Tag #	Title	Specific CFR Citations Plus Subset	Tag Text (Regulatory Text)	Survey Procedures from Interpretive Guidelines
0001	Establishment of the Emergency Program (EP)	§483.73	The [facility, except for Transplant Center] 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:	• Interview the facility leadership and ask him/her/them to describe the facility's emergency preparedness program. • Ask to see the facility's written policy and documentation on the emergency preparedness program.
0004	Develop and Maintain EP Program	§483.73(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 annually.	• Verify the facility has an emergency preparedness plan by asking to see a copy of the plan. • Ask facility leadership to identify the hazards (e.g. natural, man-made, facility, geographic, etc.) that were identified in the facility's risk assessment and how the risk assessment was conducted. • Review the plan to verify it contains all of the required elements. • Verify that the plan is reviewed and updated annually by looking for documentation of the date of the review and updates that were made to the plan based on the review.
0006	Maintain and Annual EP Updates	§483.73(a)(1)-(2)	[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (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.	• Ask to see the written documentation of the facility's risk assessments and associated strategies. • Interview the facility leadership and ask which hazards (e.g. natural, man-made, facility, geographic) were included in the facility's risk assessment, why they were included and how the risk assessment was conducted. • Verify the risk-assessment is based on an all-hazards approach specific to the geographic location of the facility and encompasses potential hazards.

None of the above tags can be waived.
None of the above tags can be FSESed.
None of the above tags qualify for SQC.

0007	EP Program Patient Population	§483.73(a)(3)	[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.	Interview leadership and ask them to describe the following: • The facility's patient populations that would be at risk during an emergency event; • Strategies the facility (except for an ASC, hospice, PACE organization, HHA, CORF, CMHC, RHC, FQHC and ESRD facility) has put in place to address the needs of at-risk or vulnerable patient populations; • Services the facility would be able to provide during an emergency; • How the facility plans to continue operations during an emergency; • Delegations of authority and succession plans. Verify that all of the above are included in the written emergency plan.
0009	Process for EP Collaboration	§483.73(a)(4)	[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (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, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.	Interview facility leadership and ask them to describe their process for ensuring cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to ensure an integrated response during a disaster or emergency situation. • Ask for documentation of the facility's efforts to contact such officials and, when applicable, its participation in collaborative and cooperative planning efforts.

None of the above tags can be waived.
None of the above tags can be FSESed.
None of the above tags qualify for SQC.

0013	Development of EP Policies and Procedures	§483.73(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 annually.	Review the written policies and procedures which address the facility's emergency plan and verify the following: • Policies and procedures were developed based on the facility- and community-based risk assessment and communication plan, utilizing an all-hazards approach. • Ask to see documentation that verifies the policies and procedures have been reviewed and updated on an annual basis.
0015	Subsistence needs for staff and patients	§483.73(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 at least annually.] 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.	• Verify the emergency plan includes policies and procedures for the provision of subsistence needs including, but not limited to, food, water and pharmaceutical supplies for patients and staff by reviewing the plan. • Verify the emergency plan includes 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 the emergency plan includes policies and procedures to provide for sewage and waste disposal.
0018	Procedures for Tracking of Staff and Patients	483.73(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 annually.] At a minimum, the policies and procedures must address the following:] (2) 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.	• Ask staff to describe and/or demonstrate the tracking system used to document locations of patients and staff. • Verify that the tracking system is documented as part of the facilities' emergency plan policies and procedures.

None of the above tags can be waived.
None of the above tags can be FSESed.
None of the above tags qualify for SQC.

0020	Policies and Procedures including Evacuation	§483.73(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 annually. At a minimum, the policies and procedures must address the following:] 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.	• 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	§483.73(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 annually.] At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility].	• Verify the emergency plan includes policies and procedures for how it will provide a means to shelter in place for patients, staff and volunteers who remain in a facility. • Review the policies and procedures for sheltering in place and evaluate if they aligned with the facility's emergency plan and risk assessment.
0023	Policies and Procedures for Medical Docs.	§483.73(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 annually.] 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.	• 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.

None of the above tags can be waived.
None of the above tags can be FSESed.
None of the above tags qualify for SQC.

0024	Policies and Procedures for Volunteers	§483.73(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 annually.] 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.	• Verify the facility has included policies and procedures for the use of volunteers and other staffing strategies in its emergency plan.
0025	Arrangement with other Facilities	§483.73(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 annually.] 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.	• Ask to see copies of the arrangements and/or any agreements the facility has with other facilities to receive patients in the event the facility is not able to care for them during an emergency. • Ask facility leadership to explain the arrangements in place for transportation in the event of an evacuation.
0026	Roles under a Waiver Declared by Secretary	§483.73(b)(8)	[(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 annually.] 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.	• Verify the facility has included policies and procedures in its emergency plan describing the facility's role in providing care and treatment at alternate care sites under an 1135 waiver.
0029	Development of Communication Plan	§483.73©	(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.	• Verify that the facility has a written communication plan by asking to see the plan. • Ask to see evidence that the plan has been reviewed (and updated as necessary) on an annual basis.

None of the above tags can be waived.
None of the above tags can be FSESed.
None of the above tags qualify for SQC.

0030	Names and Contact Information	§483.73(c)(1)	[(c) The [facility, except RNHCIs, hospices, transplant centers, and HHAs] 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:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers.	• Verify that all required contacts are included in the communication plan by asking to see a list of the contacts with their contact information. • 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	§483.73(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 annually] 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, or 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.	• Verify that all required contacts are included in the communication plan by asking to see a list of the contacts with their contact information. • Verify that all contact information has been reviewed and updated at least annually by asking to see evidence of the annual review.
0032	Primary/Alternate Means for Communication	§483.73(c)(3)	[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies.	• Verify the communication plan includes primary and alternate means for communicating with facility staff, Federal, State, tribal, regional and local emergency management agencies by reviewing the communication plan. • Ask to see the communications equipment or communication systems listed in the plan.

None of the above tags can be waived.
None of the above tags can be FSESed.
None of the above tags qualify for SQC.

0033	Methods for Sharing Information	§483.73(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 annually.] 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 §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(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).	• Verify the communication plan includes a method for sharing information and medical (or for RNHCIs only, care) documentation for patients under the facility's care, as necessary, with other health (or care for RNHCIs) providers to maintain the continuity of care by reviewing the communication plan. • Verify the facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients, by reviewing the communication plan
0034	Sharing Information on Occupancy/Needs	§483.73(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 annually.] 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.	• Verify the communication plan includes a means of providing information about the facility's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee by reviewing the communication plan. • For hospitals, CAHs, RNHCIs, inpatient hospices, PRTFs, LTC facilities, and ICF/IIDs, also verify if the communication plan includes a means of providing information about their occupancy.
0035	LTC and ICF/IID Family Notifications	§483.73(c)(8)	[(c) The [LTC facility and 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 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.	• Ask staff to demonstrate the method the facility has developed for sharing the emergency plan with residents or clients and their families or representatives. • Interview residents or clients and their families or representatives and ask them if they have been given information regarding the facility's emergency plan. • Verify the communication plan includes a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with residents or clients and their families or representatives by reviewing the plan.

None of the above tags can be waived.
None of the above tags can be FSESed.
None of the above tags qualify for SQC.

0036	Emergency Prep Training and Testing	§483.73(d)	(d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.	• Verify that the facility has a written training and testing program that meets the requirements of the regulation. • Verify the program has been reviewed and updated on, at least, an annual basis by asking for documentation of the annual review as well as any updates made.
0037	Emergency Prep Training Program	§483.73(d)(1),	(1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] 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 the training. (iv) Demonstrate staff knowledge of emergency procedures.	• Ask for copies of the facility's initial emergency preparedness training and annual emergency preparedness training offerings. • Interview various staff and ask questions regarding the facility's initial and annual training course, to verify staff knowledge of emergency procedures. • Review a sample of staff training files to verify staff have received initial and annual emergency preparedness training.
0039	Emergency Prep Testing Requirements	§483.73(d)(2),	(2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility 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 [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] 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. (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 RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is 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. (ii) Analyze the [RNHCI's and 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.	• Ask to see documentation of the annual tabletop and full scale exercises (which may include, but is not limited to, the exercise plan, the AAR, and any additional documentation used by the facility to support the exercise. • Ask to see the documentation of the facility's efforts to identify a full-scale community based exercise if they did not participate in one (i.e. date and personnel and agencies contacted and the reasons for the inability to participate in a community based exercise). • Request documentation of the facility's analysis and response and how the facility updated its emergency program based on this analysis.

None of the above tags can be waived.
None of the above tags can be FSESed.
None of the above tags qualify for SQC.

0041	Hospital CAH and LTC Emergency Power	§483.73€	§483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12–2, TIA 12–3, TIA 12–4, TIA 12–5, and TIA 12–6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12–1, TIA 12–2, TIA 12–3, and TIA 12–4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12–2 to NFPA 99, issued August 11, 2011. (iii) TIA 12–3 to NFPA 99, issued August 9, 2012. (iv) TIA 12–4 to NFPA 99, issued March 7, 2013. (v) TIA 12–5 to NFPA 99, issued August 1, 2013. (vi) TIA 12–6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12–1 to NFPA 101, issued August 11, 2011. (ix) TIA 12–2 to NFPA 101, issued October 30, 2012.	• Verify that the hospital, CAH and LTC facility has the required emergency and standby power systems to meet the requirements of the facility's emergency plan and corresponding policies and procedures • Review the emergency plan for "shelter in place" and evacuation plans. Based on those plans, does the facility have emergency power systems or plans in place to maintain safe operations while sheltering in place? • For hospitals, CAHs and LTC facilities which are under construction or have existing buildings being renovated, verify the facility has a written plan to relocate the EPSS by the time construction is completed For hospitals, CAHs and LTC facilities with generators: • For new construction that takes place between November 15, 2016 and is completed by November 15, 2017, verify the generator is located and installed in accordance with NFPA 110 and NFPA 99 when a new structure is built or when an existing structure or building is renovated. The applicability of both NFPA 110 and NFPA 99 addresses only new, altered, renovated or modified generator locations. • Verify that the hospitals, CAHs and LTC facilities with an onsite fuel source maintains it in accordance with NFPA 110 for their generator, and have a plan for how to keep the generator operational during an emergency, unless they plan to evacuate.

None of the above tags can be waived.
None of the above tags can be FSESed.
None of the above tags qualify for SQC.

0042	Integrated Health Systems	§483.73(f)	(e) [or (f)]Integrated healthcare systems. If a [facility] 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 approach. (5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively. Interpretive Guidelines Applies to: §482.15(f), §416.54(e), §418.113(e), §441.184(e), §460.84(e), §482.78(f), §483.73(f), §483.475(e), §484.22(e), §485.68(e), §485.625(f), §485.727(e), §485.920(e), §486.360(f), §491.12(e), §494.62(e).	• Verify whether or not the facility has opted to be part of its healthcare system's unified and integrated emergency preparedness program. Verify that they are by asking to see documentation of its inclusion in the program. • Ask to see documentation that verifies the facility within the system was actively involved in the development of the unified emergency preparedness program. • Ask to see documentation that verifies the facility 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). • Ask facility leadership to describe how the unified and integrated emergency preparedness program is updated based on changes within the healthcare system such as when facilities enter or leave the system.

None of the above tags can be waived.
None of the above tags can be FSESed.
None of the above tags qualify for SQC.