Condition of Participation: Emergency Preparedness
Hospice/Long Term Care Facilities/Home Health Agencies Only

Comparison Between Proposed Rule (78 Fed. Reg. 79082 (Dec. 27, 2013))
and
Final Rule (81 Fed. Reg. 63860 (Sept. 16, 2016))

Note: ~~Strikeout~~ indicates deleted text; underline indicates added text.

PART 418—HOSPICE CARE

Sec. 418.113 Condition of participation: Emergency preparedness.

The hospice must comply with all applicable ~~Federal and State~~ Federal, State, and local emergency preparedness requirements. The hospice must establish and maintain an 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 hospice 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.

(2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that ~~could~~ would affect the hospice's ability to provide care.

(3) Address patient population, including, but not limited to, the type of services the hospice has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.

(4) Include a process for ~~ensuring~~ cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to ~~ensure~~ maintain an integrated response during a disaster or emergency situation, including documentation of the hospice's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.

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

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

(2) Procedures to inform State and local officials about 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.

(3) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and ~~ensures records are secure and readily available.~~ secures and maintains the availability of records.

(4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

(5) The development of arrangements with other hospices and other providers to receive patients in the event of limitations or cessation of operations to ~~ensure~~ maintain the continuity of services to hospice patients.

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

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

(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.

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

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

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

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

(2) Emergency lighting.

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

(C) Sewage and waste disposal.

(iv) 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.

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

(c) Communication plan. The hospice must develop and maintain an emergency preparedness communication plan that complies with ~~both Federal and State law~~ 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) Hospice employees.

(ii) Entities providing services under arrangement.

(iii) Patients' physicians.

(iv) Other hospices.

(2) Contact information for the following:

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

(ii) Other sources of assistance.

(3) Primary and alternate means for communicating with the following:

(i) Hospice's employees.

(ii) Federal, State, tribal, regional, and local emergency management agencies.

(4) A method for sharing information and medical documentation for patients under the hospice's care, as necessary, with other health care providers to ~~ensure~~ 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.~~ 164.510(b)(1)(ii).

(6) 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).

(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.

(d) Training and testing. The hospice must develop and maintain an emergency preparedness training and testing program that ~~must be reviewed and updated at least annually.~~ 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.

(1) Training program. The hospice must do all of the following:

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

(ii) ~~Ensure that hospice employees can demonstrate~~ 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.

(v) Maintain documentation of all emergency preparedness training.

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

(i) Participate in a ~~community mock disaster drill at least annually. If a community mock disaster drill is not available, conduct an individual, facility-based mock disaster drill at least annually.~~

~~(ii)~~ 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 ~~mock disaster drill~~ 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-bsed or individual, facility-based.

~~(B)~~ A tabletop exercise that includes

~~(iii) 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.

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

(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 hospice may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must do 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.

PART 483—REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES

Sec. 483.73 Emergency preparedness.

The LTC facility must comply with all applicable ~~Federal and State~~ Federal, State and local emergency preparedness requirements. The LTC facility must establish and maintain an 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 LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan ~~must:~~ must do all of the following:

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents;

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

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

(4) Include a process for ~~ensuring~~ cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to ~~ensure~~ maintain an integrated response during a disaster or emergency situation, including documentation of the LTC facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.

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

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

(i) Food, water, ~~and medical supplies;~~ medical, and pharmaceutical supplies.

(ii) Alternate sources of energy to maintain--

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

(B) Emergency lighting;

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

(D) Sewage and waste disposal.

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

(3) Safe evacuation from the LTC 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.

(4) A means to shelter in place for residents, staff, and volunteers who remain in the LTC facility.

(5) A system of medical documentation that preserves resident information, protects confidentiality of resident information, and ~~ensures records are secure and readily available.~~ secures and maintains the availability of records.

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

(7) The development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to ~~ensure~~ maintain the continuity of services to LTC residents.

(8) The role of the LTC 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.

(c) Communication plan. The LTC facility must develop and maintain an emergency preparedness communication plan that complies with ~~both Federal and State law~~ 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) Residents' physicians.

(iv) Other LTC facilities.

(v) Volunteers.

(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.

(3) Primary and alternate means for communicating with the following:

(i) LTC facility's staff.

(ii) Federal, State, tribal, regional, or local emergency management agencies.

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

(5) A means, in the event of an evacuation, to release resident information as permitted under 45 CFR ~~164.510.~~ 164.510(b)(1)(ii).

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

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

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

(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.

(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 roles.

(ii) Provide emergency preparedness training at least annually.

(iii) Maintain documentation of the training.

(iv) ~~Ensure that staff can demonstrate~~ Demonstrate staff knowledge of emergency procedures.

(2) Testing. The LTC facility must conduct ~~drills and~~ exercises to test the emergency ~~plan,~~ plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do the following:

(i) ~~Participate in a community mock disaster drill at least annually. If a community mock disaster drill is not available, conduct an individual, facility-based mock disaster drill at least annually.~~

~~(ii)~~ 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 LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a ~~community or individual, facility-based mock disaster drill~~ 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) ~~(iii) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a~~ 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.

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

(e) Emergency and standby power systems. The LTC facility must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.

(1) Emergency generator location. (i) The generator must be located in accordance with the location requirements found in ~~NFPA 99 and NFPA 100.~~ the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, IA 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.

(2) Emergency generator inspection and testing. ~~In addition to the emergency power system inspection and testing requirements found in NFPA 99--Health Care Facilities and NFPA 110--Standard for Emergency and Standby Power Systems, as referenced by NFPA 101--Life Safety Code as required under paragraph (a) of this section, the LTC facility must do the following:~~

~~(i) At least once every 12 months test each emergency generator for a minimum of 4 continuous hours. The emergency generator test load must be 100 percent of the load the LTC facility anticipates it will require during an emergency.~~

~~(ii) Maintain a written record, which is available upon request, of generator inspections, tests, exercising, operation and repairs.~~ The 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.

(3) Emergency generator fuel. LTC facilities that maintain an onsite fuel source to power emergency generators must ~~maintain a quantity of fuel capable of sustaining emergency power for the duration of the emergency or until likely resupply.~~ have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.

(f) Integrated healthcare systems. If a LTC 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 LTC 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--

(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.

(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.

(x) TIA 12-3 to NFPA 101, issued October 22, 2013.

(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.

(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.
(2) [Reserved]

PART 484—HOME HEALTH SERVICES

Sec. 484.22 Condition of participation: Emergency preparedness.

The Home Health Agency (HHA) must comply with all applicable ~~Federal and State~~ Federal, State, and local emergency preparedness requirements. The HHA must establish and maintain an 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 HHA must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan ~~must:~~ must do all of the following:

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

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

(3) Address patient population, including, but not limited to, the type of services the HHA has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.

(4) Include a process for ~~ensuring~~ cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to ~~ensure~~ maintain an integrated response during a disaster or emergency situation, including documentation of the HHA's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.

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

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

(2) The procedures to inform State and local emergency preparedness officials about HHA patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical and psychiatric condition and home environment.

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

(4) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and ~~ensures records are secure and readily available.~~ secures and maintains the availability of records.

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

~~(6) The development of arrangements with other HHAs or other providers to receive patients in the event of limitations or cessation of operations to ensure the continuity of services to HHA patients.~~

(c) Communication plan. The HHA must develop and maintain an emergency preparedness communication plan that complies with ~~both Federal and State law~~ 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 HHAs.~~

~~(v)~~ (iv) Volunteers.

(2) Contact information for the following:

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

(ii) Other sources of assistance.

(3) Primary and alternate means for communicating with the HHA's staff, Federal, State, tribal, regional, and local emergency management agencies.

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

(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).

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

(d) Training and testing. The HHA 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.

(1) Training program. The HHA 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 annually.

(iii) Maintain documentation of the training.

(ii) ~~Ensure that staff can demonstrate~~ Demonstrate staff knowledge of emergency procedures.

(2) Testing. The HHA must conduct ~~drills and~~ exercises to test the emergency ~~plan.~~ plan at least annually The HHA must do the following:

(i) Participate in a ~~community mock disaster drill at least annually. If a community mock disaster drill is not available, conduct~~ full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility~~-based mock disaster drill at least annually.~~based.

~~(ii)~~ If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in a community-based or individual, facility-based ~~mock disaster drill~~ 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

~~(iii) 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.

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

(e) Integrated healthcare systems. If a HHA 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 HHA 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 all of 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.