Emergency Preparedness Final Rule:

SURVEYOR READINESS!

CMS Consortium for Quality Improvement and Survey and Certification Operations (CQISCO), Div. of Survey & Certification, Branch Managers/G5 Emergency Preparedness Workgroup

CMS Center for Clinical Standards and Quality (CCSQ), Quality, Safety, and Oversight Group (QSOG)

National Webinar – Tuesday, August 14, 2018

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Webinar- 6 sections

- **1135 Waiver Process and** *Flexibilities vs Waiver; Provider Relocation; Temporary Facilities*
- **The Emergency Preparedness Final Rule & Survey Considerations/Frequent E-Tag citations**
- **2567s to Promote Provider/Supplier Compliance**
- **E-tag Case Studies/ EP Surveyors Subject Matter Experts**

  1)Risk Assessment and Planning 2)Policies and Procedures 3) Communication Plan

  4) Training and Testing 5) Alternate Power Source
- **Emergency Preparedness Resources**
- *Questions*

Objectives

At the conclusion of this presentation you will be able to:

- Demonstrate an understanding of when 1135 Waivers can be activated and how a provider or supplier can request a waiver or flexibility
- Demonstrate knowledge of the EP Final Rule, its Four Core Elements, and understand survey considerations
- Demonstrate awareness of how E-tags have been cited and how surveyors determine compliance
- Understand the qualities/specificity needed in a Statement of Deficiencies to promote provider/supplier compliance
- Understand the E-tag citation process in each of the EP Four Core Elements and Alternate Power Source
- Demonstrate knowledge of how to access resources on Emergency Preparedness to assist providers/suppliers to develop robust plans

The 1135 Waiver Process

Purpose of an 1135 Waiver

- Is to ensure sufficient health care items and services are available to meet the needs of Medicare, Medicaid and CHIP beneficiaries; and to allow
- Health care providers that provide such services in good faith can be reimbursed for them and not subjected to sanctions for noncompliance, absent any fraud or abuse.

1135 Waiver

- **SCOPE: The 1135 focuses on** Federal Requirements only, not state licensure. **It includes determining the**: Scope and severity of event with specific focus on health care infrastructure; Are there unmet needs for health care providers? Can these unmet needs be resolved within our current regulatory authority?

- **PURPOSE: Its purpose is to** allow reimbursement during an emergency or disaster even if providers can't comply with certain requirements that would under normal circumstances bar Medicare, Medicaid or CHIP payment.

- **DURATION: It has a limited duration. It will** end no later than the termination of the emergency period, or 90 days from the date the waiver or modification is first published unless the Secretary of HHS extends the waiver by notice for additional periods of up to 60 days, up to the end of the emergency period.

Waivers DO NOT:

- 1135 waivers are not a grant or financial assistance program
- Do not allow reimbursement for services otherwise not covered
- Do not allow individuals to be eligible for Medicare who otherwise would not be eligible
- Should NOT impact any response decisions, such as evacuations.
- Do not last forever. And appropriateness may fade as time goes on.

The Final Rule: 1135 Waivers and Surveyors

- For 1135 waivers and the requirement under E-0026, a facility is to demonstrate in writing it has policy/procedure which addresses the general awareness of the 1135 process
- There is no specific form or document template.
- However, surveyors must verify that the facility has a policy and procedure to address who to contact (i.e., contact information) in the event an 1135 waiver needs to be requested and the facility's role of in the provision of care and treatment at an alternate care site identified by emergency management officials.

The Final Rule: 1135 Waivers and Surveyors

We recommend facilities have policies and procedures which address: a) knowledge of how to request a waiver, b) the circumstances when an 1135 waiver might be granted based on the risk analysis; c) how they would operate under this granted waiver (e,g., notifying staff, patients, and the community of the waiver such as providing services at an alternate site.) d) how they would plan jointly on issues related to staffing, equipment, and supplies) and e)) download or have immediate access to the CMS 1135 Website at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135waivers.html

If you as a surveyor find that the facility makes it clear they are confused by the 1135 process and requirements, we recommend giving them the contact information for the Survey State Agency and the Regional Office (which are listed on next slide).

Resources on 1135 Waivers

Email Addresses for CMS Regional Offices:

ROATLHSQ@cms.hhs.gov (Atlanta RO): Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee

RODALDSC@cms.hhs.gov (Dallas RO): Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

ROPHIDSC@cms.hhs.gov (Northeast Consortium): Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia, New York, New Jersey, Puerto Rico, Virgin Islands, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

ROCHISC@cms.hhs.gov (Midwest Consortium): Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin, Iowa, Kansas, Missouri, and Nebraska

ROSFOSO@cms.hhs.gov (Western Consortium): Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming, Alaska, Idaho, Oregon, Washington, Arizona, California, Hawaii, Nevada, and the Pacific Territories

Quality, Safety & Oversight Group 1135 Waiver Resource Website at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers.html

The Final Rule: 1135 Waivers and Surveyors

Additionally, facilities should have in place policies and procedures which address emergency situations in which a declaration was not made and where an 1135 waiver my not be applicable, such as during a disaster affecting a single facility.

In this case, policies and procedures should address potential transfers of patients, timelines of patients at alternate facilities, etc.

The reference is Appendix Z of the State Operations Manual

CMS Flexibility vs Waiver

- Question: What is the difference between a “flexibility” and a “waiver?”
- Answer: A flexibility is either a sub-regulatory policy or procedure or a policy or procedure that can be amended under the terms of the implementing statute or regulation and that, in either case, CMS can revise at will without reprogramming its systems or making an official grant of waiver. A waiver or a modification is generally thought of as a waiver or modification of a statutory requirement of the Social Security Act (Act) and implementing regulations that may be waived or modified under the authority of § 1135 of the Act.

Examples of Two Flexibilities

- Special Purpose Renal Dialysis Facility (SPRDF) – Serves ESRD patients on an emergency basis when approved permanent facilities close due to natural disasters.

- Temporary Closure – Allows facilities to retain CMS CCN while the facility is temporarily closed to complete repairs of physical structures.

Provider Relocation

- If a provider who has been adversely impacted by a declared public health emergency is unable to restart full operations, can they maintain their existing Medicare or Medicaid provider agreement while the facility is closed? Can a provider relocate, and what are the procedures for program certification if relocation is necessary?

- Reviewed on a case by case basis
- Relocation?

Provider Relocation (cont'd)

- To retain the current provider certification, the entity must demonstrate to the RO that it is functioning as essentially the same provider serving the same community.
    - The provider remains in the same State and complies with the same State licensure requirements.
    - The provider remains the same type of Medicare provider after relocation.
    - The provider maintains at least 75 percent of the same medical staff, nursing staff and other employees, and contracted personnel.

Temporary Facilities

- In the event of extensive damage, use of temporary, mobile facilities may be necessary

Emergency Preparedness Final Rule

Emergency Preparedness Final Rule

- Published September 16, 2016 & applies to all 17 provider and supplier types; **Implementation date November 15, 2017**
- Compliance required for participation in Medicare (and Medicaid, as applicable)
- Emergency Preparedness is one new Condition of Participation/Condition for Coverage of many already required
- Appendix Z contains Interpretive Guidance and survey procedures
- The new Emergency Preparedness Tags are E-Tags
- If facilities are non-compliant, the same general enforcement procedures will occur as is currently in place for any other conditions or requirements cited for non-compliance

When and How?

On what occasion will the EP conditions be surveyed?

Answer: The EP conditions will be surveyed in conjunction with existing survey cycles and not limited to- full/initial surveys, complaints…. (not a stand-alone survey, unless it's a complaint)

Per Appendix Z: These Conditions of Participation (CoP), Conditions for Coverage (CfC), Conditions for Certification and Requirements follow the standard survey protocols currently in place for each facility type and will be assessed during initial, validation, recertification and complaint surveys as appropriate. **Compliance with the Emergency Preparedness requirements will be determined in conjunction with the existing survey process/cycles for health and safety compliance surveys or Life Safety Code (LSC) surveys for each provider and supplier type**.

When and How?

On what occasion will the EP conditions be surveyed?

Answer: From Appendix Z:

These Conditions of Participation (CoP), Conditions for Coverage (CfC), Conditions for Certification and Requirements follow the standard survey protocols currently in place for each facility type and will be assessed during initial, revalidation, recertification and complaint surveys as appropriate. **Compliance with the Emergency Preparedness requirements will be determined in conjunction with the existing survey process for health and safety compliance surveys or Life Safety Code (LSC) surveys for each provider and supplier type**.

Four Provisions for All Provider Types

SURVEYING E0001 v E0004

- It is important to note that there is a difference between E0001 and E0004.
- **E0001-** Is the Emergency Preparedness PROGRAM (the overall CoP/Cfc or requirement). This should be cited if the facility has no elements of the Emergency Preparedness Plans, Policies and Procedures, Communication or Training and Testing Program.

- **E0004-** Is the Emergency PLAN. This is the risk assessment and plans, not the entire program.

SURVEYING E001

- **Survey Procedures for E001:**
- *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.*
- **Survey Procedures for E004:**
- *Verify the facility has an emergency preparedness plan by asking to see a copy of the plan.*
- *Ask facility leadership to identify the hazards 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*

Citing E0001 v E0004

- **How and where would a facility be cited for the complete omission of an emergency preparedness plan or one of the core standards/elements?**
- **Answer:** If a facility has no emergency preparedness plan**, E-0004** would be cited at the Condition level (NLTC) or as a F level deficiency (LTC). If the facility had an emergency preparedness plan, but was missing certain elements of the plan, then the surveyor would cite standard level compliance at the relevant tag for the substandard.

SURVEYING Four Provision Areas At-A-Glance

- **Risk Assessment and Planning (Annually):**
  - Develop an emergency plan based on a risk assessment; Perform risk assessment using an “all-hazards” approach, focusing on capacities and capabilities.

Interviews & Documentation Verification. Reminder: There is no specific format or document for facilities to use. May vary per provider and/or facility.

- **Policies and Procedures (Annually):**
  - Develop and implement policies and procedures based on the emergency plan and risk assessment.
  - Policies and procedures must address a range of issues including subsistence needs, evacuation plans, procedures for sheltering in place, tracking patients and staff during an emergency, to the extent applicable for each provider/type (varies by provider).

Interviews & Documentation Verification. Reminder: There is no specific format or document for facilities to use. May vary per provider and/or facility.

SURVEYING Four Provision Areas *Continued*

- **Communication Plan (Annually):**
  - Develop a communication plan that complies with both Federal and State laws.
  - Coordinate patient care within the facility, across health care providers, and with state and local public health departments and emergency management systems

Interviews & Documentation Verification.

If they have the contact information, this will suffice. They do not have to advise who they spoke to at local, state and federal levels of emergency management.

Ask to see the communications equipment or communication systems listed in the plan.

SURVEYING Four Provision Areas *Continued*

- **Training & Testing Program (Annually):**
  - Develop and maintain training and testing programs, including initial training in policies and procedures. Demonstrate knowledge of emergency procedures and provide training at least annually.
  - Conduct drills and exercises to test the emergency plan

Interviews & Documentation Verification.

Interview various staff and ask questions regarding the facility's initial and annual training course, to verify staff knowledge of emergency procedures.

Look for training rosters for staff training.

SURVEYING Emergency Power- LTC, CAH, Hospitals

- **Emergency and standby power systems. The LTC, CAH or Hospital must implement emergency and standby power systems based on the emergency plan.**

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.

REMINDER: LTC Facilities, unless they have residents on life saving equipment, do not have to have a permanent generator. It's based on their Risk Assessment.

THE EP FINAL RULE DOES NOT AFFECT EXISTING LSC REQUIREMENTS.

Cite LSC violations as appropriate under your K Tags.

SURVEYING Integrated & Unified EP Programs

- **The rule allows a provider that is part of a healthcare system consisting of multiple separately certified healthcare facilities to have one unified and integrated emergency preparedness program.**
- **The integrated emergency plan and policies and procedures must be developed in a manner that takes into account each separately certified facility's unique circumstances, patient populations, services offered. In addition, a risk assessment must be conducted for each separately certified facility within the system.**
- **Note: Each separately certified facility must meet the COP on its own, meaning upon survey each separate facility in a system is required to be able to demonstrate how they have met the requirements.**

Non-Compliance Found

Should surveyors revisit a facility if a survey finds only Emergency Preparedness condition citations?

Answer: No. The facility may submit their Emergency Preparedness Plan or deficient elements with the plan of correction.

In general, a desk review of the submitted material may be conducted to determine compliance.

Note: There may be times where an on-site survey may be necessary or appropriate- at the discretion of the SA/RO.

CMS Analysis of EP Rule Citations

- CMS will review recent emergency preparedness deficiencies among provider types.
- We will begin analyzing citations in hopes to conduct a trend analysis by Region and Provider type which may provide insight on:
  - Identify ways to strengthen emergency preparedness efforts at all levels
  - Enhance and hone future technical assistance efforts
  - Highlight geographic variances
  - Reduce surveyor variances
  - Create a reporting template that may serve many customers
  - Create a baseline of information that can be updated and monitored

Do Not Go Outside of the Scope of Survey Procedures

- CO has received multiple inquiries/complaints from facilities questioning their EP citations. Among these:
  - Surveyors requiring leadership to identify specific names on whom they spoke to in emergency management agencies
  - Surveyors stating that the facilities are being cited for the Emergency Program although the facility had some elements (E0001 v E0004 Issue)

- Stick with the survey procedures in Appendix Z or contact your RO for guidance. The rule is broad and flexible for providers. Subjective.

2567s to Promote Provider/Supplier Compliance

Citations on the Statement of Deficiencies

- The survey process determines compliance or noncompliance
- The Statement of Deficiencies (SOD) justifies the determination

- Consistent and accurate documentation is essential
- Must be based on objective, factual observations and not vague conclusions

- SOD defends the determination before the public, during the appeals process, or in court.
- Citations can also help guide the provider to make necessary corrections

8 Principles of Documentation

- Identify Compliance and Noncompliance
- Use Plain Language
- 3 Components of a Deficiency Citation--(A) a regulatory reference, (B) a deficient practice statement and (C) relevant findings.
- Relevance of Onsite Correction of Findings
- **HOW** the entity fails to comply with the regulatory requirements (not Interpretive Guidelines)
- Citation of State or Local Code Violations-when the Federal regulation requires compliance with State or local laws
- Cross-Reference-EACH citation must have sufficient evidence to stand-alone
- Condition of Participation-**identifies requirements which must be corrected to find the COP in compliance** OR by narrative description of the individual findings

Examples

E 029 Development of Communication Plan CFR(s): 483.475(c)

This STANDARD is not met as evidenced by:

Based on an XX/XX/XXXX review of the facility's Emergency Action and Response Procedures (i.e. the facility's emergency preparedness program) and an XX/XX/XXXX interview with the facility's Director of Residential Services, it was determined that the procedures failed to include an adequate communication plan. SEE E0030, E0031, and E0034.

The failure of the agency to include this information in their procedures effects all residents of the facility.

Examples

E 022 Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4)

Based on an XX/XX/XXXX review of the facility's Emergency Response Procedures, it was determined that the procedures failed to include an adequate plan for sheltering in place.

Examples

Based on documentation review and staff interview, the facility's Emergency Preparedness plan did not address policies and procedures regarding the sheltering in place of residents, staff and volunteers who remain in the facility during an emergency or disaster event. The facility lacked a policy.

The findings are:
On XX/XX/XXXX between 12pm- 2:00pm during the recertification survey, review of the facility's Emergency Preparedness plan revealed that they lacked a policy regarding the sheltering in place of residents, staff and volunteers who will remain in the facility during an emergency.
Facilities are required to have policies and procedures for sheltering in place which align with the facility's risk assessment and are expected to include the criteria for determining which patients and staff would be sheltered in place.
In an interview on XX/XX/XXXX at approximately 2:00pm, the Director of Support Services stated that they will update and revise the policies and procedures.

Examples

E 006 Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2)

This REQUIREMENT is not met as evidenced by:
Based on a review of the facility's Emergency Preparedness Plan (EPP), the facility failed to utilize an All-Hazards approach for risk assessment.

Examples—E 006

Based on a review of the facility's Emergency Preparedness Plan (EPP) and interview on
XX/XX/XXXX in the presence of administration, it was determined that the facility failed to include a potential for missing residents within the documented, facility-based and community-based risk assessment. This deficient practice was evidenced by the following:
A review of the facility's EPP revealed that the plan included a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. However, the risk assessment did not include a risk assessment for missing residents.
In an interview at 11:30 AM, the facility's Administrator was notified of the missing information.

Examples- E 015

E 015 Subsistence Needs for Staff and Patients
CFR(s): 483.73(b)(1)

Based on a review of the Emergency Response Plan and interviews, the facility failed to have policies and procedures in place to provide for subsistence needs as required.

Examples

Based on a review of the facility's Emergency Preparedness Plan (EPP) and interviews on 5/30/18 with facility management and administration, it was determined that the facility failed to provide a alternate power to maintain the safe and sanitary storage of food provisions. This deficient practice was evidenced by the following:

A review of the facility's EPP revealed that the facility's emergency generators do not supply power to food storage refrigerators and freezers in the kitchen. Further review revealed that there was no policy and procedure within the EPP for the storage of food in the facility's refrigerators and freezers in the kitchen in the event of a power loss.

In an interview, at 11:00 AM, the facility's Maintenance Director stated that emergency power was supplied to six lights in kitchen. The refrigerators and freezers are not on the emergency power system. In an interview at 11:30 AM, the facility's Administrator was notified of the missing information.

Citation Levels

If the provider has absolutely nothing done for their EP policies, cite E0001 as a **COP** or at a scope/severity of **F** if it's a LTC provider.

When 1 of the core elements is issued as deficient, cite the core element, and then cite E0001 as the COP for providers where it is a condition, or cite it as the overarching tag for NH at an F.

When documenting findings at E0001, reference the core element such as E0004 etc., to describe why E0001 is out.

Panel Discussion

E-Tag Case Studies

Linda Brown
Barbara Daggy
Michelle Veach
Bruce Wexelberg

E-Tag Case Study #1:
Risk Assessment and Planning

Linda Brown
Michelle Veach

E-Tag Case Study #1:
Risk Assessment and Planning

Survey Date: 4/26/2018
Tag: E0006

- **ASC**
- **Recertification Survey**

E0006:

“Based on record review and interview, the facility failed to document and identify, thru a risk assessment, an all hazards approach in their Emergency Preparedness Program (EPP). This in the event of a disaster or other emergency would leave the facility and its occupants vulnerable to the hazards of the event. Findings include: On (cont.)

E0006 (cont.):

04/26/2018 while reviewing the facility's EPP, the only hazards identified in the plan were hurricanes, tornadoes and fires (internal). Concurrent with the record review and during the exit conference, the Director of Nursing said that their plan would need to be updated to meet the new Federal requirements including an all hazards approach and the addition of potential hazards to their program."

General Considerations – Risk Assessment and Planning

- **Develop an emergency plan based on a risk assessment**
- **Perform a risk assessment using an “all hazards” approach focusing on capacities and capabilities.**
- **Plan updated annually**

E-Tag Case Study #2:
Policies and Procedures

Bruce Wexelberg

E-Tag Case Study #2:
Policies and Procedures

Survey Date: 4/20/2018
Tag: E0022

- **SNF/NF**
- **Recertification Survey**

E0022:

“Based on documentation review and staff interview, the facility's Emergency Preparedness plan did not address policies and procedures regarding the sheltering in place of residents, staff and volunteers who remain in the facility during an emergency or disaster event. The facility lacked a policy. The findings are: On 4/20/18 between 12pm- 2:00pm during the recertification survey, review of the facility's Emergency Preparedness plan revealed that they lacked a policy regarding the sheltering in place of residents, staff and volunteers who will (cont.)

E0022 (cont.)

remain in the facility during an emergency. Facilities are required to have policies and procedures for sheltering in place which align with the facility's risk assessment and are expected to include the criteria for determining which patients and staff would be sheltered in place. In an interview on 4/20/18 at approximately 2:00pm, the Director of Support Services stated that they will update and revise the policies and procedures."

General Considerations – Policies and Procedures

- **Policies and procedures are based on what has been determined to be a risk during the All Hazardous Risk Assessment.**
- **There should be a policy/procedure document for each item that has been determined to be a risk.**
- **Policies and procedures should include what to do in response to a risk (emergency) and what needs to be done to get back to normal operations when the emergency has passed.**

E-Tag Case Study #3:
Communication Plan

Linda Brown
Michelle Veach

E-Tag Case Study #3:
Communication Plan

Survey Date: 12/5/2017
Tag: E0029

- **ICF/IID**
- **Recertification Survey**

E0029

“Based on an 11/27/17 review of the facility’s Emergency Action and Response Procedures (i.e. the facility’s emergency preparedness program) and an 11/27/17 interview with the facility’s Directory of Residential Services, it was determined that the procedures failed to include an adequate communications plan. SEE E0030, E0031, and E0034.”

General Considerations – Communication Plan

- **E29 Development of Communication Plan**
- **E030 Names & Contact Information**
- **E 031 Emergency Officials Contact Information**
- **E034 Sharing Information Occupancy/ Needs**

E-Tag Case Study #4:
Training and Testing

Barbara Daggy

E-Tag Case Study #4:
Training and Testing

Survey Date: 2/15/2018
Tag: E0039

- **ESRD**
- **Recertification Survey**

E0039

“Based on interviews and document review the facility failed to participate in a second full scale, individual, or facility tabletop exercise resulting in the lack of data being analyzed so the facility's emergency plan could be evaluated and updated if required. Findings include: Policies: Facility Emergency Management Plan revised September 2017 provided by administrative assistant (AA) #2 read complete two drills annually. Attend a full scale community-based drill. If one is not available conduct an individual or facility based drill. 1. The facility failed to ensure an emergency preparedness (cont.)

E0039 (cont.)

drill had occurred either by a full scale community activity, individual or facility based drill. a. Facility Administrator #1 was interviewed on 2/13/18 at 9:03 a.m. He reported the facility had not completed a community based drill because there was not one available. He reported the facility had not conducted an individual or facility based drill as well. b. Medical Director #5 was interviewed on 1/18/18 at 8:57 a.m. He stated he thought this was something that had to be looked at."

General Considerations – Training and Testing

TRAINING: facility provide education and instruction

- Annual review and update Training & Testing (T&T) program
- T&T program must reflect risks identified

TESTING: training operationalized-facility evaluates effectiveness of T&T and EP overall program

- Test plan - tabletop and drills applicable to identified risks
- Testing the plan with a tabletop which applies to your risks

E-Tag Case Study #5:
Alternate Power

Michelle Veach

E-Tag Case Study #5:
Alternate Power

Survey Date: 2/8/2018
Tag: E0041

- **Hospital/CAH**
- **Recertification Survey**

E0041

“Based on observation, interview, and document review, the Critical Access Hospital failed to implement emergency power system inspection, testing, and maintenance requirements. Failure to monitor and maintain the emergency generator places patients, staff, and visitors at risk of injury and unsafe conditions during a power failure. Findings included: 1. On 02/07/18 at 11:20 AM, the Deputy Fire Marshal reviewed the hospital's Emergency Preparedness Plan, revised 10/17. The plan did not include the following required elements: a. No battery back-up (cont.)

E0041 (cont.)

emergency lights in the ATS (automatic transfer switch) room. b. No annual fuel quality test. c. Weekly inspections not documented for the preceding three weeks. 2. An interview with hospital staff at the time of review confirmed the findings."

General Considerations – Alternate Power

- **The appropriate NFPA code and section need to be included in the surveyor's deficiency notes.**
- **Be familiar with the requirements located in NFPA 99, 101, and 110 and their applicability for EP surveys.**

EP Resources / Web links

EP Resources/ web links

- Centers for Medicare & Medicaid (CMS) Survey and Certification Emergency Preparedness Website: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html
- Assistant Secretary for Preparedness and Response (ASPR) TRACIE Website: https://asprtracie.hhs.gov/
- State Operations Manual Appendix Z- Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/Advanced-Copy-SOM-Appendix-Z-EP-IGs.pdf

Surveyor FAQs and More

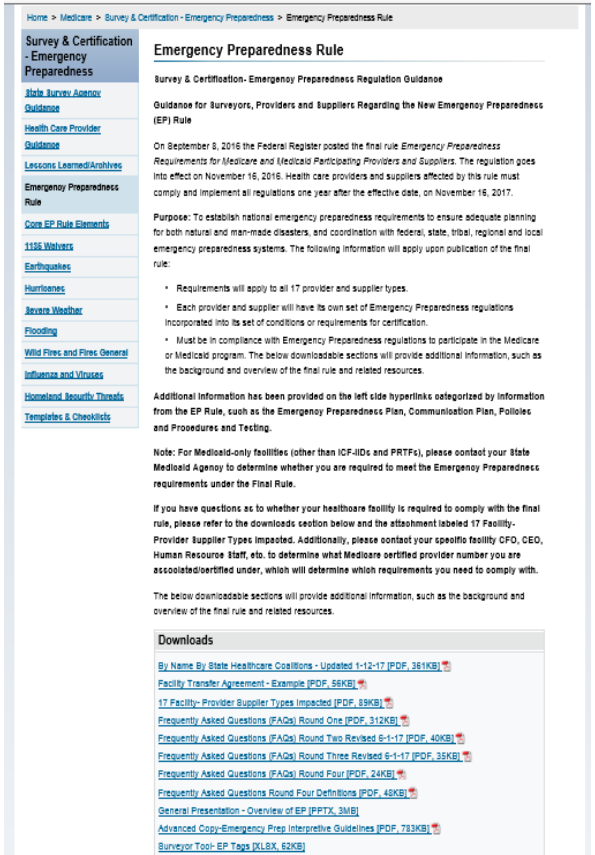
- CO/RO Hosted a Webinar for Providers on 6/19. This presentation, along with the FAQs from the webinar is on both surveyor and provider sides of the QSEP Training Portal

- https://surveyortraining.cms.hhs.gov/pubs/ClassInformation.aspx?cid=0CMSEPPR_WEB

- We will be posting the slides from today on the surveyor side. Also, please review the Surveyor Only FAQs under the Emergency Prep training in QSEP

If you can't access the link, please search "Emergency Preparedness" under the course catalog

The Quality, Safety & Oversight EP Website



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Survey & Certification - Emergency Preparedness

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Emergency Preparedness Rule

Survey & Certification- Emergency Preparedness Regulation Guidance

Guidance for Surveyors, Providers and Suppliers Regarding the New Emergency Preparedness (EP) Rule

On September 8, 2016 the Federal Register posted the final rule *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers*. The regulation goes into effect on November 16, 2016. Health care providers and suppliers affected by this rule must comply and implement all regulations one year after the effective date, on November 16, 2017.

Purpose: To establish national emergency preparedness requirements to ensure adequate planning for both natural and man-made disasters, and coordination with federal, state, tribal, regional and local emergency preparedness systems. The following information will apply upon publication of the final rule:

- Requirements will apply to all 17 provider and supplier types.
- Each provider and supplier will have its own set of Emergency Preparedness regulations incorporated into its set of conditions or requirements for certification.
- Must be in compliance with Emergency Preparedness regulations to participate in the Medicare or Medicaid program. The below downloadable sections will provide additional information, such as the background and overview of the final rule and related resources.

Additional information has been provided on the left side hyperlinks categorized by information from the EP Rule, such as the Emergency Preparedness Plan, Communication Plan, Policies and Procedures and Testing.

Note: For Medicaid-only facilities (other than ICF-IIDs and PRTFs), please contact your State Medicaid Agency to determine whether you are required to meet the Emergency Preparedness requirements under the Final Rule.

If you have questions as to whether your healthcare facility is required to comply with the final rule, please refer to the downloads section below and the attachment labeled 17 Facility-Provider Supplier Types Impacted. Additionally, please contact your specific facility CFO, CEO, Human Resource Staff, etc. to determine what Medicare certified provider number you are associated/certified under, which will determine which requirements you need to comply with.

The below downloadable sections will provide additional information, such as the background and overview of the final rule and related resources.

Downloads

- By Name By State Healthcare Coalitions - Updated 1-12-17 [PDF, 361KB]
- Facility Transfer Agreement - Example [PDF, 56KB]
- 17 Facility- Provider Supplier Types Impacted [PDF, 89KB]
- Frequently Asked Questions (FAQs) Round One [PDF, 312KB]
- Frequently Asked Questions (FAQs) Round Two Revised 6-1-17 [PDF, 40KB]
- Frequently Asked Questions (FAQs) Round Three Revised 6-1-17 [PDF, 35KB]
- Frequently Asked Questions (FAQs) Round Four [PDF, 24KB]
- Frequently Asked Questions Round Four Definitions [PDF, 48KB]
- General Presentation - Overview of EP [PPTX, 3MB]
- Advanced Copy-Emergency Prep Interpretive Guidelines [PDF, 783KB]
- Surveyor Tool- EP Tags [XLSX, 62KB]

QSO Emergency Preparedness Website has an area with FAQs and resources available to surveyors and stakeholders: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html

SUMMARY & WRAP UP

We are all working together to evaluate the emergency preparedness of our providers and suppliers

– all 17 types

… through our solid examination of required emergency preparedness …

… .using this EP survey process to strengthen emergency preparedness of our Medicare healthcare providers and suppliers and protect our Medicare beneficiaries.

Questions

THANKS!

We appreciate and would like to acknowledge the contributions of the CMS CQISCO Division of Survey & Certification Branch Managers-G5 EP Workgroup and the CCSQ Quality, Safety, and Oversight Group:

- Caecilia Blondiaux, Special Assistant, CMS, Quality, Safety & Oversight Group (QSOG), Center for Clinical Standards and Quality,
- Linda G. Brown, RN, Nurse Surveyor, CMS Region III, Northeast Division of Survey & Certification
- Barbara Daggy, RN, Nurse Surveyor and LSC, CMS Region X, Western Division of Survey & Certification
- Karen Fuller, Branch Manager, CMS Region IX, and WDSC Emergency Coordinator, Western Division of Survey & Certification
- Hulio Griffin, Branch Manager, CMS Region IV, Atlanta Division of Survey & Certification
- Captain Gregory Hann, USPHS, CMS Region V, Midwest Division of Survey & Certification
- Shannon Hills-Kline, Branch Manager, CMS Region VI, Dallas Division of Survey & Certification

.....continued.....

…and more THANKS!

We appreciate and would like to acknowledge the contributions of the CMS CQISCO Division of Survey & Certification Branch Managers-G5 EP Workgroup and the CCSQ Quality, Safety, and Oversight Group:

- CAPT Nancy Miller, Branch Manager, CMS Region II, Northeast Division of Survey & Certification
- Lauren Reinertsen, Associate Regional Administrator, Northeast Division, Survey & Certification
- Adriane Saunders, Technical Advisor, CMS Region IV, Atlanta Division of Survey & Certification
- Michelle Veach, Life Safety Engineer, CMS Central Office, Division of Nursing Homes
- Bruce Wexelberg, Safety Engineer, CMS Region V, Midwest Division of Survey & Certification

Special Thanks to Sandra Pace, Associate Consortium Administrator, Consortium for Quality Improvement and Survey & Certification Operations, for 1135 Waiver material.

Thank You for your Participation.

For Additional Questions, please contact your Regional Offices.