STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001116	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BLDG B. WING	(X3) DATE SURVEY COMPLETED 05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLI SURGERY CENTER	1601 W LINCOLN RD P.O. BOX 6550, KOKOMO, Indiana, 46904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	INITIAL COMMENTS A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 416.44(b). Survey Date: 05/16/23 Facility Number: 002845 Provider Number: 15C0001116 AIM Number: 200421610B At this LSC survey, CLi Surgery Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 416.44(b), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 21, Existing Ambulatory Health Care Occupancies. This one story facility was determined to be of Type V (111) construction and not sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has 2 certified operating rooms. Quality Review completed on 05/25/23	K0000		
K0223	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors required to be self-closing are permitted to be held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment, entire facility, and all stair enclosure doors upon activation of: * Required manual fire alarm system, and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke	K0223		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K0223	Continued from page 1 detection system; and * Automatic sprinkler system, if installed; and * Loss of power 20.2.2.4, 20.2.2.5, 21.2.2.4, 21.2.2.5 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure 2 of 2 required self closing doors to a hazardous area enclosure and smoke barrier are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2. This deficient practice could affect all occupants. Based on observations during a tour of the facility with the Director of Nursing (DON) on 05/16/23 at 2:10 p.m., the clean holding room which contained combustible storage and the main entrance smoke barrier door were held open with a kick down door stop which did not release when the fire alarm is activated. Based on interview at the time of observation, the Director of Nursing agreed the doors were held open with a device that did not release with the fire alarm. This finding was reviewed with the DON at the exit conference.	K0223		
K0281	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 20.2.8, 21.2.8, 7.8 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure continuity of egress lighting for 2 of 2 exits. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways and exit passageways leading to a public way. This deficient practice could affect all patients, staff and visitors if needing to exit the facility from the front and rear exit doors.	K0281		

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K0281	Continued from page 2 Based on observations with the Director of Nursing (DON) during a tour of the facility at 2:10 p.m. on 05/16/23, the front and rear exit discharges were not provided with emergency egress lighting. THe hours of operation for this facility are 7:00 a.m. to 5:00 p.m. on Tuesdays and Thursdays. During the winter months, the exit discharge from the facility would need to be illuminated. Based on interview at the time of the observations, the DON acknowledged the front and rear exit discharges were not provided with emergency egress lighting. These findings were reviewed with the DON at the exit conference.	K0281		
K0291	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 20.2.9.1, 21.2.9.1, 7.9 This STANDARD is NOT MET as evidenced by: Based on interview, the facility failed to ensure testing for all emergency battery powered lighting units. NFPA 101 2012 edition 7.9.3.1.1 testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds. (2) The test interval shall be permitted to be extended beyond 30 days with approval of the authority having jurisdiction (3) Functional testing shall be conducted annually for a minimum of 1 ½ hours if the emergency lighting is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the test. (5) Written records of visual inspections and tests shall be kept by the owner for inspection for the authority having jurisdiction	K0291		

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K0291	Continued from page 3 This deficient practice could affect all occupants if the facility were required to evacuate in an emergency during a loss of normal power. Based on record review with the Director of Nursing (DON) on 05/16/23 at 11:55 a.m., there was documentation of annual testing of battery-operated emergency lights in the facility, but it was described as a 30 second test instead of the required 90 minute test. Based on interview at the time of record review, the DON acknowledged there was no written record of an annual 90 minute test regarding the battery-operated emergency lights. This finding was reviewed with the DON at the exit conference.	K0291		
K0321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas must meet one of the following: *Contain 1 hour rated enclosure when non-sprinklered *Sprinkler protected with smoke resistive separation *Severe Hazard locations contain sprinkler protection and 1 hour separation with 3/4 hour rated self-closing doors 20.3.2, 21.3.2, 38.3.2, 38.3.2.2, 39.3.2.1, 39.3.2.2, 8.7 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure 2 of 2 hazardous area rooms were protected in accordance with 21.3.2. Section 21.3.2 refers to Section 39.3.2. Section 39.3.2.1 states hazardous areas including, but not limited to, areas used for general storage, boiler or furnace rooms, and maintenance shops that include woodworking and painting areas shall be protected in accordance with Section 8.7. Section 8.7.1.3 requires doors in barriers required to have a fire resistance rating shall have a minimum 3 D4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8. Section 21.3.2.1 also requires doors to hazardous areas to be self-closing or automatic-closing in accordance with 21.2.2.4. Section 21.2.2.4 states any door required to be self-closing shall be permitted to be held open only	K0321		

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K0321	Continued from page 4 by an automatic release device that complies with 7.2.1.8.2. The required manual fire alarm system and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility. This deficient practice could affect staff only. Based on observation with the Director of Nursing (DON) on 05/16/23 at 2:00 p.m. in the clean holding room which is over 50 square feet and had two ten foot by four foot shelf racks filled with supplies, the door had a fire rating of 20 minutes instead of the required 45-minute rating for a non-sprinklered facility. On the door to the soiled holding room there was a kick down stop installed that would not allow the door to close if activated by the fire alarm system. Based on interview at the time of observation, the DON confirmed the clean holding room door was a 20-minute fire-rated door and the soiled holding room failed to self-close because there was a kick down stop installed. This finding was reviewed with the DON at the exit conference.	K0321		
K0323	Anesthetizing Locations CFR(s): NFPA 101 Anesthetizing Locations Areas designated for administration of general anesthesia (i.e., inhalation anesthetics) are in accordance with 8.7 and NFPA 99. Zone valves are located immediately outside each life-support, critical care, and anesthetizing location of moderate sedation, deep sedation, or general anesthesia for medical gas or vacuum; readily accessible in an emergency; and arranged so shutting off any one anesthetizing location will not affect others. Area alarm panels are provided to monitor all medical gas, medical-surgical vacuum, and piped WAGD systems. Panels are at locations that provide for surveillance, indicate medical gas pressure decreases of 20 percent and vacuum decreases of 12 inch gauge HgV, and provide visual and audible indication. Alarm sensors are installed either on the source side of individual room zone valve box assemblies or on the patient/use side of each of the individual zone box valve assemblies. The EES critical branch supplies power for task	K0323		

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K0323	Continued from page 5 illumination, fixed equipment, select receptacles, and select power circuits, and EES equipment system supplies power to ventilation system. Heating, cooling, and ventilation are in accordance with ASHRAE 170. Medical supply and equipment manufacturer's instructions for use are considered before reducing humidity levels to those allowed by ASHRAE, per S&C 13-58. 21.3.2.3, NFPA 99 5.1.4.8.7, 5.1.4.8.7.2, 5.1.9.3.4, 6.4.2.2.4.2 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to provide emergency lighting annual testing in 2 of 2 operating rooms where general anesthesia is administered in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.2.11.1 states one or more battery-powered lighting units shall be provided within locations where deep sedation and general anesthesia is administered. The lighting level of each unit shall be sufficient to terminate procedures intended to be performed within the operating room. The sensor for units shall be wired to the branch circuit(s) serving general lighting within the room. Units shall be capable of providing lighting for 90 minutes and shall be tested monthly for 30 seconds and annually for 30 minutes. Section 3.3.17 defines battery-powered lighting units as individual unit equipment for backup illumination consisting of a rechargeable battery, battery-charging means, provisions for one or more lamps mounted on the equipment, or with terminals for remote lamps, or both, and relaying device arranged to energize the lamps automatically upon failure of the supply to the unit equipment. This deficient practice could affect two patients and staff in operating rooms where general anesthesia or life support equipment is used. Based on observations with the Director of Nursing (DON) at 02:10 p.m. on 05/16/23, Operating Room 1 and Operating Room 2 were each provided with battery operated emergency lighting to provide continuous illumination where general anesthesia is administered. Based on interview at the time of the observations, the DON agreed patients in each of the aforementioned three operating rooms can be completely sedated using general anesthesia and acknowledged there is no battery operated back up emergency lighting system annual 30 minute testing to ensure continuous illumination in each of the two operating rooms where general anesthesia is administered. There was documentation	K0323		

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K0323	Continued from page 6 provided of annual testing done on the battery operated emergency lights within the last year but it was listed as a 30 second test. This finding was reviewed with the DON at the exit conference.	K0323		
K0345	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm Systems - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Section 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by Section 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semiannually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all occupants in the facility. Based on record review on 05/16/23 at 12:30 p.m. with the Director of Nursing (DON) no documentation could be provided regarding a semi-annual visual inspection of the fire alarm system. The most recent annual fire alarm inspections were performed on 02/15/23. There was	K0345		

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K0345	Continued from page 7 no semiannual visual inspection documentation completed six months before the annual inspection date available for review. Based on interview at the time of record review, the DON said that a visual inspection of the fire alarm system's devices was not performed on a semiannual basis. This finding was reviewed with the DON at the exit conference.	K0345		
K0918	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for four continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to exercise the generator once every 36 months for four continuous hours to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Section 8.4.9 which states	K0918		

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K0918	Continued from page 8 Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.5.1 states for a diesel-powered EPS, loading (exercising) shall be not less than 30 percent of the nameplate kW rating of the EPS. A supplemental load bank shall be permitted to be used to meet or exceed the 30 percent requirement. This deficient practice could affect all occupants Based on review of generator testing documentation with the Director of Nursing (DON) at 1:45 p.m. on 05/16/23, there was no documentation to show the diesel powered generator was exercised continuously for 4 hours within the last 36 months. Based on interview at the time of record review, the DON acknowledged there was no documentation of the generator being exercised for 4 continuous hours in the past 36 months. This finding was reviewed with the DON at the exit conference.	K0918		
K0920 Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure 4 of 4 flexible cords were not used as a substitute for fixed wiring according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code.	K0920		

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K0920 Bldg. 01	Continued from page 9 NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and patients in the Operating Rooms and staff in the changing room. Based on observation with the Director of Nursing on 05/16/23 between 1:50 p.m. to 2:00 p.m. the following was discovered: a) a power strip was powering a microwave and toaster in the changing room b) a power strip was being used in Operating room A that was not medical grade. c) a dangling power strip was powering equipment in Operating room A and in Operating room B. Based on interview at the time of observation, the DON acknowledged the misuse of electrical cords. This finding was reviewed with the DON at the exit conference.	K0920		

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 416.54 Survey Date: 05/16/23 Facility Number: 002845 Provider Number: 15C0001116 AIM Number: 200421610B At this Emergency Preparedness survey, CLI Surgery Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 416.54 The facility has 2 certified operating rooms. Quality Review completed on 05/25/23	E0000		
E0023	Policies/Procedures for Medical Documentation CFR(s): 416.54(b)(4) §403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.542(b)(5), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]	E0023		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E0023	Continued from page 1 [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b) and REHs at §485.542(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records in accordance with 42 CFR 416.54. This deficient practice could affect all occupants. Based on record review with the Director of Nursing on 05/16/23 at 11:00 a.m., the provided Emergency Preparedness Plan (EPP) did not contain documentation to indicate the use of a system to preserve resident medical documentation during an emergency. Based on interview at the time of record review then again at the exit conference, the Director of Nursing was unable to find a policy on a system to preserve resident medical documentation in the EPP. This finding was reviewed with the DON during the exit conference.	E0023		
E0026	Roles Under a Waiver Declared by Secretary CFR(s): 416.54(b)(6) §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv),	E0026		

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E0026	Continued from page 2 §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.542(b)(7), §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 facilities]. 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. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure the Emergency Preparedness Plan (EEP) includes the role of the ASC 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 in accordance with 42 CFR 416.54. This deficient practice could affect all occupants. Based on records review with the Director of Nursing (DON) on 05/16/23 at 11:10 a.m., a policy and procedure for the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act was not available for review. Based on interview at the time of record review the DON stated 1135 waiver policy could not be found. This finding was reviewed with the DON during the exit conference.	E0026		
E0029	Development of Communication Plan	E0029		

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E0029	Continued from page 3 CFR(s): 416.54(c) §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.542(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to create an emergency preparedness (EPP) communication plan that complies with Federal, State, and local laws that was reviewed and updated at least every two years in accordance with 42 CFR 416.54. This deficient practice could affect all occupants. Based on review of the facility's EPP with the Director of Nursing on 05/16/23 at 11:15 a.m., no documentation for an emergency preparedness communication plan was available for review. Based on interview at the time of record review, the Director of Nursing stated the EPP did not contain a communication plan. The finding was reviewed with the Director of Nursing during the exit conference.	E0029		
E0036	EP Training and Testing CFR(s): 416.54(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of	E0036		

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E0036	Continued from page 4 this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that is based on the emergency plan accordance with 42 CFR 416.54. This deficient practice could affect all occupants. Based on record review with the Director of Nursing on	E0036		

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E0036	Continued from page 5 05/16/23 at 11:30 a.m., the provided Emergency Preparedness Plan (EPP) did not include a training and testing program. Based on interview at the time of record review then again at the exit conference, the Director of Nursing stated the facility does not have an EPP training program This finding was reviewed with the DON during the exit conference.	E0036		
E0037	EP Training Program CFR(s): 416.54(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies	E0037		

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E0037	Continued from page 6 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,	E0037		

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E0037	Continued from page 7 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	E0037		

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E0037	Continued from page 8 emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure staff were trained in emergency preparedness policies and procedures. The ASC facility must do all of the following: (i) Initial training in	E0037		

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E0037	Continued from page 9 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 two 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 in accordance with 42 CFR 416.54. This deficient practice could affect all occupants. Based on records review with the Director of Nursing on 05/16/23 at 11:30 a.m., there was no documentation available for review to indicate all facility staff were trained and demonstrate knowledge of the Emergency Preparedness Program (EPP) initially for new staff and every two years for existing staff. Based on an interview at the time of records review, the Director of Nursing stated no documentation for staff training could not be found during the survey. The findings were review with the Director of Nursing during the exit conference.	E0037		