State Operations Manual
Appendix Z- Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance

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(Rev.)

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E-0001

(Rev.)

§403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12

The [facility, except for Transplant *Programs*] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements:

* (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.)

*[For hospitals at §482.15:] **The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:**

*[For CAHs at §485.625:] **The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:**

Interpretive Guidelines applies to: §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12.

NOTE: This does not apply to Transplant *Programs*.
NOTE: The word comprehensive is not used in the language for ASCs.

Guidance is pending and will be updated in future release.

E-0002
(Rev.)

§482.78 Condition of participation: Emergency preparedness for transplant *programs*. A transplant *program* must be included in the emergency preparedness planning and the emergency preparedness program as set forth in § 482.15 for the hospital in which it is located. However, a transplant *program* is not individually responsible for the emergency preparedness requirements set forth in § 482.15.

Interpretive Guidelines for §482.78.
A representative from each transplant *program* must be actively involved in the development and maintenance of the hospital's emergency preparedness program, as required under §482.15(g)(1).

Transplant *programs* would still be required to have their own emergency preparedness policies and procedures as required under §482.78(a), as well as participate in mutually-agreed upon protocols that address the transplant *program*, hospital, and OPO's duties and responsibilities during an emergency.

Survey Procedures
- Verify that a representative from the transplant *program* was included in the planning of the emergency preparedness program of the hospital in which the transplant *program* is located.

E-0004
(Rev.)

§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).

The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.

The emergency preparedness program must include, but not be limited to, the following elements:

(a) Emergency Plan. **The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least *every 2 years.* The plan must do all of the following:**

***** [For hospitals at §482.15 and CAHs at §485.625(a):] ***Emergency Plan.*** **The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.**

** [For LTC Facilities at §483.73(a):]* ***Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually.***

* [For ESRD Facilities at §494.62(a):] **Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least *every 2 years*.**

Interpretive Guidelines applies to: §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).

NOTE: This does not apply to Transplant *Programs*.
Guidance is pending and will be updated in future release.

E-0005
(Rev.)

§482.78(a) Standard: Policies and procedures. A transplant *program* must have policies and procedures that address emergency preparedness. These policies and procedures must be included in the hospital's emergency preparedness program.

Interpretive Guidelines for §482.78(a).
Transplant *programs* must be actively involved in their hospital's emergency planning and programming under §482.15(g). The transplant *program*'s emergency preparedness plans must be included in the hospital's emergency plans. All of the Medicare-approved transplant *programs* are located within certified hospitals and, as part of the hospital, must be included in the hospital's emergency preparedness plans. The transplant *program* needs to be involved in the hospital's risk assessment because there may be risks to the transplant *program* that others in the hospital may not be aware of or appreciate. However, most of the risk assessment of the hospital and transplant *program* would be the same since the transplant *program* is located within the hospital. Therefore a separate risk assessment would be unnecessary and overly burdensome.

Survey Procedures
- Verify the transplant *program* has emergency preparedness policies and procedures.
- Verify that the transplant *program*'s emergency preparedness policies and procedures are included in the hospital's emergency preparedness program.

E-0006

(Rev.)

§403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2)

[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least *every 2 years*. The plan must do the following:]

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*

(2) Include strategies for addressing emergency events identified by the risk assessment.

[For LTC facilities at §483.73(a)(1):]* ***Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:*
(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.
(2) Include strategies for addressing emergency events identified by the risk assessment.

*[For ICF/IIDs at §483.475(a)(1):] ***Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:***
(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.
(2) Include strategies for addressing emergency events identified by the risk assessment.

* [For Hospices at §418.113(a)(2):] ***Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:***
(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.
(2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.

Interpretive Guidelines applies to: §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2),

§485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2).

NOTE: This does not apply to Transplant *Programs*.
Guidance is pending and will be updated in future release.

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§403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3).

[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least *every 2 years*. The plan must do the following:]

(3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**

[For LTC facilities at §483.73(a)(3):]* ***Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.*
(3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.

Interpretive Guidelines applies to: §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3).

NOTE: This does not apply to Transplant *Programs* and OPOs.
***NOTE: [**"Persons at risk" does not apply to**: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.]**
Guidance is pending and will be updated in future release.

E-0008
(Rev.)

§486.360(a)(3) Condition for Participation:
[(a) Emergency Plan. The OPO must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least *every 2 years*. The plan must do the following:]

(3) Address the type of hospitals with which the OPO has agreements; the type of services the OPO has the capacity to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.

Interpretive Guidelines for §486.360(a)(3).
The emergency plan must address the type of hospitals with which the OPO has agreements and the types of services that the OPO would be able to provide in an emergency. The emergency plan must also identify which staff would assume specific roles in another's absence through succession planning and delegations of authority. Succession planning is a process for identifying and developing staff with the potential to fill key business leadership positions in the company. Succession planning increases the availability of experienced and capable employees that are prepared to assume these roles as they become necessary. During times of emergency, facilities must have internal employees who are capable of assuming various critical roles in the event that current staff and leaders are not available. At a minimum, facilities should designate 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.

In addition to the facility- and community-based risk assessment, continuity of operations planning generally considers elements such as: essential personnel, essential functions, critical resources, vital records and IT data protection, alternate facility identification and location, and financial resources. Facilities are encouraged to refer to and utilize resources from various agencies such as FEMA and ASPR when developing strategies for ensuring continuity of operations.

Survey Procedures
Interview leadership and ask them to describe the following:

- Services the OPO would be able to provide during an emergency;
- How the OPO plans to continue operations during an emergency;
- Delegations of authority and succession plans.
- How the OPO has included/addressed all of the hospitals with which it has agreements into its emergency plan.

Verify that all of the above are included in the written emergency plan.

E-0009
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§403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.*102*(a)(4), §485.68(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4)

[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least *every 2 years* (annually for LTC facilities). The plan must do the following:]

(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. **

* [For ESRD facilities only at §494.62(a)(4)]: **(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency.**

Interpretive Guidelines applies to: §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.*102*(a)(4), §485.68(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4).

NOTE: This does not apply to Transplant *Programs*.
Guidance is pending and will be updated in future release.

E-0010
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§485.727(a)(4) Condition for Participation:
[(a) Emergency Plan. The Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services ("Organizations") must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least *every 2 years*. The plan must do the following:]

(4) Address the location and use of alarm systems and signals; and methods of containing fire.

Interpretive Guidelines for §485.727(a)(4).
Guidance is pending and will be updated in future release.

E-0011
(Rev.)

§485.68(a)(5) Condition for Participation:

[(a) Emergency Plan. The Comprehensive Outpatient Rehabilitation Facility (CORF) must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least *every 2 years*. The plan must do the following:]

(a)(5) Be developed and maintained with assistance from fire, safety, and other appropriate experts.

§485.727(a)(6) Condition for Participation:
[(a) Emergency Plan. The Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services ("Organizations") must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least *every 2 years*. The plan must do the following:]

(a)(6) Be developed and maintained with assistance from fire, safety, and other appropriate experts.

Interpretive Guidelines applies to: §485.68(a)(5), §485.727(a)(6).
The CORF and Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services must collaborate with fire, safety and other appropriate experts to develop and maintain its emergency plan. They must document their collaboration with these experts and include them in the *2-year* review of the plan.

Survey Procedures
- Ask for a list of/documentation for which experts were collaborated with to develop and maintain its plan.

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(Rev.)

§ 482.78 Condition of participation: Emergency preparedness for transplant *programs*. A transplant *program* must be included in the emergency preparedness planning and the emergency preparedness program as set forth in § 482.15 for the hospital in which it is located. However, a transplant *program* is not individually responsible for the emergency preparedness requirements set forth in § 482.15.

(a) Standard: Policies and procedures.
A transplant *program* must have policies and procedures that address emergency preparedness. These policies and procedures must be included in the hospital's emergency preparedness program.

(b) Standard: Protocols with hospital and OPO. A transplant *program* must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the transplant *program*, the hospital in which the transplant

program **is operated, and the OPO designated by the Secretary, unless the hospital has an approved waiver to work with another OPO, during an emergency.**

Interpretive Guidelines applies to: §482.78(a), and §482.78(b).
Hospitals which have transplant *programs* must include within their emergency planning and preparedness process one representative, at minimum, from the transplant *program*. If a hospital has multiple transplant *programs*, each *program* must have at least one representative who is involved in the development and maintenance of the hospital's emergency preparedness process. The hospital must include the transplant *programs* in its emergency preparedness plan policies and procedures, communication plans, as well is the training and testing programs.

Both the hospital and the transplant *programs* are required to demonstrate during a survey that they have coordinated in planning and the development of the emergency program. Both are required to have written documentation of the emergency preparedness plans. However, the transplant *programs* is not individually responsible for the emergency preparedness requirements under §482.15.

Survey Procedures

- Verify the hospital has written documentation to demonstrate that a representative of each transplant *programs* participated in the development of the emergency program.
- Ask to see documentation of emergency protocols that address transplant protocols that include the hospital, the transplant *programs* and the associated OPOs.

E-0013

(Rev.)

§403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).

(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least *every 2 years*.

[For LTC facilities at §483.73(b):]* ***Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.*

*Additional Requirements for PACE and ESRD Facilities:

*[For PACE at §460.84(b):] **Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: *F*ire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least *every 2 years*.**

*[For ESRD Facilities at §494.62(b):] **Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least *every 2 years* These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.**

Interpretive Guidelines applies to: §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).

NOTE: This does not apply to Transplant *Programs*.
Guidance is pending and will be updated in future release.

E-0014
(Rev.)

§482.78(b) Standard: Protocols with hospital and OPO. A transplant *program* must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the transplant *program*, the hospital in which the transplant *program* is operated, and the OPO designated by the Secretary, unless the hospital has an approved waiver to work with another OPO, during an emergency.

Interpretive Guidelines for §482.78(b).
Transplant *programs* must be involved in the development of mutually agreed upon protocols that address the duties and responsibilities of the hospital, transplant program and the designated OPO during emergencies.

All transplant *programs* are located within Medicare participating hospitals. Any hospital that furnishes organ transplants and other medical and surgical specialty services for the care of transplant patients is defined as a transplant hospital (42 CFR 482.70). Therefore, transplant *programs* must meet all hospital CoPs at §§482.1 through 482.57 (as set forth at §482.68(b)), and the hospitals in which they are located must meet the

provisions of § 482.15, however, a transplant *program* is not individually responsible for the emergency preparedness requirements in §482.15.

The hospital in which a transplant *program* is located (i.e., a transplant hospital) would be responsible for ensuring that the transplant *program* is involved in the development of an emergency preparedness program. This requirement does not oblige a transplant *program* that agrees to care for another transplant *program*'s patients during an emergency to put those patients on its waiting lists. We anticipate that most emergencies would be of short duration and that the transplant *program* that is affected by an emergency will resume its normal operations within a short period of time. However, if a transplant *program* does arrange for its patients to be transferred to another transplant *program* during an emergency, both transplant *program* would need to determine what care would be provided to the transferring patients, including whether and under what circumstances the patients from the transferring transplant *program* would be added to the receiving *transplant program's* waiting lists.

Survey Procedures

- Verify the transplant *program* has developed mutually agreed upon protocols that address the duties and responsibilities of the transplant *program*, the hospital in which the transplant *program* is operated, and the designated OPO.
- Ask to see documentation of the protocols.

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(Rev.)

§403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1)

[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated *every 2 years (annually for LTC)*. At a minimum, the policies and procedures must address the following:

(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:

(i) Food, water, medical and pharmaceutical supplies

(ii) Alternate sources of energy to maintain the following:

(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.

(B) Emergency lighting.

(C) Fire detection, extinguishing, and alarm systems.

(D) Sewage and waste disposal.

*[For Inpatient Hospice at §418.113(b)(6)(iii):] **Policies and procedures.**

(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:

(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:

(A) Food, water, medical, and pharmaceutical supplies.

(B) Alternate sources of energy to maintain the following:

(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.

(2) Emergency lighting.

(3) Fire detection, extinguishing, and alarm systems.

(C) Sewage and waste disposal.

Interpretive Guidelines applies to: §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1).

NOTE: This does not apply to ASCs, Outpatient Hospice Providers [applies to inpatient hospices], Transplant *Programs*, HHA, CORFs, CMHCs, RHCs/FQHCs, ESRD facilities.

Guidance is pending and will be updated in future release.

E-0016

(*Rev.*)

§418.113(b)(1): Condition for Participation:

[(b) Policies and procedures. The hospice must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least *every 2 years*.] At a minimum, the policies and procedures must address the following:

(1) Procedures to follow up with on duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency. The hospice must inform State and local officials of any on-duty staff or patients that they are unable to contact.

Interpretive Guidelines for §418.113(b)(1).

Hospices have the flexibility to determine how best to develop these policies and procedures. For administrative purposes, all hospices should already have some mechanism in place to keep track of patients and staff contact information. However, the information regarding patient services that are needed during or after an interruption in their services and on-duty staff and patients that were not able to be contacted must be readily available, accurate, and shareable among officials within and across the emergency response system, as needed, in the interest of the patient.

Survey Procedures

- Review the emergency plan to verify it includes policies and procedures for following up with staff and patients.
- Interview a staff member or leadership and ask them to explain the procedures in place in the event they are unable to contact a staff member or patient.

E-0017

(Rev.)

§484.102(b)(1) Condition for Participation:

[(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least *every 2 years*.]
At a minimum, the policies and procedures must address the following:]

(1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55.

Interpretive Guidelines for §484.102(b)(1).
HHAs must include policies and procedures in its emergency plan for ensuring all patients have an individualized plan in the event of an emergency. That plan must be included as part of the patient's comprehensive assessment.

For example, discussions to develop individualized emergency preparedness plans could include potential disasters that the patient may face within the home such as fire hazards, flooding, and tornados; and how and when a patient is to contact local emergency officials. Discussions may also include patient, care providers, patient representative, or any person involved in the clinical care aspects to educate them on steps that can be taken to improve the patient's safety. The individualized emergency plan should be in writing and could be as simple as a detailed emergency card to be kept with the patient. HHA personnel should document that these discussions occurred and also keep a copy of the individualized emergency plan in the patient's file as well as provide a copy to the patient and or their caregiver.

Survey Procedures

- Through record review, verify that each patient has an individualized emergency plan documented as part of the patient's comprehensive assessment.

E-0018

(Rev.)

§403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1).

[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least *every 2 years (annually for LTC)*.] At a minimum, the policies and procedures must address the following:]

[(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.

*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] **Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.**

*[For Inpatient Hospice at §418.113(b)(6):] **Policies and procedures.**
(ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.
(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.

*[For CMHCs at §485.920(b):] **Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.**

*[For OPOs at § 486.360(b):] **Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.**

*[For ESRD at § 494.62(b):] **Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.**

Interpretive Guidelines applies to: §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1).

NOTE: This does not apply to Transplant *Programs*, HHAs, Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services, RHCs/FQHCs.
Guidance is pending and will be updated in future release.

E-0019
(Rev.)

§418.113(b)(2), §460.84(b)(4), §484.102(b)(2)

[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least *every 2 years*. At a minimum, the policies and procedures must address the following:]

*[For homebound Hospice at §418.113(b)(2), PACE at §460.84(b)(4), and HHAs at §484.102(b)(2):] **The procedures to inform State and local emergency preparedness officials about [homebound Hospice, PACE or HHA] patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical and psychiatric condition and home environment.**

Interpretive Guidelines applies to: §418.113(b)(2), §460.84(b)(4), §484.102(b)(2).

NOTE: The regulatory language for hospices under §418.113(b)(2) does not include the terms "emergency preparedness" when describing officials.
NOTE: This only applies to homebound Hospice, PACE and HHAs.
Guidance is pending and will be updated in future release.

E-0020
(Rev.)

§403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2)

[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set

forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least *every 2 years (annually for LTC)*. At a minimum, the policies and procedures must address the following:]

[(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

*[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):]
Safe evacuation from the [RNHCI or ASC] which includes the following:

(i) Consideration of care needs of evacuees.
(ii) Staff responsibilities.
(iii) Transportation.
(iv) Identification of evacuation location(s).
(v) Primary and alternate means of communication with external sources of assistance.

* [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):]
Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients.

* [For RHCs/FQHCs at §491.12(b)(1):] **Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients**.

Interpretive Guidelines applies to: §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2)

NOTE: This does not apply to HHAs, OPOs, and Transplant *Programs*.
NOTE: The requirements under §418.113(b)(6)(ii) is not a requirement for outpatient hospice providers.
Guidance is pending and will be updated in future release.

E-0021
(Rev.)

§484.102(b)(3) Condition of Participation:
[(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in

paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least *every 2 years*.] At a minimum, the policies and procedures must address the following:]

(3) The procedures to follow up with on-duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency. The HHA must inform State and local officials of any on-duty staff or patients that they are unable to contact.

Interpretive Guidelines for §484.102(b)(3).
Guidance is pending and will be updated in future release.

E-0022
(Rev.)

§403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3).

(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least *every 2 years (annually for LTC)*.] At a minimum, the policies and procedures must address the following:]

[(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility].

*[For Inpatient Hospices at §418.113(b):] **Policies and procedures.**
(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:

> **(i) A means to shelter in place for patients, hospice employees who remain in the hospice.**

Interpretive Guidelines applies to: §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3).

NOTE: This does not apply to Transplant *Programs*, HHAs or OPOs.
Guidance is pending and will be updated in future release.

E-0023
(Rev.)

§403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4).

[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least *every 2 years (annually for LTC)*.] At a minimum, the policies and procedures must address the following:]

[(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.

*[For RNHCIs at §403.748(b):] **Policies and procedures. (5) A system of care documentation that does the following:**

(i) Preserves patient information.
(ii) Protects confidentiality of patient information.
(iii) Secures and maintains the availability of records.

*[For OPOs at §486.360(b):] **Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.**

Interpretive Guidelines applies to: §403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360 (b)(2), §491.12(b)(3), §494.62(b)(4).

NOTE: This does not apply to Transplant *Programs*.
Guidance is pending and will be updated in future release.

E-0024
(Rev.)

§403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5).

[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this

section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least *every 2 years (annually for LTC)*.] At a minimum, the policies and procedures must address the following:]

(6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

*[For RNHCIs at §403.748(b):] **Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.**

***[**For Hospice at §418.113(b):] **Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.**

Interpretive Guidelines applies to: §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5).

NOTE: This does not apply to Transplant *Programs*, or OPOs.
Guidance is pending and will be updated in future release.

E-0025
(Rev.)

§403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6).

[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least *every 2 years (annually for LTC)*.] At a minimum, the policies and procedures must address the following:]

*[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] **Policies and procedures. (7) [or (5)] The development of 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.**

*[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] **Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.**

*[For RNHCIs at §403.748(b):] **Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients.**

Interpretive Guidelines applies to: §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6).

NOTE: The differences for some providers and suppliers between "and" and "or" are referenced above. Additionally, the there are differences between continuity of "operations" and "services" within the regulatory language.

NOTE: This does not apply to ASCs, Transplant *Programs*, HHAs, CORFs, Clinics, Rehabilitation Agencies and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services, OPOs, RHCs/FQHCs. *Guidance is pending and will be updated in future release.*

E-0026

(Rev.)

§403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7) §494.62(b)(7).

[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least *every 2 years (annually for LTC)*.] At a minimum, the policies and procedures must address the following:]

(8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

*[For RNHCIs at §403.748(b):] **Policies and procedures.** (**8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in**

the provision of care at an alternative care site identified by emergency management officials.

Interpretive Guidelines applies to: §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7)

NOTE: This does not apply to Transplant *Programs*, HHAs, CORFs, Clinics, Rehabilitation Agencies and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services, OPOs, RHCs/FQHCs.
Guidance is pending and will be updated in future release.

E-0027
(Rev.)

§494.62(b)(8) Condition for Coverage:
[(b) Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least *every 2 years*.] At a minimum, the policies and procedures must address the following:]

(8) How emergency medical system assistance can be obtained when needed.

Interpretive Guidelines for §494.62(b)(8).
ESRD facilities must include in its emergency plan, policies and procedures for obtaining emergency medical assistance when needed. Medical system assistance can be considered but not limited to, outside assistance such as from a nearby hospital. Additionally, this can mean assistance from other ESRD facilities including personnel to assist during a single-facility disaster.

Survey Procedures
- Verify the ESRD facility has included in its emergency plan, policies and procedures for obtaining emergency medical assistance when needed.

E-0028
(Rev.)

§494.62(b)(9) Condition for Coverage:
[(b) Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least *every 2 years*.] At a minimum, the policies and procedures must address the following:]

(9) A process by which the staff can confirm that emergency equipment, including, but not limited to, oxygen, airways, suction, defibrillator or automated external defibrillator, artificial resuscitator, and emergency drugs, are on the premises at all times and immediately available.

Interpretive Guidelines for §494.62(b)(9).
ESRD facilities must include policies and procedures in its emergency plan that address a process that confirms that the specific requirements listed under this standard are on the premises at all times and immediately available in the event of an emergency. The process must be in writing. It is the facilities responsibility to determine what equipment is should on the premises and available during an emergency to assist patients in an emergency. Additionally, it is the responsibility of the facility to ensure that all necessary equipment identified in this area, should be in working order at all times in accordance with the manufacturer instructions. Emergency drugs should not be out of date and should be stored and maintained based on the manufacturer instructions. The facility is in the best position to determine what emergency equipment it needs to have available. In addition, dialysis facilities need to be able to manage care-related emergencies during an emergency when other assistance, emergency medical services systems, may not be immediately available to them.

Survey Procedures
- Verify the dialysis facility has a process in place by which its staff can confirm that emergency equipment is on the premises and immediately available.
- Verify that the process includes at least the listed emergency equipment within its emergency plan by asking to see a copy of the written processes/ policy on emergency equipment and medications.
- Check to see that all of the above equipment is available and in working order. Ask to see procedures/checklist for ensuring equipment is checked
- Check to see that all emergency drugs are not out of date.

PACE - NON-CITABLE (No assigned tags)
Reference Only (PACE)
(Rev.)

§460.84(b)(10) Requirement:
[(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 be reviewed and updated at least *every 2 years*.]

The policies and procedures must address management of medical and non-medical 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. Policies and procedures must be reviewed and updated at *every 2 years*. At a minimum, the policies and procedures must address the following:
(10)(i) Emergency equipment, including easily portable oxygen, airways, suction, and emergency drugs.
(ii) Staff who know how to use the equipment must be on the premises of every center at all times and be immediately available.
(iii) A documented plan to obtain emergency medical assistance from outside sources when needed.

Interpretive Guidelines for §460.84(b)(10).
Guidance is pending and will be updated in future release.

E-0029
(Rev.)

§403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c).

(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least *every 2 years (annually for LTC).*

Interpretive Guidelines applies to: §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c).

NOTE: This does not apply to Transplant *Programs*.
Guidance is pending and will be updated in future release.

E-0030
(Rev.)

§403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1).

[(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least *every 2 years (annually for LTC)*.] The communication plan must include all of the following:]

(1) Names and contact information for the following:
(i) Staff.

(ii) Entities providing services under arrangement.
(iii) Patients' physicians
(iv) Other [facilities].
(v) Volunteers.

*[For Hospitals at §482.15(c) and CAHs at §485.625(c)] **The communication plan must include all of the following:**

(1) Names and contact information for the following:
(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Patients' physicians
(iv) Other [hospitals and CAHs].
(v) Volunteers.

*[For RNHCIs at §403.748(c):] **The communication plan must include all of the following:**

(1) Names and contact information for the following:
(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Next of kin, guardian, or custodian.
(iv) Other RNHCIs.
(v) Volunteers.

*[For ASCs at §416.45(c):] **The communication plan must include all of the following:**

(1) Names and contact information for the following:
(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Patients' physicians.
(iv) Volunteers.

*[For Hospices at §418.113(c):] **The communication plan must include all of the following:**

(1) Names and contact information for the following:
(i) Hospice employees.
(ii) Entities providing services under arrangement.
(iii) Patients' physicians.
(iv) Other hospices.

*[For HHAs at §484.102(c):] **The communication plan must include all of the following:**

(1) Names and contact information for the following:
(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Patients' physicians.
(iv) Volunteers.

*[For OPOs at §486.360(c):] **The communication plan must include all of the following:**

(2) Names and contact information for the following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Volunteers.

(iv) Other OPOs.

(v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).

Interpretive Guidelines applies to: §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1).

NOTE: This does not apply to Transplant *Programs*.
Guidance is pending and will be updated in future release.

E-0031

(Rev.)

§403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2).

[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least *every 2 years (annually for LTC).*] The communication plan must include all of the following:

(2) Contact information for the following:

(i) Federal, State, tribal, regional, and local emergency preparedness staff.

(ii) Other sources of assistance.

*[For LTC Facilities at §483.73(c):] **(2) Contact information for the following:**

(i) Federal, State, tribal, regional, and local emergency preparedness staff.

(ii) The State Licensing and Certification Agency.

(iii) The Office of the State Long-Term Care Ombudsman.

(iv) Other sources of assistance.

*[For ICF/IIDs at §483.475(c):] **(2) Contact information for the following:**

(i) Federal, State, tribal, regional, and local emergency preparedness staff.

(ii) Other sources of assistance.

(iii) The State Licensing and Certification Agency.

(iv) The State Protection and Advocacy Agency.

Interpretive Guidelines applies to: §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2).

NOTE: This does not apply to Transplant *Programs*.
Guidance is pending and will be updated in future release.

E-0032
(Rev.)

§403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3).

[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least *every 2 years (annually for LTC)*.] 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.**

Interpretive Guidelines applies to: §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3).

NOTE: This does not apply to Transplant *Programs*.
Guidance is pending and will be updated in future release.

E-0033
(Rev.)

§403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6),

§483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.102(c)(4)-(5), §485.68(c)(4), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6).

[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least *every 2 years (annually for LTC)*.] The communication plan must include all of the following:

(4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care.

(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)]

(6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4).

*[For RNHCIs at §403.748(c):] **(4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative.**

*[For RHCs/FQHCs at §491.12(c):] **(4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).**

Interpretive Guidelines applies to: §403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.102(c)(4)-(5), §485.68(c)(4), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6).

NOTE: For RHCs/FQHC's the regulatory language differs under (c)(4). Additionally, a method for sharing information and medical documentation for patients under the RHC/FQHC's care, as necessary, with other health providers to maintain the continuity of care and a means of providing information about the general condition and location of patients does not apply.

NOTE: This does not apply to Transplant *Programs*.
Guidance is pending and will be updated in future release.

E-0034
(Rev.)

§403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7).

[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least *every 2 years (annually for LTC)*.] The communication plan must include all of the following:

(7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.

*[For ASCs at 416.54(c)]: **(7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.**

*[For Inpatient Hospice at §418.113(c):] **(7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee**.

Interpretive Guidelines applies to: §403.748(c)(7), §416.54(c)(7), §418.113(c)(7), §441.184(c)(7), §460.84(c)(7), §482.15(c)(7), §483.73(c)(7); §483.475(c)(7); §484.102(c)(6); §485.68(c)(5), §485.625(c)(7); §485.727(c)(5); §485.920(c)(7); §491.12 (c)(5), §494.62(c)(7).

NOTE: This does not apply to outpatient hospices or Transplant *Programs*.
Guidance is pending and will be updated in future release.

E-0035
(Rev.)

§483.73(c)(8); §483.475(c)(8)

**[For ICF/IIDs at §483.475(c):]*
[(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years.] The communication plan must include all of the following:

**[For LTC Facilities at §483.73(c):]*
[(c) The LTC 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:

(8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives.

Interpretive Guidelines for §483.73(c)(8) and §483.475(c)(8).
NOTE: This ONLY applies to LTC Facilities and ICF/IIDs.
Guidance is pending and will be updated in future release.

E-0036
(Rev.)

§403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).

**[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, RHC/FHQs at §491.12:]*
(d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.

[For LTC at §483.73(d):]* **(d) Training and testing. The *LTC* facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

*[For ICF/IIDs at §483.475(d):] **Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least *every 2 years*. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).**

*[For ESRD Facilities at §494.62(d):] **Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be *evaluated* and updated at *every 2 years*.**

Interpretive Guidelines applies to: §403.748(d), §416.54(d), §418.113(d), §441.184(d), §482.15(d), §460.84(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).

NOTE: This does not apply to Transplant *Programs*.
Guidance is pending and will be updated in future release.

E-0037
(Rev.)

§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).

**[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]*

(1) Training program. The [facility] must do all of the following:

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.

*[For Hospices at §418.113(d):] **(1) Training. The hospice must do all of the following:**

(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least *every 2 years*.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis

placed on carrying out the procedures necessary to protect patients and others.

(v) Maintain documentation of all emergency preparedness training.

(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] **(1) Training program. The PRTF must do all of the following:**

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) After initial training, provide emergency preparedness training *every 2 years*.

(iii) Demonstrate staff knowledge of emergency procedures.

(iv) Maintain documentation of all emergency preparedness training.

(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] **(1) The PACE organization must do all of the following:**

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least *every 2 years*.

(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.

(iv) Maintain documentation of all training.

(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

[For LTC Facilities at §483.73(d):] *(1) Training Program. The LTC facility must do all of the following:*

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.

(ii) Provide emergency preparedness training at least annually.

(iii) Maintain documentation of all emergency preparedness training.

(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):]**(1) Training. The CORF must do all of the following:**

(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least *every 2 years*.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] **(1) Training program. The CAH must do all of the following:**

(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least *every 2 years*.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.

*[For CMHCs at §485.920(d):] **(1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least *every 2 years*.**

Interpretive Guidelines applies to: §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1)

NOTE: This does not apply to Transplant *Programs* or ESRD facilities.
Guidance is pending and will be updated in future release.

E-0038
(Rev.)

§494.62(d)(1): Condition for Coverage:

(d)(1) Training program. The dialysis facility must do all of the following:

(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least *every 2 years*.

Staff training must:

(iii) Demonstrate staff knowledge of emergency procedures, including informing patients of—

(A) What to do;

(B) Where to go, including instructions for occasions when the geographic area of the dialysis facility must be evacuated;

(C) Whom to contact if an emergency occurs while the patient is not in the dialysis facility. This contact information must include an alternate emergency phone number for the facility for instances when the dialysis facility is unable to receive phone calls due to an emergency situation (unless the facility has the ability to forward calls to a working phone number under such emergency conditions); and

(D) How to disconnect themselves from the dialysis machine if an emergency occurs.

(iv) Demonstrate that, at a minimum, its patient care staff maintains current CPR certification; and

(v) Properly train its nursing staff in the use of emergency equipment and emergency drugs.

(vi) Maintain documentation of the training.

(vii) If the emergency preparedness policies and procedures are significantly updated, the dialysis facility must conduct training on the updated policies and procedures.

Interpretive Guidelines for §494.62(d)(1).

Guidance is pending and will be updated in future release.

E-0039

(Rev.)

§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).

**[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]:*

(2) Testing. The [*facility*] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:

(i) Participate in a full-scale exercise that is community-based ***every 2 years; or***

(A) W**hen a community-based exercise is not accessible,** ***conduct a facility-based functional exercise every 2 years; or***

(B) **If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in** ***its next required*** **community-based or individual, facility-based** ***functional*** **exercise following the onset of the actual event.**

(ii) Conduct an additional exercise ***at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted,*** **that may include, but is not limited to the following:**

(A) A second full-scale exercise that is community-based or individual, facility-based ***functional exercise*****;** ***or***

(B) ***A mock disaster drill; or***

(C) **A tabletop exercise** ***or workshop*** **that** ***is*** **led by a facilitator** ***and includes a group discussion*** **using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.**

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

****[For Hospices at 418.113(d):]***

(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:

(i) Participate in a full-scale exercise that is community based every 2 years; or

(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or

(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or a facility based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or

(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional annual exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or a facility based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.

**[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]*

(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or

(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.

**[For PACE at §460.84(d):]*

(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or

(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.

**[For LTC Facilities at §483.73(d):]*

(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.

(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional annual exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency

scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.

**[For ICF/IIDs at §483.475(d)]:*

(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.

(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional annual exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.

*[For OPOs at §486.360]

(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:

(i) Conduct a paper-based, tabletop exercise *or workshop* at least annually. A tabletop exercise is led by a facilitator *and includes a group discussion*, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. *If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.*

(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.

Interpretive Guidelines applies to: §403.748(d)(2), §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §486.360(d)(2)§491.12(d)(2), §494.62(d)(2)

NOTE: This does not apply to Transplant *Programs*.
Guidance is pending and will be updated in future release.

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(Rev.)

§482.15(g)
(g) Transplant hospitals. If a hospital has one or more transplant *programs* (as defined in § 482.70)—

(1) A representative from each transplant *program* must be included in the development and maintenance of the hospital's emergency preparedness program; and

(2) The hospital must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the hospital, each transplant *program*, and the OPO for the DSA where the hospital is situated, unless the hospital has been granted a waiver to work with another OPO, during an emergency.

Interpretive Guidelines for §482.15(g).
Hospitals which have transplant *programs* must include within their emergency planning and preparedness process one representative, at minimum, from the transplant *program*. If a hospital has multiple transplant *programs*, each center must have at least one representative who is involved in the development and maintenance of the hospital's emergency preparedness process. The hospital must include the transplant *program* in its emergency plan's policies and procedures, communication plans, as well is the training and testing programs.

The hospital must also collaborate with each OPO in its designated service area (DSA) or other OPO if the hospital was granted a waiver to develop policies and procedures (protocols) that address the duties and responsibilities of each entity during an emergency.

Both the hospital and the transplant *program* are required to demonstrate during a survey that they have collaborated in the planning and development of the emergency program. Both are required to have written documentation of the emergency preparedness plans. However, the transplant *program* is not individually responsible for the emergency preparedness requirements under §482.15 (see Tag E-005 at §482.78).

Survey Procedures

- Verify the hospital has written documentation to demonstrate that a representative of each transplant *program* participated in the development of the emergency program.
- Ask to see documentation of emergency protocols that address transplant protocols that include the hospital, the transplant *program* and the associated OPOs.