	Hospice:		Survey Date:	Surveyor:	
Tag #	Title	CFR Citation	Tag Text (Regulatory Text)	Interpretive Guidelines - Refer to Appendix Z of SOM	Met/Not Met
0001	Establishment of the Emergency Program (EP)	§418.113	The hospice must comply with all applicable Federal, State and local emergency preparedness requirements. The hospice 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:	Under this condition/requirement, hospices are required to develop an emergency preparedness program that meets all of the standards specified within the condition/requirement. The emergency preparedness program must describe a facility's comprehensive approach to meeting the health, safety, and security needs of their staff and patient population during an emergency or disaster situation. The program must also address how the hospice would coordinate with other healthcare facilities, as well as the whole community during an emergency or disaster (natura man-made, facility). The emergency preparedness program must be reviewed annually. Survey Procedures • Request the hospice's EP program. The program includes the risk assessments, EP plan, policies and procedures, communication plan, and training and testing program. • Verify the agency has a program that meets all requirements.	
0004	Develop and Maintain EP Plan	§418.113(a)	Survey Procedure for hospice operated residences and inpatient units:	The plan must be reviewed and updated at least annually. The annual review must be documented to include the date of the review and any updates made to the emergency plan based on the review. The format of the emergency preparedness plan that a facility uses is at its discretion. An emergency plan is one part of a hospice's emergency preparedness program. Survey Procedures • Review the hospice's emergency preparedness plan. Verify the plan contains all of the required elements. • Verify that the plan is reviewed and updated annually.	
0006	Maintain and Annual EP Updates	§418.113(a)(1)-(2)	• Verify policies and procedures for the provision of subsistence needs including, but not limited to, food, water and pharmaceutical supplies for patients and staff.	Hospices are expected to develop an emergency preparedness plan that is based on the facility-based and community-based risk assessment using an “all-hazards” approach. Facilities must document both risk assessments. An example consideration may include, but is not limited to, natural disasters prevalent in a facility’s geographic region such as wildfires, tornados, flooding, etc. An all-hazards approach is an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters. This approach is specific to the location of the facility considering the types of hazards most likely to occur in the area. When developing an emergency preparedness plan, facilities are expected to consider, among other things, the following: • Identification of all business functions essential to the facility’s operations that should be continued during an emergency; • Identification of all risks or emergencies that the facility may reasonably expect to confront; • Identification of all contingencies for which the facility should plan; • Consideration of the hospice's location; • Assessment of the extent to which natural or man-made emergencies may cause the facility to cease or limit operations; and, • Determination of what arrangements may be necessary with other health care facilities, or other entities that might be needed to ensure that essential services could be provided during an emergency. In situations where the hospice does not own the structure(s) where care is provided, it is the hospice's responsibility to discuss emergency preparedness concerns with the landlord to ensure continuation of care if the structure of the building and its utilities are impacted. (inpatient unit or hospice residence) Hospices must develop strategies for addressing emergency events that were identified during the development of the facility- and community-based risk assessments. Examples of these strategies may include, but are not limited to, developing a staffing strategy if staff shortages were identified during the risk assessment or developing a surge capacity strategy if the facility has identified it would likely be requested to accept additional patients during an emergency. Hospices must include contingencies for managing the consequences of power failures, natural disasters, and other emergencies that would affect the hospice’s ability to provide care. Survey Procedures • Verfiy documentation of the hospice based and community based risk assessments and associated strategies. • Verify the risk-assessment is based on an all-hazards approach specific to the geographic location of the hospice and encompasses potential hazard	
0007	EP Program Patient Population	§418.113(a)(3)	• Verify policies and procedures to ensure adequate alternate energy sources necessary to maintain;	The emergency plan must specify the population served within the facility, such as inpatients and/or outpatients, and their unique vulnerabilities in the event of an emergency or disaster. Mobility is an important part in effective and timely evacuations, and therefore facilities are expected to properly plan to identify patients who would require additional assistance, ensure that means for transport are accessible and available and that those involved in transport, as well as the patients and residents are made aware of the procedures to evacuate. For hospices, the emergency plan is required to ensure that patients with limited mobility are addressed within the plan. The emergency plan must also address the types of services that the facility would be able to provide in an emergency. The emergency plan must identify which staff would assume specific roles in another’s absence through succession planning and delegations of authority. At a minimum, there should be a qualified person who "is authorized in writing to act in the absence of the administrator or person legally responsible for the operations of the facility." Survey Procedures - verify the EP plan includes: • Services the hospice would be able to provide during an emergency; • How the hospice plans to continue operations during an emergency (ex. staffing strategies, priortizing patient visits); • Designated person who will be responsible during the emergency in the absence of the administrator (Delegations of authority)	
0009	Process for EP Collaboration	§418.113(a)(4)	o Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions;	The hospice must document its efforts to contact these officials to engage in collaborative planning for an integrated emergency response. The hospice must include this integrated response process in its emergency plan. Facilities are encouraged to participate in a healthcare coalition as it may provide assistance in planning and addressing broader community needs that may also be supported by local health department and emergency management resources. Survey Procedures • Verify the EP plan includes a process to cooperate with state and local emergency management (OEM).	

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0013	Development of EP Policies and Procedures	§418.113(b)	o Emergency lighting; and,	Hospices must develop and implement policies and procedures per the requirements of this standard. The policies and procedures are expected to align with the identified hazards within the hospice's risk assessment and the hospice's overall emergency preparedness program. Hospice may choose whether to incorporate the emergency policies and procedures within their emergency plan or to be part of the facility's Standard Operating Procedures or Operating Manual. Survey Procedures • Verify hospice has written policies and procedures based on their EP plan/program. • Verify the policies and procedures have been reviewed and updated on an annual basis.	
0015	Subsistence needs for staff and patients	§418.113(b)(6)(iii)	o Fire detection, extinguishing, and alarm systems.	Hospice operated inpatient units ONLY must be able to provide for adequate subsistence for all patients and staff for the duration of an emergency or until all its patients have been evacuated and its operations cease. There are no set requirements or standards for the amount of provisions to be provided in facilities, Provisions include, but are not limited to, food, pharmaceuticals and medical supplies. Provisions should be stored in an area which is less likely to be affected by disaster, such as storing these resources above ground-level to protect from possible flooding. Additionally, when inpatient facilities determine their supply needs, they are expected to consider the possibility that volunteers, visitors, and individuals from the community may arrive at the facility to offer assistance or seek shelter. Alternate sources of energy depend on the resources available to a facility, such as battery-operated lights, or heating and cooling, in order to meet the needs of a facility during an emergency. Facilities are not required to upgrade their electrical systems, but after review of their risk assessment, facilities may find it prudent to make any necessary adjustments to ensure that occupant health and safety needs are met, and that facilities maintain safe and sanitary storage areas for provisions. This specific standard does not require facilities to have or install generators or any other specific type of energy source. It is up to each individual facility, based on its risk assessment, to determine the most appropriate alternate energy sources to maintain temperatures to protect patient health and safety and for the safe and sanitary storage of provisions, emergency lighting, fire detection, extinguishing, and alarm systems and sewage and waste disposal. Whatever alternate sources of energy a facility chooses to utilize must be in accordance with local and state laws as well as relevant LSC requirements. Facilities must establish policies and procedures that determine how required heating and cooling of their facility will be maintained during an emergency situation, as necessary, if there were a loss of the primary power source. If a facility determines the best way to maintain temperatures, emergency lighting, fire detection and extinguishing systems and sewage and waste disposal would be through the use of a portable generator, then the Life Safety Code (LSC) provisions, such as generator testing and fuel storage, etc. outlined under the NFPA guidelines would not be applicable. Portable generators should be operated, tested, and maintained in accordance with manufacturer, local and/or State requirements. If a facility, however, chooses to utilize a permanent generator to maintain emergency power, LSC provisions such as generator testing and maintenance will apply and the facility may be subject to LSC surveys to ensure compliance is met. Facilities are not required to provide onsite treatment of sewage but must make provisions for maintaining necessary services. For example, LTC facilities are already required to meet Food Receiving and Storage provisions at §483.35(i) Sanitary Conditions, which contain requirements for keeping food off the floor and clear of ceiling sprinklers, sewer/waste disposal pipes, and vents can also help maintain food quality and prevent contamination. Additionally, we would expect facilities under this requirement to ensure current practices are followed, such as those outlined by the Environmental Protection Agency (EPA) and under State-specific laws. Maintaining necessary services may include, but are not limited to, access to medical gases; treatment of soiled linens; disposal of bio-hazard materials for different infectious diseases; and may require additional assistance from transportation companies for safe and appropriate disposal in accordance with nationally accepted industry guidelines for emergency preparedness. Survey Procedure for hospice operated residences and inpatient units: • Verify policies and procedures for the provision of subsistence needs including, but not limited to, food, water and pharmaceutical supplies for patients and staff. • Verify policies and procedures to ensure adequate alternate energy sources necessary to maintain; o Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions; o Emergency lighting; and, o Fire detection, extinguishing, and alarm systems. • Verify policies and procedures to provide for sewage and waste disposal	
0016	Hospice Procedures for Follow-ups	§418.113(b)(1):	• Verify policies and procedures to provide for sewage and waste disposal.	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 •Verify hospice has procedures to follow up with patients to determine services needed in the event there is disruption in services due to emergency. (may see patient priority levels and prioritizing patient visits, staff call down list) Verify hospice has procedures to follow up staff and patients and to inform State DOH and local OEM if they are unable to locate any of them. This # would be reported to State DOH on HERDS survey and they should provide local EOM with patient/on duty staff specific information to assist in locating them.	
0018	Procedures for Tracking of Staff and Patients	418.113(b)(6)(ii) and (v)	(b) Policies and procedures. At a minimum, the policies and procedures must address the following: For hospice operated Inpatient units (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	Hospice operated Inpatient units and Hospice residences must develop a means to track patients and on-duty staff in the facility's care during an emergency event. In the event staff and patients are relocated, the facility must document the specific name and location of the receiving facility or other location for sheltered patients and on-duty staff who leave the facility during the emergency. Facilities are not required to track the location of patients who have voluntarily left on their own, or have been appropriately discharged, since they are no longer in the facility's care. However, this information must be documented in the patient's medical record should any questions later arise as to the patient's whereabouts. Survey Procedures for hospice operated residence or hospice operated inpatient unit • Verify there is a tracking system used to document locations of patients and staff that have relocated during an evacuation. • Verify that the tracking system is documented as part of the hospice's emergency plan policies and procedures.	

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0019	Policies and Procedures of Risk Assessment	§418.113(b)(2)	(b) Policies and procedures. At a minimum, the policies and procedures must address the following: For homebound Hospice at §418.113(b)(2) The procedures to inform State and local emergency preparedness officials about homebound Hospice 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.	Home bound hospices are required to inform State and local emergency preparedness officials of the need for patient evacuations. These policies and procedures must address when and how this information is communicated to emergency officials and also include the clinical care needed for these patients. For instance, in the event an in-home hospice patient requires evacuation, the responsible agency should provide emergency officials with the appropriate information to facilitate the patient's evacuation and transportation. This should include, but is not limited to, the following: • Whether or not the patient is mobile. • What type of life-saving equipment does the patient require? • Is the life-saving equipment able to be transported? (E.g., Battery operated, transportable, condition of equipment, etc.) • Does the patient have special needs? (E.g., Communication challenges, language barriers, intellectual disabilities, special dietary needs, etc.) Survey Procedures • Verify there is written procedure to inform State and local emergency preparedness officials about patients in need of evacuation from their homes at any time due to an emergency situation based on the patient's medical and psychiatric condition and home environment. This would be reported on the HERDS Emergency survey including TALs, Classification level, Vents, etc.	
0020	Policies and Procedures including Evacuation	§418.113(b)(6)(ii)	(b) Policies and procedures. At a minimum, the policies and procedures must address the following: Safe evacuation from the hospice inpatient unit 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.	Facilities must develop policies and procedures that provide for the safe evacuation of patients from the facility and include all of the requirements of this standard. Facilities must have policies and procedures which address the needs of evacuees. The facility should also consider in development of the policies and procedures, the evacuation protocols for not only the evacuees, but also staff members and families/patient representatives or other personnel who sought potential refuge at the facility. Additionally, the policies and procedures must address staff responsibilities during evacuations. Facilities must consider the patient population needs as well as their care and treatment. For example, if an evacuation is in progress and the facility must evacuate, leadership should consider the needs for critically ill patients to be evacuated and accompanied by staff who could provide care and treatment enroute to the designated relocation site, in the event trained medical professionals are unavailable by the transportation services. Facilities must consider in their development of policies and procedures, the needs of their patient population and what designated transportation services would be most appropriate. For instance, if a facility primarily cares for critically ill patients with ventilation needs and life-saving equipment, the transportation services should be able to assist in evacuation of this special population and be equipped to do so. Additionally, facilities may also find it prudent to consider alternative methods for evacuation and patient care and treatment, such as mentioned above to have staff members evacuate with patients in given situations. Additionally, facilities should consider their triaging system when coordinating the tracking and potential evacuation of patient/residents/clients. For instance, a triaging system for evacuation may consider the most critical patients first followed by those less critical and dependent on life-saving equipment. Considerations for prioritization may be based on, among other things, acuity, mobility status (stretch-bound/wheelchair/ambulatory), and location of the unit, availability of a known transfer destination or some combination thereof. Included within this system should be w (specifically) will be tasked with making triage decisions. Following the triaging system, staff should consider the communication of patient care requirements to the in-taking facility, such as attaching hard copy of standard abbreviated patient health condition/history, injuries, allergies, and treatment rendered. On the same method for communicating this information, a facility could consider color coordination of triage level (i.e. green folder with this information is for less critical patients; red folders for critical and urgent evacuated patients, etc.). Additionally, this hard copy could include family member/representative contact information. Finally, facilities policies and procedures must outline primary and alternate means for communication with external sources for assistance. For instance, primarily methods may be considered via regular telephone services to contact transportation companies for evacuation or reporting evacuation needs to emergency officials; whereas alternate means account for loss of power or telephone services in the local area. In this event, alternate means may include satellite phones for contacting evacuation assistance. Survey Procedures • Review the emergency plan to verify it includes policies and procedures for safe evacuation from the facility and that it includes all of the required elements.	
0022	Policies and Procedures for Sheltering	§418.113(b)(6)(i)	(b) Policies and procedures. For Hospice Operated Inpatient Units/Hospice Residences: (6) The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice.	Emergency plans must include a means for sheltering all patients, staff, and volunteers who remain in the facility in the event that an evacuation cannot be executed. . In certain disaster situations (such as tornadoes) , sheltering in place may be more appropriate as opposed to evacuation and would require a facility to have a means to shelter in place for such emergencies. Therefore, facilities are required to have policies and procedures for sheltering in place which align with the facility's risk assessment. Facilities are expected to include in their policies and procedures the criteria for determining which patients and staff that would be sheltered in place. When developing policies and procedures for sheltering in place, facilities should consider the ability of their building(s) to survive a disaster and what proactive steps they could take prior to an emergency to facilitate sheltering in place or transferring of patients to alternate settings if their facilities were affected by the emergency. For example, if it is dangerous to evacuate or the emergency affects available sites for transfer or discharge, then the patients would remain in the facility until it was safe to effectuate transfers or discharges. The plan should take into account the appropriate facilities in the community to which patients could be transferred in the event of an emergency. Facilities must determine their policies based on the type of emergency and the types of patients, staff, volunteers and visitors that may be present during an emergency. Based on its emergency plan, a facility could decide to have various approaches to sheltering some or all of its patients and staff. Survey Procedures for hospice operated residences and inpatient units • Verify policies and procedures include means to shelter in place for patients, staff and volunteers who remain in a facility. • Policies should address criteria for determining which pateints and staff would shelter in place.	

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0023	Policies and Procedures for Medical Docs.	§418.113(b)(3)	(b) Policies and procedures. At a minimum, the policies and procedures must address the following: (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.	In addition to any existing requirements for patient records found in existing laws, under this standard, facilities are required to ensure that patient records are secure and readily available to support continuity of care during emergency. This requirement does not supersede or take away any requirements found under the provider/supplier's medical records regulations, but rather, this standard adds to such policies and procedures. These policies and procedures must also be in compliance with the Health Insurance Portability and Accountability Act (HIPAA), Privacy and Security Rules at 45 CFR parts 160 and 164, which protect the privacy and security of individual's personal health information. Survey Procedures • Ask to see a copy of the policies and procedures that documents the medical record documentation system the facility has developed to preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.	
0025	Arrangement with other Facilities	§418.113(b)(5)	(b) Policies and procedures. At a minimum, the policies and procedures must address the following: The development of arrangements with other hospices and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to hospice patients.	Hospices are required to have policies and procedures which include prearranged transfer agreements, which may include written agreements or contracted arrangements with other facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to hospice patients. Hospices should consider all needed arrangements for the transfer of patients during an evacuation. Additionally, the policies and procedures and facility agreements should include pre-arranged agreements for transportation between the facilities. The arrangements should be in writing, such as Memorandums of Understanding (MOUs) and Transfer Agreements, in order to demonstrate compliance. Survey Procedures • Verify hospice has written arrangements and/or any agreements with other facilities to receive patients in the event the facility is not able to care for them during an emergency.	
0026	Roles under a Waiver Declared by Secretary	§418.113(b)(6)(C)(iv)	(b) Policies and procedures. At a minimum, the policies and procedures must address the following: The role of the hospice 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.	Survey Procedures • Verify the hospice has included policies and procedures in its emergency plan describing the hospice's role in providing care and treatment at alternate care sites under an 1135 waiver. (would not cite if missing)	
0029	Development of Communication Plan	§418.113 c	(c) The hospice 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.	Hospices must have a written emergency communication plan that contains how the facility coordinates patient care within the facility, across healthcare providers, and with state and local public health departments. The communication plan should include how the facility interacts and coordinates with emergency management agencies and systems to protect patient health and safety in the event of a disaster. The development of a communication plan will support the coordination of care. The plan must be reviewed annually and updated as necessary. We are allowing facilities flexibility in how they formulate and operationalize the requirements of the communication plan. Survey Procedures • Verify that the hospice has a written communication plan by asking to see the plan. • Verify that the plan has been reviewed (and updated as necessary) on an annual basis.	
0030	Names and Contact Information	§418.113(c)(1)	(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.	A facility must have the contact information for those individuals and entities outlined within the standard. The requirement to have contact information for "other facilities" requires a provider or supplier to have the contact information for another provider or supplier of the same type as itself. All contact information must be reviewed and updated as necessary at least annually. Contact information contained in the communication plan must be accurate and current. Facilities must update contact information for incoming new staff and departing staff throughout the year and any other changes to information for those individuals and entities on the contact list. Survey Procedures • Verify hospice has required contact information- staff call down list, entities provding services under arrangement, patients' physicians, other hospices. • Verify that all contact information has been reviewed and updated at least annually by asking to see evidence of the annual review.	
0031	Emergency Officials Contact Information	§418.113(c)(2)	(c) 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.	A hospice must have the contact information for those individuals and entities outlined within the standard. Hospices have discretion in the formatting of this information, however it should be readily available and accessible to leadership during an emergency event. Facilities are encouraged but not required to maintain these contact lists both in electronic format and hard-copy format in the event that network systems to retrieve electronic files are not accessible. All contact information must be reviewed and updated at least annually. Survey Procedures • Verify hospice has contact info for State DOH, REgional DOH, State OEM, Local OEM. • Verify that all contact information has been reviewed and updated at least annually.	
0032	Primary/Alternate Means for Communication	§418.113(c)(3)	(c) The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) hospice staff. (ii) Federal, State, tribal, regional, and local emergency management agencies.	Hospices are required to have primary and alternate means of communicating with staff, Federal, State, tribal, regional, and local emergency management agencies. Facilities have the discretion to utilize alternate communication systems that best meets their needs. However, it is expected that facilities would consider pagers, cellular telephones, radio transceivers (that is, walkie-talkies), and various other radio devices such as the NOAA Weather Radio and Amateur Radio Operators' (HAM Radio) systems, as well as satellite telephone communications systems. We recognize that some facilities, especially in remote areas, may have difficulty using some communication systems, such as cellular phones, even in non-emergency situations, which should be outlined within their risk assessment and addressed within the communications plan. It is expected these facilities would address such challenges when establishing and maintaining a well-designed communication system that will function during an emergency. Survey Procedures • Verify the communication plan includes primary and alternate means for communicating with hospice staff and OEM.	

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0033	Methods for Sharing Information	§418.113(c)(4)-(6)	(c) The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the hospice'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). (6)A means of providing information about the general condition and location of patients under the hospice's care as permitted under 45 CFR 164.510(b)(4).	Hospices are required to develop a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health care providers to maintain continuity of care. Such a system must ensure that information necessary to provide patient care is sent with an evacuated patient to the next care provider and would also be readily available for patients being sheltered in place. While the regulation does not specify timelines for delivering patient care information, facilities are expected to provide patient care information to receiving facilities during an evacuation, within a timeframe that allows for effective patient treatment and continuity of care. Facilities should not delay patient transfers during an emergency to assemble all patient reports, tests, etc. to send with the patient. Facilities should send all necessary patient information that is readily available and should include at least, patient name, age, DOB, allergies, current medications, medical diagnoses, current reason for admission (if inpatient), blood type, advance directives and next of kin/emergency contacts. There is no specified means (such as paper or electronic) for how facilities are to share the required information. Survey Procedures • Verify the communication plan includes a method for sharing information and medical documentation for patients under the hospice's care, as necessary, with other health providers to maintain the continuity of care. • Verify the hospice has developed policies and procedures that address the means the hospcie will use to release patient information to include the general condition and location of patients.	
0034	Sharing Information on Occupancy/Needs	§418.113(c)(7)	(c) The communication plan must include all of the following: (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.	Hospices have a means of providing information about the facility's needs and its ability to provide assistance to the authority having jurisdiction (local and State emergency management agencies, local and state public health departments, the Incident Command Center, the Emergency Operations Center, or designee). For inpatient hospices they must also have a means for providing information about their occupancy. Occupancy reporting is considered, but not limited to, reporting the number of patients currently at the facility receiving treatment and care or the facility's occupancy percentage. The hospice should consider how its occupancy affects its ability to provide assistance. For example, if the facility's occupancy is close to 100% the facility may not be able to accept patients from nearby facilities. The types of "needs" a facility may have during an emergency and should communicate to the appropriate authority would include but is not limited to, shortage of provisions such as food, water, medical supplies, assistance with evacuation and transfers, etc. Survey Procedures • Verify the communication plan includes a means of providing information to State DOH about the hospice's needs, and its ability to provide assistance. (report on HERDS Emergency survey) • For inpatient hospice unitsverify the communication plan includes a means of providing information about their occupancy. (report on HERDS Emergency survey)	
0036	Emergency Prep Training and Testing	§418.113(d)	(d) Training and testing. The hospice 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.	An emergency preparedness training and testing program as specified in this requirement must be documented and reviewed and updated on at least an annual basis. The training and testing program must reflect the risks identified in the facility's risk assessment and be included in their emergency plan. For example, a facility that identifies flooding as a risk should also include policies and procedures in their emergency plan for closing or evacuating their facility and include these in their training and testing program. This would include, but is not limited to, training and testing on how the facility will communicate the facility closure to required individuals and agencies, testing patient tracking systems and testing transportation procedures for safely moving patients to other facilities. Additionally, for facilities with multiple locations, such as multi-campus or multi-location hospitals, the facility's training and testing program must reflect the facility's risk assessment for each specific location. Training refers to a facility's responsibility to provide education and instruction to staff, contractors, and facility volunteers to ensure all individuals are aware of the emergency preparedness program. Testing is the concept in which training is operationalized and the facility is able to evaluate the effectiveness of the training as well as the overall emergency preparedness program. Testing includes conducting drills and/or exercises to test the emergency plan to identify gaps and areas for improvement. Survey Procedures • Verify that the facility has a written training and testing program. • Verify the program has been reviewed and updated at least annually.	

Tag #	Title	CFR Citation	Tag Text (Regulatory Text)	Interpretive Guidelines - Refer to Appendix Z of SOM	Met/Not Met
0037	Emergency Prep Training Program	§418.113(d)(1)	(1) Training program. The Hospices 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 annually. (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.	Facilities are required to provide initial training in emergency preparedness policies and procedures that are consistent with their roles in an emergency to all new and existing staff, individuals providing services under arrangement, and volunteers. This includes individuals who provide services on a per diem basis such as agency nursing staff and any other individuals who provide services on an intermittent basis and would be expected to assist during an emergency. Facilities should provide initial emergency training during orientation (or shortly thereafter) to ensure initial training is not delayed. We recommend initial training be completed by the time the staff has completed the facility's new hire orientation program. Additionally, in the case of facilities with multiple locations, such as multi-campus hospitals, staff, individuals providing services under arrangement should be provided initial training at their specific location and when they are assigned to a new location. Facilities have the flexibility to determine the focus of their annual training, as long as it aligns with the emergency plan and risk assessment. Ideally, annual training should be modified each year, incorporating any lessons learned from the most recent exercises, real-life emergencies that occurred in the last year and during the annual review of the facility's emergency program. Fo example, annual training could include training staff on new evacuation procedures that were identified as a best practice and documented in the facility "After Action Report" (AAR) during the last emergency drill and were incorporated into the emergency plan during the program's annual review. Facilities must maintain documentation of the annual training for all staff. The documentation must include the specific training completed as well as the methods used for demonstrating knowledge of the training program. Facilities have flexibility in ways to demonstrate staff knowledge of emergency procedures. The method chosen is likely based on the training delivery method. For example: computer-based or printed self-learning packets may contain a test to demonstrate knowledge. If facilities choose instructor-led training, a question and answer session could follow the training. Regardless of the method, facilities must maintain documentation that training was completed and that staff are knowledgeable of emergency procedures. Survey Procedures • Ask for copies of the hospice's initial/orientation EP training and annual EP training offerings. • Review a sample of Personnel Records to verify staff have received initial and annual emergency preparedness training.	
0039	Emergency Prep Testing Requirements	§418.113(d)(2)	(2) Testing. The facility must conduct exercises to test the emergency plan at least annually. The hospice must do all of the following: (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the hospice experiences an actual natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	Facilities must on an annual basis conduct exercises to test the emergency plan. This must include a full-scale community-based exercise and another full scale, agency specific, or tabletop exercise annually. Hospices must document their compliance and ensuring that this information is available for review at any time for a period of no less than three (3) years. Hospices should also document the lessons learned following their tabletop and full-scale exercises and real-life emergencies and demonstrate that they have incorporated any necessary improvements in their emergency preparedness program. Hospices may complete an after action review process to help them develop an actionable after action report (AAR). The process includes a roundtable discussion that includes leadership, department leads and critical staff who can identify and document lessons learned and necessary improvements in an official AAR. The AAR, at a minimum, should determine 1) what was supposed to happen; 2) what occurred; 3) what went well; 4) what the facility can do differently or improve upon; and 5) a plan with timelines for incorporating necessary improvement. Finally, an actual emergency event or response of sufficient magnitude that requires activation of the relevant emergency plans meets the annual exercise requirements and exempts the hospice for engaging in the required exercises for one year following the actual event; and hospice must be able to demonstrate this through written documentation. Survey Procedures • Verify documentation participation in 2 drills/year begining 11/15/16. The hospice must reating documentation of all exercises for a 3 year period. THis can be full scale exercise, agency exercise, or tabletop. • Request documentation of the hospice's after action report for the drill/exercises that documents analysis and response for each of the drills. • Ask to see the documentation if the hospice had a real emergency and activated thier EP plan, this exempts them from engaging in a drill for the one year following the real event.	

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0042	Integrated Health Systems	§418.113€	(e) Integrated healthcare systems. If a hospice is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the [facility] may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must do all of the following: (1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program. (2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered. (3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance [with the program]. (4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following: (i) A documented community-based risk assessment, utilizing an all-hazards approach. (ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards	Survey Procedures apply only if hospice has opted to be part of its healthare system's unified and integrated emergency preparedness program: • Ask to see documentation that verifies the hospice within the system was actively involved in the development of the unified emergency preparedness program. • Ask to see documentation that verifies the hospice was actively involved in the annual reviews of the program requirements and any program updates. • Ask to see a copy of the entire integrated and unified emergency preparedness program and all required components (emergency plan, policies and procedures, communication plan, training and testing program). Review for compliance with hospice requirements using tool and tags above.	
0669	**State Requirements**		794.9 (b) The hospice shall furnish annually to the department a copy of: (1) the current annual report submitted to its governing body; and (2) other such data, records and reports as may be required by the department.	Survey Procedures: Verify hospice participated in most recent DOH required Emergency Drill	
0353	**State Requirements** **DAL Issued 12/1/16**		794.1 Governing authority (m) ensure the development, implementation and annual review of a written emergency plan which is current and includes hospice emergency contact information, current staff call down list, and community partners contact list and procedures to be followed to assure health care needs of patients continue to be met in emergencies that interfere with the delivery of services, and orientation of all employees to their responsibilities in carrying out such a plan; and compliance with DAL issued 12/1/16	Survey Procedures:Verify agency maintains patient roster that includes the following information: - patient name, address and telephone number - emergency contact numbers of family, caregiver(s) and/or healthcare proxy - Patient Classification Level (1-3) - Transportation Assistance Level (TAL) - identification if ventilator dependent - identification if dependent on use of electricity for health care needs - other specific patient information critical to first responders Verify hospice has an updated accurate Call down list of hospice staff with telephone numbers Verify hospice has contact list that includes at a minimum: local health dept., local emergency management, Emergency Medical Services and law enforcement	