's emergency plan (EP). The finding is: The EP risk assessment was not specific to the needs of the client population. Review on 4/16/18 of facility documents revealed the following: A training for fire and tornado drills and the evacuation procedures. There was no risk assessment available specific to the at-risk client population at the facility. Interviews (2) on 4/16/18 with the qualified intellectual disabilities professional (QIDP) and the facility administrator (via phone) revealed they were not aware of the risk assessment to address the specific needs of the facility population.	E 007		
E 013	Development of EP Policies and Procedures CFR(s): 483.475(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	E 013		

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E 013	Continued From page 3 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 annually. *[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 annually. 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 interview, the facility failed to develop specific policies and procedures to address emergency preparedness, considering risk	E 013		

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E 013	Continued From page 4 assessment and their communication plan in case of an emergency evacuation of the clients in the facility. The finding is: During an interview on 4/16/18, with management revealed they did not have policies and procedures specifically for the emergency preparedness plan.	E 013		
E 032	Primary/Alternate Means for Communication CFR(s): 483.475(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 annually.] 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 documentation and interviews, the facility failed to develop an alternate means for communicating with facility staff, regional and local governments during an emergency. The finding is: The facility failed to develop an alternate means for communicating with staff, regional and local governments during an emergency.	E 032		

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E 032	Continued From page 5 Review on 4/16/18 of the facility's emergency preparedness (EP) did not include any information regarding alternate means of communication. During an interview on 4/16/18, management revealed if the land line phone and cell service were down there was not another way to communicate during an emergency.	E 032		
E 036	EP Training and Testing CFR(s): 483.475(d) (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 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 annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).	E 036		

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E 036	Continued From page 6 *[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 reviewed and updated at least annually. This STANDARD is not met as evidenced by: Based on document review and interviews, the facility failed to develop an emergency preparedness (EP) training and testing program. The finding is: The facility failed to develop an EP training and testing program. Review on 4/16/18 of the facility's EP manual, it did not include any information on training or testing for the staff. During an interview on 4/17/18, staff revealed they had not been tested on the EP and they could only provide the training for fire and tornado drills. During an interview on 4/16/18, the qualified intellectual disabilities professional (QIDP) confirmed there was no documentation for staff training or tesing regarding the EP.	E 036		