

Critical Access Hospital Accreditation

Survey Process Guide

Summary of Changes

Note: Updates from the last published version of the Survey Process Guide are identified by underlined and ~~strikethrough~~ text throughout this document.

Changes effective January 1, 2026

- Added survey process for Joint Commission requirements not related to CoPs
- Added new and revised requirements for critical access hospitals and hospitals that align with updated US Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoPs) related to obstetric care
- Revised survey process for 485.608
- Updated CAH Medical Records Documentation Requirement (C Tag) Tool
- Updated Psychiatric and Rehab Distinct Part Units (DPU) Medical Records Documentation Requirements (A Tags and 412.27, 412.29) Tool
- Updated Tethering requirements in the Kitchen Tracer Survey Guidance tool
- Added Building Tour Guidance Document- HAP and CAH Review Tool
- Added Business and Ambulatory Occupancy Tour Guidance in HAP and CAH Review Tool
- Updated the Surgical Services EP references in Infection Prevention and Control Program Assessment Tool
- Updated the Performance Improvement Evaluation Tool
- Removed the Performance Improvement Checklist
- Added Emergency Management (EM) Discussion Tool
- Added the Suicide Prevention, including Ligature and Other Safety Risks Assessment tool
- Added survey process information for NPG.05.02.01
- Revised survey process for NPG.14.02.01
- Updated the Primary Care Medical Home (PCMH) Certification Evaluation Guide
- Editorial corrections throughout the SPG

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Critical Access Hospital Survey Process

The purpose of a Joint Commission survey is to evaluate an organization's compliance with standards based on CMS Conditions of Participation (CoPs) and Joint Commission National Performance Goals (NPGs), that is, principles of patient safety and quality of care. A standard defines the performance expectations, structures, or processes that must be substantially in place in an organization to enhance the quality of care, treatment, or services being provided. Using observation, interviews, and document review surveyors evaluate an organization's compliance with applicable standards in all locations where patient care, treatment, and services are being provided.

During a survey, an organization must be prepared to provide evidence of its compliance with each applicable standard. To attain accreditation, an organization must demonstrate compliance with the applicable standards and their elements of performance (EPs).

For deemed status surveys, Joint Commission surveyors assess critical access hospital (CAH) compliance with the CMS Conditions of Participation for all services, areas and locations in which the provider receives reimbursement for patient care services billed under its CMS Certification Number (CCN) as well as certain entities that provide services to the CAH on a contractual basis. These areas include all inpatient and outpatient services and practice locations, buildings and facilities (including, but not limited to, generators, electrical rooms, food services, HVAC, supply areas, sterilization areas, etc.)

On-site Surveys

All CAH surveys are unannounced[1]. Although not a routine practice, Joint Commission surveyors may conduct some survey activities during early morning, evening, night, and weekend hours, as necessary. These "off-shift" visits do not occur before the opening conference at the start of the survey.

Joint Commission determines the length of a survey and the number and type of surveyors assigned based on information supplied in the Electronic Application for Accreditation (E-App) that describes the organization's size and scope of services.

Survey Team

Based on the size and complexity of the organization being surveyed, an accreditation survey may be conducted by one surveyor or a team of surveyors. Each survey team should include at least one RN with hospital/CAH survey experience, as well as other surveyors who have the expertise needed to determine whether the CAH is in compliance with the standards and CMS Conditions of Participation. A *Life Safety Code* surveyor will also be part of every critical access hospital survey. The composition of an organization's survey team is based on the information provided in its E-App.

On surveys with more than one surveyor, one of the surveyors is designated as the team leader. The team leader is responsible for integration, coordination, and communication of survey activities. In addition to being one of the surveyors conducting the survey, the team leader serves as the primary point of contact between the organization and Joint Commission. Among other responsibilities, the team leader leads the opening conference and the daily and exit briefings.

[1] See the Accreditation Manual for Critical Access Hospitals, Accreditation Process chapter for exceptions to this rule.

Pre-Survey Preparation

Surveyor Preparation

In preparation for the survey event, the surveyor(s) reviews available information about the organization, including the following:

- Electronic Application for Accreditation (E-App) to determine the scope of survey that will be required and begins planning
- Report of available Basic Building Information (BBI) which contains sites/buildings information and the history and audit trail
- Organization website, if available, to compare the services noted to those reported on the E-App
- Report(s) and the organization's historical SAFER™ matrix(s) from previous survey events
- CMS complaint surveys
- ORYX data.

The surveyor(s) will use what they learn from review of the above information to prepare a preliminary plan for the on-site survey event that is customized to the organization and that covers all required evaluation activity. If this is a team survey, the team leader will begin formulating this plan. Team members are expected to review this same data in preparation to aid the team leader in verifying that all required activities are covered in the preliminary survey plan.

Organization Preparation

Prepare a plan for staff to follow when surveyors arrive. The plan should include:

- Greeting surveyors: Identify the staff usually at the main entrance of your organization. Tell them about Joint Commission and educate them about what to do upon arrival of the surveyor(s). Explain the importance of verifying any surveyor's identity by viewing their Joint Commission identification badge. This badge is a picture ID.
- Persons to notify upon surveyor(s) arrival: Identify leaders and staff who must be notified when surveyors arrive. Create a list of names, phone numbers, or cell phone numbers. Also, include the individual who will be the surveyor's "contact person" during the survey. Identify alternate individuals if leaders and staff are unavailable.
- A location for surveyors: Ask surveyors to wait in the lobby until an organization contact person is available. The surveyor(s) will need a location that they will call their "base" throughout the survey. This location should have a desk or table, electrical outlet, phone access, and internet access.
- Validation of survey: Identify who in the organization will handle the validation of the survey and confirm the identity of the surveyor(s) and supply instructions for this activity.
- Being prepared with requested documents for surveyor(s) review. Surveyor(s) will begin the survey with an individual tracer if documentation is not readily available.
- Identifying who will provide the Safety Briefing for the surveyor(s).
    - The purpose of the Safety Briefing is for your organization to inform surveyor(s) about any current safety or security concerns and how Joint Commission staff should respond if your safety plans are implemented while they are on site.

- **The briefing is informal, five minutes or less**, and should take place once the surveyor(s) are settled in the "base" location reserved for their use throughout the survey.
- Situations that should be covered include fire, smoke or other emergencies; workplace violence events (including active shooter scenarios); any contemporary issues the surveyor(s) may experience during the time they are with you (for example, seasonal weather-related events, anticipated or current civil unrest, or labor action)

- Identifying who will serve as escorts for the surveyor(s).
- Identifying who will assist the surveyor(s) with review of the patient health record.

Surveyor Arrival and Preliminary Planning

The surveyor(s) arrives no earlier than 7:45 a.m. on the first day of an unannounced survey. If more than one surveyor is assigned, the entire team will enter the organization together on the first day of survey.

Upon arrival, surveyors will check in with reception, present their identification, and indicate their purpose for visiting. Surveyors will initiate confirmation of the unannounced survey by attesting to their arrival and introduction to organization personnel in MST.

Organization staff should be prepared with a plan and instructions for how to proceed, including the name and extension of the representative(s) who can access the organization's extranet site.

Surveyors will ask staff to check the organization's Joint Commission *Connect* extranet site for confirmation of the unannounced Joint Commission event authorizing the presence of the surveyor(s), and surveyors' names, pictures and biographical sketches.

> **NOTE:** If the organization is **unable** to validate the authenticity of the survey via computer, they should contact their Account Executive for validation and surveyor identity. The surveyor will call the Field Director on call informing them of the situation. Surveyors will not begin the survey until the organization verifies authenticity of the survey event and confirms surveyor(s) identity, or they receive directions to begin from Joint Commission's Central Office.

Once the survey is validated, the organization can escort the surveyor(s) to the location that will serve as their working base for the survey event and where they can secure their belongings.

The organization is asked to provide the surveyor(s) with a **Safety Briefing** (informal, no more than five minutes). The purpose of this briefing is to inform the surveyor(s) of any current organization safety or security concerns and how Joint Commission staff should respond if the safety plans are implemented while they are on site. Situations to cover include:

- Fire, smoke, or other emergencies
- Workplace violence events (including active shooter scenarios)
- Any contemporary issues the surveyor(s) may experience during the time they are with you (for example, seasonal weather-related events, anticipated or current civil unrest, or labor action)

The surveyor is required to see the following organization information, in electronic or paper format, before proceeding with the survey:

- Average daily census

- Scope of services to determine what specifically is included under the critical access hospital provider number (CCN), including identifying any significant changes from information reported in the E-App.
- The critical access hospital meets the statutory definition of a critical access hospital, specifically. https://www.cms.gov/medicare/health-safety-standards/certification-compliance/critical-access-hospitals

The surveyor(s) will also require the following information, in electronic or paper format, to facilitate survey activity and begin evaluating compliance.

- A list of current inpatients, providing each patient's name, room number, diagnosis(es), admission date, age, attending physician, and other significant information as it applies to that patient.
- A list of department heads with their locations and telephone numbers;
- A copy of the CAH's organizational chart;
- The names and addresses of all off-site locations operating under the same provider number (CCN);
- A list of employees by department;
- The medical staff bylaws and rules and regulations;
- A list of contracted services; and
- A copy of the CAH's floor plan, indicating the location of patient care and treatment areas;

This is not an all-inclusive list, and other documents may be requested throughout the survey.

If this is a team survey, the designated team leader will review and confirm the scope of the survey with the team and what sites, services, and topics each member is assigned to as lead evaluator.

Additional Planning Notes

Owned and Contracted Onsite Laboratory Services in a Joint Commission Accredited Critical access hospital

Some critical access hospitals may have a combination of owned and contracted onsite laboratory services. For example, the critical access hospital may operate its own general and point-of-care laboratory services but engage a local donor center to provide onsite blood bank services. All owned and contracted onsite laboratory services must be accredited by Joint Commission or one of its cooperative partners, namely the College of American Pathologists (CAP), ASHI or the state of Washington. An organization with contracted onsite laboratory services that are solely either state inspected or accredited by another laboratory agency (AOA, AABB) does not meeting the accreditation policy. Surveyors will communicate this information to the organization's Account Executive via the surveyor comments. After survey, the Account Executive will work with the organization on their submission of an application for accreditation of the laboratory services.

If the surveyor(s) discovers significant changes in organization volume, sites and services before or upon arrival on site they will contact the organization's Account Executive or the Field Director On-Call immediately to determine next steps related to these circumstances. The surveyor(s) will ask the organization to provide them with as much information about the changes as possible before calling Joint Commission's Central Office. [APR.01.03.01, EP 1]

Opening Conference

The surveyor, or designated survey team leader will continue with the on-site event by sharing some introductory remarks and plans as follows:

- Explain the purpose, scope, and structure of the survey.
- Introduce themselves (name, length of time with Joint Commission (optional), and one or two items of biographical information that is specific to the organization), including any additional surveyors who may join the team at a later time or at another location.
- Briefly explain the survey process.
    - Most survey activity occurs at the point where care, treatment, and services are provided. Tracer methodology will be the primary means of evaluation which includes a combination of interview, document review, and observation.
    - Interviews will be conducted privately with patients, staff, and visitors, unless requested otherwise by the interviewee
    - Emphasize with the organization the importance of surveyors being able to interact with and observe direct care givers.
    - The surveyor(s) may occasionally request a small gathering of individuals if necessary to understand, for example, a workflow or a cross-department process, or multi-disciplinary team's function and interaction. The surveyor(s) will work with the organization's survey coordinator on arrangements.
    - Provide a preliminary date and time for interim exit conferences when applicable (for example Life Safety Code Surveyor exiting before clinical team) and the final exit conference.
    - When a situation is identified that could be a threat to health and safety, surveyors contact Joint Commission's administrative team. Joint Commission either sends a different surveyor to investigate the issue or the surveyor on site will be assigned to conduct the investigation. Investigations include interviews, observation of care, treatment and service delivery and document review. Your cooperation is an important part of this process. Surveyors collaborate with Joint Commission's administrative team and outcomes will be communicated to your organization when a determination is reached.
- Review the ground rules that will be observed during the survey event and invites the organization to contribute any additional rules.
- Inquire whether the CAH wishes to have CAH personnel accompany surveyors during their survey activities. Explain that this is allowed as long as the CAH personnel do not interfere or delay the survey.
- Discuss arrival times with leaders and staff for subsequent survey days.
- Answer questions about the on-site visit, activity schedule, availability of documents or people, and any other related topics.
- Ask attendees to introduce themselves (name, title, functional responsibility).

Orientation to the Organization

The surveyor(s) will continue engaging staff and leaders in an interactive dialogue to learn more about the organization such as how it is governed and operated, leaders' planning priorities, patient population and community health care needs, staffing and availability of licensed practitioners, and performance monitoring and improvement processes.

Initial On-Site Team Meeting

The surveyor(s) will gather one final time before setting out on tracers. This meeting is to review and adjust the preliminary plan, if necessary, based on the information gathered during the Opening and Orientation to the Organization activities.

Sample Size and Selection

Whenever possible and appropriate, the surveyor(s) selects patients who are admitted to and receiving, or accessing patient care, treatment and services during the time of survey. Surveyors will make their selections of patients to trace, which includes open record review, by proceeding to the various locations throughout the organization. Upon arrival, surveyors will engage staff in identifying patients that will allow for evaluation of patient care, treatment, and services being provided in the location. Open records allow surveyors to conduct a patient-focused survey and enable surveyors to validate the information obtained through record reviews with observations and patient and staff interviews. There may be situations where closed records are needed to supplement the open records reviewed (e.g., too few open records, complaint investigation, etc.), surveyors should use their professional judgment in these situations and select a sample that will enable them to make compliance determinations.

The selected patient records should reflect the scope of services provided by the facility. Select a cross section of the patient population and services, to include contracted services, for example, telemedicine, teleICU, telestroke. The sample needs to be no fewer than 20 inpatient records, provided that number is adequate to determine compliance. Additionally, select a sample of outpatients in order to determine compliance in outpatient and emergency services.

The surveyor(s) assigns each patient in the sample a unique identifier. The standardized medical record naming convention requires the use of the last 4 digits of the medical record identifier used by the healthcare organization followed by the patient's initials. See examples below:

	Patient Name	Medical Record Identifier Used by the HCO	Standardized TJC Medical Record Naming Convention
Non-VA HCOs	John Jones	123456789	6789JJ
VA HCOs	Peter Piper	SS# 123459876	9876PP

Organizations are provided with a report that allows them to understand which RFIs are tied to specific records so that they can take targeted action and correct any deficiencies associated with those records. Following is a sample of the Record Review Report.

Record Review Report**

Program: Critical access hospital

Record Number	Reviewed/Observed	Standard	EP	CoP
6789JJ	Observed	PC.01.02.13	EP 2	§482.61(b)(7)-(A-1637)
9876PP	Observed	RC.02.01.01	EP 2	

Organizations can access the report on their Joint Commission *Connect* extranet site under the "Survey Process" tab, by selecting "Accreditation Record Review Reports." Once the user accesses the .pdf icon it will open to the Record Review Report.

Initial Surveys

To conduct an initial survey of a critical access hospital there must be enough inpatients currently in the critical access hospital and patient records (open and closed) for the surveyor(s) to determine whether the critical access hospital can demonstrate compliance with all the applicable CoPs. The number of current and discharged inpatients and outpatients in relation to the complexity of care provided to patients and the length of stay of those patients needs to be large enough for surveyors to evaluate the manner and degree to which the critical access hospital satisfies all the standards within each CoP including any CoP applying to optional services offered by the critical access hospital. Utilize the same sample size and selection methods as previously discussed.

Information Gathering and Evaluation Activity

During an accreditation survey, Joint Commission evaluates an organization's performance of functions and processes for compliance with standards based on CMS Conditions of Participation (CoPs) and Joint Commission National Performance Goals (NPGs). Throughout the event, the surveyor(s) will work to minimize any disruption to patient care when conducting survey activities.

The survey process focuses on assessing performance of important patient-centered and organization functions that support the safety and quality of care, treatment, and services. Surveyors perform this assessment by

- Tracing the care, treatment, and services provided to patients throughout the organization and visiting locations and evaluating services, including those provided under contract, that are part of an individual patients' health care encounter.
- Observing patient care, treatment, and services provided by organization staff.
- Interviewing organization staff who plan, direct, facilitate, provide, and monitor patient care, treatment, and services, and interviewing patients or their families.
- Reviewing a variety of organization documentation, such as policies and procedures, patient health care records, performance monitoring and improvement data, planning and operations-related information, governance and leadership meeting minutes, human resources files and records, and contracts.
- Evaluating compliance with standards based on *NFPA 99-2012 Health Care Facilities Code* and *NFPA 101-2012 Life Safety Code®* requirements through observation, document review, and interviews with the leaders and staff responsible for the physical environment in which patient care, treatment and services are provided.

These activities will take place in the locations and at facilities where the organization provides patient care, treatment, and services as identified in the E-App.

Patient Review

A comprehensive review of care and services received by each patient in the sample should be part of the critical access hospital survey. A comprehensive review includes observations of care/services provided to the patient, patient and/or family interview(s), staff interview(s), and medical record review. After obtaining the patient's permission, observe each sample patient receiving treatments (e.g., intravenous therapy, tube feedings, wound dressing changes) and observe the care provided in a variety of treatment settings, as necessary, to determine if patient needs are met.

Observations

Observations provide first-hand knowledge of critical access hospital practice. The regulations and interpretive guidelines offer guidance for conducting observations. Observation of the care environment provides valuable information about how the care delivery system works and how critical access hospital departments work together to provide care. Surveyors are encouraged to make observations, complete interviews, and review records and policies/procedures by stationing themselves as physically close to patient care as possible. While completing a chart review, for instance, it may be possible to also observe the environment and the patients, as far as care being given, staff interactions with patients, safety hazards, and infection control practices. **When conducting observations, particular attention should be given to the following:**

- Patient care, including treatments and therapies in all patient care settings;
- Staff member activities, equipment, documentation, building structure, sounds, and smells;
- People, care, activities, processes, documentation, policies, equipment, etc., that are present that should not be present, as well as, those that are not present that should be present;
- Integration of all services, such that the facility is functioning as one integrated whole;
- Whether quality assessment and performance improvement (QAPI) is a facility-wide activity, incorporating every service and activity of the provider and whether every facility department and activity reports to, and receives reports from, the facility's central organized body managing the facility-wide QAPI program; and
- Storage, security and confidentiality of medical records.
- Environmental risks. Examples may include, but are not limited to, unattended cleaning carts, unattended hazardous cleaning solutions, unlocked medications, and ligature risks in areas where psychiatric patients may have care provided.

The surveyor will take complete notes of all observations and document the date and time of the observation(s); location; patient identifiers, individuals present during the observation, and the activity being observed (e.g., therapy, treatment modality, medication administration, patient education).

A surveyor should have observations verified by the patient, family, facility staff, other survey team member(s), or by another mechanism. For example, when finding an outdated medication in the pharmacy, ask the pharmacist to verify that the drug is outdated. In addition, a surveyor should integrate the data from observations with data gathered through interviews and document reviews.

Interviews

Interviews provide a method to request and collect information, and to verify and validate information obtained through observations. Informal interviews should be conducted throughout the duration of the survey. Use the information obtained from interviews to determine what additional

observations, interviews, and document and record reviews are necessary. When conducting interviews, observe the following:

- Maintain detailed documentation of each interview conducted. Document the interview date, time, and location; the full name and title of the person interviewed; and key points made and/or topics discussed.
- Interviews with facility staff should be brief. Use a few well-phrased questions to elicit the desired information. For example, to determine if a staff member is aware of disaster procedures and his/her role in such events, simply ask, "If you smelled smoke, what would you do?"
- When interviewing staff, begin your interviews with staff that work most closely with the patient.
- Conduct patient interviews regarding their knowledge of their plan of care, the implementation of the plan, and the quality of the services received. Other topics for patient or family interview may include patient rights, advanced directives, and the facility's grievance/complaint procedure.
- Interviews with patients must be conducted in privacy and with the patient's prior permission.
- Use open-ended questions during your interview.
- Validate all information obtained.
- Telephone interviews may be conducted, if necessary, but a preference should be made for in-person interviews.
- Integrate the data from interviews with data gathered through observations and document reviews.

Staff interviews should gather information about the staff's knowledge of the patient's needs, plan of care, and progress toward goals. Problems or concerns identified during a patient or family interview should be addressed in the staff interview in order to validate the patient's perception, or to gather additional information.

Patient interviews should include questions specific to the patient's condition, reason for critical access hospital admission, quality of care received, and the patient's knowledge of their plan of care. For instance, a surgical patient should be questioned about the process for preparation for surgery, the patient's knowledge of and consent for the procedure, pre-operative patient teaching, post-operative patient goals and discharge plan.

Document Review

Document review focuses on a facility's compliance with the standards and CoPs. When conducting a document review, document the source and date of the information obtained. Once a document review is completed, integrate the data obtained with data gathered through observations and interviews to decide if the critical access hospital is in compliance with the standards and CoPs. Documents reviewed may be both written and electronic and include the following:

- Patient's clinical records, to validate information gained during the interviews, as well as for evidence of advanced directives, discharge planning instructions, and patient teaching. This review will provide a broad picture of the patient's care. Plans of care and discharge plans should be initiated immediately upon admission and be modified as patient care needs change. The record review for that patient who has undergone surgery would include a

review of the pre-surgical assessment, informed consent, operative report, and pre-, inter-, and post-operative anesthesia notes. Although team members may have a specific area assigned during the survey, the team should avoid duplication of efforts during review of medical records and each surveyor should review the record as a whole instead of targeting the assigned area of concern. Surveyors should use open patient records rather than closed records, whenever possible;

- Closed medical records may be used to determine past practice, and the scope or frequency of a deficient practice. Closed records should also be reviewed to provide information about services that are not being provided by the critical access hospital at the time of the survey. For example, if there are no obstetrical patients in the facility at the time of the survey, review closed OB records to determine care practices, or to evaluate past activities that cannot be evaluated using open records. In the review of closed clinical records, review all selected medical records for an integrated plan of care, timelines of implementation of the plan of care, and the patient responses to the interventions.
- Personnel files to determine if staff members have the appropriate educational requirements, have had the necessary training required, and are licensed, if it is required;
- Credentials/privileges files to determine if the facility complies with CMS requirements and State law, as well as, follows its own written policies for medical staff privileges and credentialing;
- Maintenance records to determine if equipment is periodically examined and to determine if it is in good working order and if environmental requirements have been met;
- Staffing documents to determine if adequate numbers of staff are provided according to the number and acuity of patients;
- Policy and procedure manuals. When reviewing policy and procedure manuals, verify with the person in charge of an area that the policy and procedure manuals are current; and
- Contracts, if applicable, to determine if patient care, governing body, QAPI, and other CoP requirements are included.
- Diet menus to ensure they meet the needs of the sampled patients.

Surveyor Planning and Team Meetings

The surveyor(s) will take time daily to assess the progress of the survey, review areas of concern, and plan for subsequent tracer selection and focus. If this is a team survey the designated team leader will lead this meeting and expect a report out from each surveyor that includes:

- All significant issues, adverse events, potential threats to health and safety
- Patient tracers conducted, including areas and locations visited, observations of care, treatment and services, interviews conducted, documentation reviewed
- Review of observations, issues for further follow-up
- National Performance Goals that have been evaluated
- Personnel and medical staff files reviewed
- Inpatient and outpatient medical/health records reviewed
- Any outstanding requests for information, and

- Topics to cover at the Daily Briefing.

Daily Briefings

The surveyor(s) will summarize the events of the previous day and communicate observations according to standards areas that may or may not lead to findings of non-compliance. If a surveyor is visiting a remote location, organizations may be asked for assistance with setting up a conference call to include all surveyors and appropriate staff from locations that were visited.

Accreditation Report Preparation

The surveyor(s) will use this time to compile, analyze, and organize the data collected throughout the survey into a Preliminary Accreditation Report reflecting the organization's compliance with standards and CoPs.

The performance expectations for determining if a standard is in compliance are included in its elements of performance (EPs). If an EP is determined to be out of compliance, then it will be cited as a requirement for improvement (RFI). Each RFI is placed in the SAFER[2] Matrix according to how likely it is that the RFI will harm a patient(s), staff, and/or visitor (low, moderate, high) and the scope, or prevalence, at which the RFI was cited (limited, pattern, widespread). As the risk level of a finding or an observation increases, the placement of the standard and EP moves from the bottom left corner (lowest risk level) to the upper right corner (highest risk level).

Determining Standard Level and Condition Level Deficiencies

For organizations that utilize Joint Commission for deeming purposes, observations noted within the Requirements for Improvement (RFI) section that are crosswalked to a CMS Condition of Participation (CoP)/Condition for Coverage (CfC) are highlighted. The table included within this section incorporates, from a Centers for Medicare and Medicaid Services (CMS) perspective, the CoPs/CfCs that were noted as noncompliant during the survey, the Joint Commission standard and element of performance the CoP/CfC is associated with, the CMS score (either Standard or Condition Level), and if the standard and EP will be included in an upcoming Medicare Deficiency Survey (MEDDEF) if applicable.

Exit Conference

The surveyor(s) will offer to meet with the most senior leader, usually the CEO or administrator, or the leadership team to conduct a private Exit Briefing. During the Exit Briefing, the surveyor(s) will present the survey findings and review the Preliminary Accreditation Report (including the SAFER Matrix results), discuss any concerns senior leaders have with the preliminary report, and determine the need for any special arrangements for the Organization Exit Conference.

The organization determines which staff will attend the exit conference.

During the Organization Exit Conference the surveyor(s) will review the survey findings (if desired by senior leaders), review the issues of standards compliance that have been identified during the survey, and review required follow-up actions, as applicable. The surveyor(s) will not reveal any identifying information for either patients or staff members during the presentation of survey results.

[2] Survey Analysis for Evaluating Risk (SAFER) Matrix. The SAFER Matrix is only a visual representation of risk associated with survey findings. Placement of findings on the SAFER Matrix does not enter into the accreditation decision process.

Post-Survey Activities

Refer to the Accreditation Manual for Critical Access Hospitals, the Accreditation Process chapter for detailed information.

Critical Access Hospital Document List

To facilitate the survey activities and compliance evaluation work, please have the following information and documents (as they become available) for the surveyor(s) to begin reviewing during the Surveyor Arrival and Preliminary Planning activity. This review will continue throughout the survey.
Note*: The 12-month reference in the following items is not applicable to initial surveys.*

In addition to the documents noted below, please be prepared to provide the Life Safety Surveyor, upon arrival, the documents found on the Physical Environment Document List and Review Tool, which is located later in this Guide.
Note: *This is not intended to be a comprehensive list of documentation that may be requested during the survey. Surveyors may ask, on an as needed basis, to see additional documents throughout the survey to further explore or validate observations or discussions with staff.*

Needed During …	Requested Documents
Surveyor Arrival and Preliminary Planning	1. Name of key contact person who can assist surveyors in planning tracer selection. 2. Any available regulatory reports (CMS, State). 3. Waivers and variances if they exist. 4. Complexity of services offered, including outpatient services to include, names and addresses of all off-site locations operating under the same provider number. a) List of all sites that are eligible for survey. b) List of sites where deep or moderate sedation is in use. c) List of sites where high-level disinfection and/or sterilization is in use. d) List of sites where medication compounding (simple, hazardous, etc.) within the organization. e) List of departments, units, area, programs, and services within the organization, if applicable f) List of Department or Service leaders with locations/area responsibility and phone numbers 5. Copy of facilities floor Plan indicating location of patient care and treatment areas
Surveyor Arrival and Preliminary Planning	Hospital license, Prior to Survey Activities; **Note:** *Refer to Hospital Compliance with Federal, State, and Local Laws Evaluation Module (482.11)*
Surveyor Arrival and Preliminary Planning	1. List of current inpatients a) patient's name b) room number c) diagnosis(es) d) admission date e) age f) attending physician, g) and other significant information as it applies to that patient 2. Lists of scheduled surgeries and special procedures

Needed During ...	Requested Documents
	➢ *For example, cardiac catheterization, endoscopy lab, electroconvulsive therapy, caesarian sections, including location of procedure and time.*
Surveyor Arrival and Preliminary Planning	Medical Staff 1. Medical Staff Bylaws 2. Rules and Regulation 3. Medical Staff Policies *Note: If your organization has had any changes or updates to your Medical Staff Bylaws and/or Medical Staff Rules and Regulations since your last full triennial survey, please have those sections flagged for your survey team to review.)* 4. Medical Executive Committee meeting minutes
End of Day 1	List of employees 1. Name 2. Position (LPN, RN, RT, PT, Pharmacy Tech, etc.) 3. Primary Location of Work
End of Day 1	Infection Control 1. Annual infection risk assessment 2. Infection Control surveillance data from the past 12 months
Survey Activities	Antibiotic Stewardship 1. Organization approved antibiotic stewardship protocols *For example, policies, procedures, or order sets* 2. Antibiotic stewardship data 3. Antibiotic stewardship program reports to leadership and prescribers
Pharmacy Tracer	Final Reports of Certification/Testing for all Primary Engineering Controls and Secondary Engineering Controls associated with Sterile Medication Compounding (including any documentation of remediation/retesting conducted based on reported results)
Survey Activities	1. Performance improvement data from the past 12 months 2. Documentation of performance improvement projects being conducted, including the reasons for conducting the projects and the measurable progress achieved (this can be documentation in governing body minutes or other minutes) 3. Patient flow documentation: Dashboards and other reports reviewed by hospital leadership; documentation of any patient flow projects being conducted (including reasons for conducting the projects); internal throughput data collected by emergency department, inpatient units, diagnostic services, and support services such as patient transport and housekeeping

Needed During ...	Requested Documents
	4. Analysis from a high-risk process 5. Most recent culture of safety and quality evaluation data 6. ORYX data – an organization should be prepared to share ORYX Performance Measurement data and/or Accelerate PI Dashboard reports.
Survey Activities	The organization's signed and dated agreement with the QIO; in the absence of an agreement with a QIO, the organization's Utilization Review plan
Survey Activities	1. Blood transfusion policy 2. Agreement with outside blood supplier 3. Autopsy policy 4. CLIA Certificates 5. Waived testing policy and quality control plan 6. Organ Procurement Organization agreement 7. Tissue and Eye Procurement Organization agreement 8. Organ, tissue, and eye procurement policies
Survey Activities	1. Organization chart 2. Governing Body minutes for the last 12 months 3. List of Contracted Services
Survey Activities	1. Abuse and neglect policy for inpatient, and ambulatory sites, if applicable 2. Fall risk assessment and policy 3. Complaint/grievance policy 4. Restraint and seclusion policy 5. Environmental risk assessment identifying features in the physical environment that could be used to attempt suicide *(Applies to psychiatric hospitals and psychiatric units in general hospitals)* 6. Medication management policy (which defines what is a complete medication order and therapeutic duplication
Survey Activities	1. Environment of Care data (see Life Safety & Environment of Care Document List and Review Tool) 2. Environment of Care multidisciplinary team meeting minutes for the 12 months prior to survey
Survey Activities	Emergency Management documentation for each of the following (each must be updated and reviewed at least every 2 years): a) Emergency management program b) Hazard vulnerability analysis c) Emergency operation plan and policies and procedures

Needed During ...	Requested Documents
	i. Fire response and evacuation plans d) Communications plan e) Continuity of operations & recovery plan f) Education and training program g) Exercises and testing program h) Emergency management program evaluation (after-action/improvement plans) i) Unified and integrated Emergency management program, plans, policies & procedures (if applicable) j) Transplant program-specific protocols (if applicable)

Critical Access Hospital Accreditation Survey Activity List

Survey Activity Name	Brief Description and Scheduling Suggestions	Suggested Organization Participants
Surveyor Arrival and Preliminary Planning (Includes the Safety Briefing)	Surveyors will learn about any current organization safety or security concerns and how they should respond if organization safety plans are implemented. Surveyor(s) will begin review of available documents to become acquainted with your organization. Surveyor(s) will plan for tracer activity. 1st day, upon arrival	The organization's accreditation contact or survey coordinator, individual or individuals that will provide the Safety Briefing to surveyors.
Opening Conference and Orientation to the Organization	Surveyors will describe the structure of the survey, and answer questions about the survey at the Opening Conference . During Orientation to the Organization, the surveyors(s) will learn how your organization is governed and operated, discuss leaders' planning priorities, and explore your organization's performance improvement process. 1st day, as early as possible	Senior leadership representing the accredited program and services; member(s) of the governing body, or organization trustee; administrators; leader(s) of the medical staff; leader(s) of the nursing staff; and accreditation contact
Individual Tracer - Infection Control - Medication Safety and Pharmacy Review	Surveyor(s) will evaluate the organization's compliance with standards related to the care, treatment, and services provided to patients. The Individual Tracer activity occurs each day throughout the survey tracing the care experiences of patients. The number of patients that surveyors trace varies by organization. The evaluation includes processes and procedures to prevent patient harm and errors related to ordering of medications through monitoring; and evaluating medication safety practices (including medication reconciliation). Infection prevention practices (including antibiotic use, appropriate use of PPE, and hand hygiene) and infection prevention practices related to CLABSI, CAUTI, and/or MDROs will be evaluated during patient tracer activity. If travel is required to perform tracer activity (e.g., to	Staff, physicians, other licensed practitioners, and management involved in the individual's care, treatment, and services

Critical Access Hospital Accreditation Survey Activity List

Survey Activity Name	Brief Description and Scheduling Suggestions	Suggested Organization Participants
	an outpatient setting), it will be planned into this time.	
Lunch	At a time negotiated with the organization	
Issue Resolution **OR** Surveyor Planning / Team Meeting	Issue Resolution is dedicated time for surveyors to explore any issues that may have surfaced during the survey and could not be resolved at the time they were identified (staff unavailable for interview, visit to another location required, documented care procedures additional file review required, etc.). End of each day except last; can be scheduled at other times as necessary	For Issue Resolution, the surveyor(s) will identify individuals if needed. None for Surveyor Planning / Team Meeting
Daily Briefing	The surveyor(s) will summarize the events of the previous day and communicate observations according to standards areas that may or may not lead to findings. Start of each survey day except the first day; can be scheduled at other times as necessary	Participants include representative(s) from governance, CEO/Administrator or Executive Director, individual coordinating the Joint Commission survey, and other staff at the discretion of organization leaders.
Competence Assessment	The surveyor will review your organization's competence assessment process for staff and review identified personnel/staff files. After some individual tracer activity has occurred; at a time negotiated with the organization	Participants include: Staff responsible for human resources functions, orientation and education of staff and assessing staff competency; individual(s) with authority to access information contained in personal files.
Medical Staff Credentialing & Privileging	The surveyor will evaluate the process used to collect data relevant to appointment decisions, the process for granting and delineating privileges, and the structures that guide consistency of implementation (e.g., bylaw requirements). The surveyor will evaluate the credentialing and privileging process for the medical staff and other physicians and licensed practitioners who are privileged through the medical staff process. This will include credentials/privileges file review. After some individual tracer activity has occurred; at a time negotiated with the organization	President of the medical staff; medical director and medical staff coordinator, if applicable; and medical staff credentials committee representatives.
Emergency Management	The surveyor will review of the hospital's emergency management program, the application and use of the emergency	Leaders and other individuals familiar with all aspects of the Emergency Management (EM)

Critical Access Hospital Accreditation Survey Activity List

Survey Activity Name	Brief Description and Scheduling Suggestions	Suggested Organization Participants
	operations plan and policies and procedures during an emergency (real or simulated), and to assess the hospital's degree of compliance with relevant emergency management chapter standards and applicable law and regulation. After some individual tracer activity has occurred; group interview at a time negotiated with the organization May be conducted with Life Safety surveyor.	program. Participants may include the following EM multidisciplinary team members (as available): EM program lead, Senior leadership, Nursing leadership, Medical staff, Pharmacy, Infection prevention and control, Facilities engineering, Safety & security, Ancillary staff, and Information technology.
Organization Quality and Performance Improvement	The surveyor will evaluate how data is used to monitor performance and improve processes throughout the organization; and assess how the organization is using process and outcome data to evaluate the safety and quality of care being provided to patients. After some individual tracer activity has occurred; at a time negotiated with the organization	Participants may include representatives from Quality Assessment and Performance Improvement, Staff involved in the selected performance improvement activities and projects, Infection Prevention and Control program staff, Leadership, (for example, hospital board members, senior leader(s), administrator(s), Pharmacy staff, Medical Staff, and Nursing
Organization governance, administration, and management or "Leadership"	The surveyor will evaluate the responsibilities and accountabilities of leaders for the critical access hospital's total operation (including priority setting) and for administering policies to provide quality health care in a safe environment. This is a group interview at a time negotiated with the organization.	Participants include senior leaders who have responsibility and accountability for design, planning, and implementation of organization processes. Leaders typically include but are not limited to members of the governing body/trustee, CEO, and leaders of the medical staff and clinical staff.
Report Preparation	This time for the surveyor to compile, analyze, and organize the data collected during the survey into a report reflecting your organization's compliance with the standards. This will be the last opportunity for the organization to provide any outstanding surveyor requests or further evidence to present from the last day of survey activity. Last day of survey	None
CEO Exit Briefing	The surveyor(s) will review the Summary of Survey Findings Report (organized by chapter) with the most senior leader. Surveyors will discuss any patterns or trends in performance.	Participants include the Chief Executive Officer (CEO) or Administrator, if available

Critical Access Hospital Accreditation Survey Activity List

Survey Activity Name	Brief Description and Scheduling Suggestions	Suggested Organization Participants
	Last day of survey	
Organization Exit Conference	The surveyor(s) will review the Summary of Survey Findings Report with participants. Discussion will include the SAFER™ matrix, Requirements for Improvement, and any patterns or trends in performance. If follow-up is required in the form of an Evidence of Standard Compliance (ESC) the surveyors explain the ESC submission process. Last day, final activity of survey	Participants include the CEO/Administrator (or designee), senior leaders and staff as identified by the CEO/Administrator or designee.
Interim Exit – w/ early departing surveyors and organization	This is an activity for a scheduled early departure of s survey team member. the LSC Surveyor and the Team Leader conduct a verbal interim exit briefing with staff designated by the organization to review your observations. At the end of any day another program surveyor or Life Safety Code surveyor is departing from the survey in advance of the team	Participants include the CEO/Administrator (or designee), senior leaders and staff as identified by the CEO/Administrator or designee.
Life Safety Code® Survey Activity		
Life Safety Code Surveyor Arrival and Preliminary Planning Session	Surveyors will learn about any current organization safety or security concerns and how they should respond if organization safety plans are implemented. The surveyor(s) will begin review of available PE documents to become acquainted with your organization. LSCS survey 1st day, early	The organization's accreditation contact or survey coordinator and/or individual who manages your organization's facility(ies)
Facility Orientation and Document Review	The surveyor will review identified building systems, life safety drawings, including construction drawings, if available, and select policies to support the building tour activities. Take note of the building construction type identified in the SOC/BBI to prepare for discussion with the organization and confirmation with visual observation. The surveyor will determine the type of building construction and where it will be possible, without disturbing patient care, confirm by direct observation the structure and building materials used in construction. Exposed areas above the ceiling or vertical pips shafts may provide insight. At a time negotiated with the organization	Participants include the individual who manages your organization's facility(ies) and other staff at the discretion of your organization. **Due to the limited amount of time the Life Safety surveyor is onsite, please be prepared to facilitate this activity upon their arrival.**

Critical Access Hospital Accreditation Survey Activity List

Survey Activity Name	Brief Description and Scheduling Suggestions	Suggested Organization Participants
Life Safety Code® Building Assessment	The surveyor will evaluate the degree of compliance with relevant *Life Safety Code® (NFPA 101-2012)* and Health Care Facilities Code (NFPA 99-2012) requirements. The surveyor will visit areas where it can be confirmed by direct observation the structure and building materials used in construction. Exposed areas above the ceilings or vertical pipe shafts may provide insight. At a time negotiated with the organization	Participants include the individual who manages organization facilities and other staff at the discretion of your organization.
Lunch	At a time negotiated with the organization	
Emergency Management (**See above description)**	At a time negotiated with the organization. May be conducted with a Clinical surveyor.	**See above**
Report Preparation	This time for the surveyor to compile, analyze, and organize the data collected during the LSC survey into a report reflecting your organization's compliance with the Physical Environment standards. This will be the last opportunity for the organization to provide any outstanding surveyor requests or further evidence to present from the last day of survey activity. Towards the end of last day of survey	None
Interim Exit	This is an activity for a scheduled early departure of a survey team member. The LSC Surveyor and the Team Leader conducts a verbal interim exit briefing with staff designated by the organization to review your observations. Last activity on last day of survey.	Participants include the individual who manages your organization's facility(ies), CEO/Administrator (or designee), senior leaders and staff as identified by the CEO/Administrator or designee.

Critical Access Hospital Basis and Scope (485.601), Rural Health Network (485.603), Personnel Qualifications (485.604), and Designation and Certification (485.606) Evaluation Module

Joint Commission Standards / EPs	Critical Access Hospital CoP	Critical Access Hospital Survey Process
Statutory basis and scope for designating hospitals as critical access hospitals.	**485.601 (Basis and Scope)** (a) Statutory basis. This subpart is based on section 1820 of the Act which sets forth the conditions for designating certain hospitals as CAHs. (b) Scope. This subpart sets forth the conditions that a hospital must meet to be designated as a CAH.	
LD.13.01.01, EP 6: If the critical access hospital is a member of a rural health network, the network meets the criteria required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.603. Note: See the Glossary for a definition of rural health network.	**485.603 (Rural Health Network)** A rural health network is an organization that meets the following specifications: (a) It includes— (1) At least one hospital that the State has designated or plans to designate as a CAH; and (2) At least one hospital that furnishes acute care services. (b) The members of the organization have entered into agreements regarding— (1) Patient referral and transfer; (2) The development and use of communications systems, including, where feasible, telemetry systems and systems for electronic sharing of patient data; and (3) The provision of emergency and nonemergency transportation among members. (c) Each CAH has an agreement with respect to credentialing and quality assurance with at least— (1) One hospital that is a member of the network when applicable; (2) One QIO or equivalent entity; or (3) One other appropriate and qualified entity identified in the State rural health care plan.	**Interview** ☐ Interview leadership and confirm that if the CAH is a member of a rural health network, the network meets the criteria required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.603. **Document Review** **General** ☐ Review the criteria and confirm the CAH meets the established CMS criteria.

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NPG.12.01.01, EP 2: Staff that provide care, treatment, and services meet the personnel qualifications required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.604. Note: The following terms are defined in the Glossary: clinical nurse specialist, nurse practitioner, physician assistant.	**485.604 (Personnel Qualifications)** Staff that furnish services in a CAH must meet the applicable requirements of this section. (a) Clinical nurse specialist. A clinical nurse specialist must be a person who— (1) Is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed in accordance with State nurse licensing laws and regulations; and (2) Holds a master's or doctoral level degree in a defined clinical area of nursing from an accredited educational institution. (b) Nurse practitioner. A nurse practitioner must be a registered professional nurse who is currently licensed to practice in the State, who meets the State's requirements governing the qualification of nurse practitioners, and who meets one of the following conditions: (1) Is currently certified as a primary care nurse practitioner by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates. (2) Has successfully completed a 1 academic year program that— (i) Prepares registered nurses to perform an expanded role in the delivery of primary care; (ii) Includes at least 4 months (in the aggregate) of classroom instruction and a component of supervised clinical practice; and (iii) Awards a degree, diploma, or certificate to persons who successfully complete the program. (3) Has successfully completed a formal educational program (for preparing registered nurses to perform an expanded role in the delivery of primary care) that does not meet the requirements of paragraph (a)(2) of this section, and has been performing an expanded role in	**Document Review** **Personnel/Credential File** ☐ Review job descriptions to confirm personnel qualifications meet the requirements to perform care and services in accordance with State nurse licensing laws and regulations. ☐ Verify the required licensure

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	the delivery of primary care for a total of 12 months during the 18-month period immediately preceding June 25, 1993. (c) Physician assistant. A physician assistant must be a person who meets the applicable State requirements governing the qualifications for assistants to primary care physicians, and who meets at least one of the following conditions: (1) Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians. (2) Has satisfactorily completed a program for preparing physician assistants that— (i) Was at least one academic year in length; (ii) Consisted of supervised clinical practice and at least 4 months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and (iii) Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation. (3) Has satisfactorily completed a formal educational program (for preparing physician assistants) that does not meet the requirements of paragraph (c)(2) of this section and has been assisting primary care physicians for a total of 12 months during the 18-month period immediately preceding June 25, 1993.	
This is the responsibility of the State and CMS.	**485.606 (Designation and Certification)** (a) Criteria for State Designation. (1) A State that has established a Medicare rural hospital flexibility program described in section 1820(c) of the Act may designate one or more facilities as CAHs if each facility meets the CAH conditions of participation in this subpart F. (2) The State must not deny any hospital that is otherwise eligible for designation as a CAH under this	

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	paragraph (a) solely because the hospital has entered into an agreement under which the hospital may provide posthospital SNF care as described in §482.58 of this chapter. (b) Criteria for CMS certification. CMS certifies a facility as a CAH if— (1) The facility is designated as a CAH by the State in which it is located and has been surveyed by the State survey agency or by CMS and found to meet all conditions of participation in this part and all other applicable requirements for participation in part 489 of this chapter. (2) The facility is a medical assistance facility operating in Montana or a rural primary care hospital designated by CMS before August 5, 1997, and is otherwise eligible to be designated as a CAH by the State under the rules in this subpart.	

Critical Access Hospital Compliance with Federal, State, and Local Laws Evaluation Module (485.608)

Joint Commission Standards / EPs	Critical Access Hospital CoP	Critical Access Hospital Survey Process
LD.13.01.01, EP 1: The critical access hospital provides care, treatment, and services in accordance with licensure requirements and federal, state, and local laws, rules, and regulations. **LD.13.01.01, EP 2:** The critical access hospital is licensed in accordance with law and regulation, to provide the care, treatment, or services for which the critical access hospital is seeking accreditation from Joint Commission. Note: For rehabilitation or psychiatric distinct part units in critical access hospitals: The critical access hospital is licensed or approved as meeting the standards for licensing established by the state or responsible locality. **HR.11.01.03, EP 1 :** All staff who provide patient care, treatment, and services are qualified and possess a current license, certification, or registration, in accordance with law and regulation. **MS.17.01.03, EP 3:** The credentialing process requires that the critical access hospital verifies in writing and from the primary source whenever feasible, or from a credentials	**§485.608 Condition of Participation: Compliance with Federal, State, and Local Laws and Regulations** The CAH and its staff are in compliance with applicable Federal, State and local laws and regulations. **§485.608(c) Standard: Licensure of CAH** The CAH is licensed in accordance with applicable Federal, State and local laws and regulations. §**485.608(d) Standard: Licensure, Certification or Registration of Personnel** Staff of the CAH are licensed, certified, or registered in accordance with applicable Federal, State, and local laws and regulations.	**Document Review** **General** □ Prior to the survey, determine whether the CAH is subject to licensure requirements and verify that the licensing agency has approved the CAH as meeting the standards for licensure as set forth by the agency of the State or locality responsible for licensing CAHs. Verify the CAH has □ Established, and follows, procedures for determining that personnel providing patient care services are properly licensed as required by the State. □ Procedures in place to guarantee licensure of employees working at the CAH under contract or agreement. □ Policies regarding certification, licensure, and registration of personnel. ○ Are the CAH policies compliant with State and local laws? ○ Are the personnel in compliance with CAH policy? **Personnel File** □ Check a sample of personnel files to verify that licensure information is up to date. Verify ○ Appropriate categories of staff and personnel are licensed in accordance with State requirements. ○ State licensure compliance of the direct care personnel, as well as administrators and

Joint Commission Standards / EPs	Critical Access Hospital CoP	Critical Access Hospital Survey Process
~~verification organization (CVO), the following information for the applicant:~~ ~~- Current licensure at the time of initial granting, renewal, and revision of privileges and at the time of license expiration~~ ~~- Relevant training~~ ~~- Current competence~~ ~~**MS.17.02.01, EP 9:** All physicians and other licensed practitioners that provide care, treatment, and services possess a current license, certification, or registration, as required by law and regulation.~~		~~supervisory personnel, and any contracted personnel.~~ ~~o Personnel meet all state or local law requirements for certification, minimum qualifications and training/education.~~
LD.13.01.01, EP 1: The critical access hospital provides care, treatment, and services in accordance with licensure requirements and federal, state, and local laws, rules, and regulations.	**§485.608 Condition of Participation: Compliance with Federal, State, and Local Laws and Regulations** The CAH and its staff are in compliance with applicable Federal, State and local laws and regulations. **§485.608(a) Standard: Compliance with Federal Laws and Regulations** The CAH is in compliance with applicable Federal laws and regulations related to the health and safety of patients. .	**Document Review** **General** □ Review the CAH's advance directive[3] notice for the following: o Advisement to inpatients or applicable outpatients, or their representatives, of the patient's right to formulate an advance directive and to have CAH staff comply with the advance directive (in accordance with State law) o A clear, precise, and valid statement of limitation if the CAH cannot implement an advance directive on the basis of conscience? **Patient Health Record**

[3] *An advance directive is defined at 42 CFR 489.100 as "a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." In accordance with the provisions of 42 CFR 489.102(a), the advance directives regulations apply to CAHs.*

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		☐ Review the records of a sample of patients for evidence of CAH compliance with advance directive notice requirements. o Does every inpatient or applicable outpatient record contain documentation that notice of the CAH's advance directives policy was provided at the time of admission or registration? o Is there documentation of whether or not each patient has an advance directive? o For those patients who have reported an advance directive, has a copy of the patient's advance directive been placed in the medical record? **Interview** ☐ CEO or appropriate individual designated by the hospital to determine if the CAH is in compliance with Federal laws and regulations related to patient health and safety. *This includes other Medicare regulations and Federal laws and regulations not specifically addressed in the CoPs. State Survey Agencies are expected to assess the CAH's compliance with the following Medicare provider agreement regulation provisions when surveying for compliance with §485.608(a)*: o Ask CAH staff about the o Process in place to allow patients to formulate an advance directive or to update their current advance directive. o Education the CAH has provided staff regarding advance directives.

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		○ CAHs promotion and protection of each patient's right to formulate an advance directive, including providing education to the patient population about their rights under State law. ○ Knowledge they have of the advance directives of the patients in their care. ○ Process for identifying patients who have an advance directive designating a particular individual to make medical decisions for him/her when incapacitated, and providing the designated individual with the information required to make informed decisions about the patient's care. ○ Process for seeking the consent of the patient's representative when informed consent is required for a care decision while the patient is incapacitated. Ask patient care leaders ○ How the CAH complies, as permitted under State law, with patient advance directives that delegate decisions about the patient's care to a designated individual.
LD.13.01.01, EP 1: The critical access hospital provides care, treatment, and services in accordance with licensure requirements and federal, state, and local laws, rules, and regulations.	**Required CAH Disclosures to Patients: Physician Ownership** 42 CFR 489.3 defines a "physician-owned hospital" as any participating hospital, including a CAH, in which a physician or immediate family member of a physician (as defined in §411.351) has an ownership or investment interest in the CAH, except for those satisfying an exception found at §411.356(a) or (b). Surveyors are not required to make an independent	**Document Review** **General** *If the CAH indicates that it is physician-owned but is exempt under §489.20(v) from the disclosure requirement of §489.20(u)(2),* ☐ Ask to see the signed attestation that it does not have any referring physicians with an ownership/investment interest or whose

Joint Commission Standards / EPs	Critical Access Hospital CoP	Critical Access Hospital Survey Process
	determination regarding whether a CAH meets the Medicare definition of "physician-owned," but they □ [Surveyors] must ask whether the CAH is physician-owned. • However, the notice requirement does not apply to any physician-owned CAH that does not have at least one referring physician (as defined at §411.351 of this chapter) who has an ownership or investment interest in the CAH or who has an immediate family member who has an ownership or investment interest in the CAH. In such cases-- □ The CAH must sign an attestation statement that it has no referring physician with an ownership or investment interest or whose immediate family member has an ownership or investment interest in the CAH. The CAH must maintain this attestation in its records. □ 42 CFR 489.20(u)(1) requires that all physician-owned CAHs provide written notice to their patients at the beginning of each patient's CAH inpatient stay or outpatient visit stating that the CAH is physician-owned, in order to assist the patient in making an informed decision about his or her care. □ A planned inpatient stay or outpatient visit which is subject to the notice requirement begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned CAH admission for inpatient care or for an outpatient service subject to notice. An unplanned inpatient stay or outpatient visit subject to the notice requirement begins at the earliest point at which the patient presents to the CAH.	immediate family member was has an ownership/ investment interest in the CAH. *(As with any other on-the-spot correction of a deficiency during a survey, creation of an attestation at the time of a survey does not mean that there was no deficiency and that the CAH would not be cited.)* *If the CAH is physician-owned but not exempt from the physician ownership disclosure requirements:* □ Verify that appropriate policies and procedures are in place to assure that written notices are provided to all patients at the beginning of an inpatient stay or outpatient encounter. □ Review the notice the CAH issues to each patient to verify that it discloses, in a manner reasonably designed to be understood by all patients, that the CAH meets the Federal definition of "physician-owned," that a list of owners and investors who are physicians or immediate family members of physicians is available upon request, and that such list is provided to the patient at the time the request is made by or on behalf of the patient. **Interview** □ Determine through staff interviews, observation, and a review of policies and procedures whether the CAH furnishes its list of physician owners and investors at the time

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	○ The notice must disclose, in a manner reasonably designed to be understood by all patients, that the CAH is physician-owned and that a list of owners or investors who are physicians or immediate family members of physicians is available upon request. □ If the patient (or someone on behalf of the patient) requests this list, the CAH must provide it at the time of the request. □ 42 CFR 489.20(u)(2) provides that physician-owned CAHs must require each physician owner who is a member of the hospital's medical staff to agree, as a condition of obtaining/retaining CAH medical staff membership or admitting privileges, to disclose in writing to all patients they refer to the CAH their ownership or investment interest or that of any immediate family member in the CAH. The CAH must require that this disclosure be made at the time of the referral and the requirement should be reflected in the hospital's policies and procedures governing privileges for physician owners. *The CAH may exempt from this disclosure requirement any physician owner who does not refer any patients to the CAH.* *42 CFR 489.12 permits CMS to refuse to enter into a provider agreement with a physician-owned CAH applicant that does not have procedures in place to notify patients of physician ownership in the hospital, as required under §483.20(u)* *42 CFR 489.53(c) permits CMS to terminate the provider agreement of a physician-owned CAH if the CAH fails to comply with the requirements at §489.20(u).*	a patient or patient's representative requests it. □ Determine through staff interviews and review of policies, procedures, and staff records whether a physician-owned CAH's medical staff membership and admitting privileging requirements include a requirement that, as a condition of continued membership or admitting privileges, physician owners who refer patients to the CAH agree to provide written disclosure of their own or any immediate family member's ownership or investment interest to all patients at time of the referral to the CAH.

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LD.13.01.01, EP 1: The critical access hospital provides care, treatment, and services in accordance with licensure requirements and federal, state, and local laws, rules, and regulations.	**MD/DO 24/7 On-Site Presence** □ 42 CFR 489.20(w) mandates that if there is no doctor of medicine or osteopathy present in the CAH 24 hours per day, seven days per week the CAH must provide written notice to all inpatients at the beginning of a planned or unplanned inpatient stay, and to outpatients for certain types of outpatient visits. *The purpose of the requirement is to assist the patient in making an informed decision about his/her care. CAHs that have an MD/DO (including residents who are MDs or DOs) on-site 24/7 do not need to issue any disclosure notice about emergency services capability.* □ The notice must be provided to all inpatients and to those outpatients who are under observation or who are having surgery or any other procedure using anesthesia. □ A planned inpatient stay or outpatient visit which is subject to the notice requirement begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned CAH admission for inpatient care or for an outpatient service subject to notice. An unplanned inpatient stay or outpatient visit subject to the notice requirement begins at the earliest point at which the patient presents to the CAH. *Individual notices are not required in the CAH's dedicated emergency department (DED) (as that term is defined in 42 CFR 489.24(b)), but*	**Interview** □ Determine through interviews, observation, and medical record review whether an MD/DO is present in the CAH 24 hours per day, 7 days per week. Ask a sample of inpatients and affected outpatients whether they were provided notice about an MD/DO not being present at all times in the CAH. **Document Review** **General** For each required location where a doctor of medicine (MD) or doctor of osteopathy (DO) is not present: □ Verify that policies and procedures are in place to assure that written notices that a MD/DO is not present at all times are provided at the beginning of a planned or unplanned inpatient stay or outpatient visit to all inpatients and to all outpatients receiving observation services, surgery or another procedure requiring anesthesia. **Patient Health Record** □ Verify that the CAH obtained, a signed acknowledgement by the patient of being informed that an MD/DO is not present at all times. ○ Was the patient informed prior to admission or before applicable outpatient services were provided? **Observation**

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	□ The DED must post a notice conspicuously, in a place or places likely to be noticed by all individuals entering the dedicated emergency department. ○ The posted notice must state that the CAH does not have a doctor of medicine or a doctor of osteopathy present in the hospital 24 hours per day, 7 days per week, and must indicate how the CAH will meet the medical needs of any patient with an emergency medical condition, as defined in 42 CFR 489.24(b) [the EMTALA definition], at a time when there is no doctor of medicine or doctor of osteopathy present in the CAH. If an emergency department patient is determined to require admission, then the individual notice provisions of 42 CFR 489.20(w) would apply to that patient. □ Before admitting an inpatient or providing outpatient services requiring notice, the CAH must obtain a signed acknowledgement from the patient stating that he/she understands that a doctor of medicine or doctor of osteopathy may not be present during all hours services are furnished to him/her. □ In the event of an unplanned surgery or inpatient admission to treat an emergency medical condition, it may in some cases be necessary in the interest of the patient's safety to proceed with treatment before the required notice can be given and acknowledgement can be obtained. In such circumstances the CAH must provide notice and obtain acknowledgement as soon as possible after the patient's stay or visit begins.	□ Verify that the CAH's emergency department has signage stating: □ An MD/DO is not present 24 hour per day, 7 days per week. □ How the CAH will meet the medical needs of any patient who develops an emergency medical condition at a time when no physician is present at that CAH, including any remote location. Note: For a CAH that participates in Medicare with multiple campuses providing inpatient services (e.g., a main provider campus and a separate remote location for a psychiatric or rehabilitation distinct part unit (DPU)) under one CMS Certification Number) a separate determination is made for each campus/location with inpatient services as to whether the disclosure notice is required.

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	For a CAH that participates in Medicare with multiple campuses providing inpatient services (e.g., a main provider campus and a separate remote location for a psychiatric or rehabilitation distinct part unit (DPU)) under one CMS Certification Number) a separate determination is made for each campus/location with inpatient services as to whether the disclosure notice is required. *For example, if a CAH has a main campus with 25 inpatient beds and a remote location with 10 psychiatric DPU beds and 10 rehabilitation DPU beds, and a physician is present 24/7 on the main campus, but not at the DPU remote location, the CAH is required to provide the disclosure notice at the DPU location. No notice is required for patients coming to the main provider campus. In this same example, if the CAH also has a provider-based, off-campus ambulatory surgery department, no notice is required at that off-campus surgery site, since the CAH's main campus does have an MD/DO present 24/7.* *42 CFR 489.53(c) permits CMS to terminate a provider agreement with a CAH if the CAH fails to comply with the requirements at §489.20(w) when it does not have an MD or DO on-site 24/ 7.*	
LD.13.01.01, EP 1: The critical access hospital provides care, treatment, and services in accordance with licensure requirements and federal, state, and local laws, rules, and regulations.	**Other Federal Requirements** Other Federal requirements also apply to patient health and safety in the CAH. For example, Federal laws and regulations govern both the disposal of medical waste and occupational health. However, surveyors are not expected to be knowledgeable about the requirements of other Federal agencies and therefore do not assess compliance with non-CMS regulations. A surveyor who suspects a CAH may not be in compliance with other Federal requirements may refer the matter to the	**Other Federal Requirements** Surveyors do not assess compliance with Medicare payment provisions or non-Medicare requirements. However, a surveyor may refer suspected noncompliance with Federal laws and regulations to the appropriate agency having jurisdiction (e.g., hazardous chemical and waste issues to EPA, blood-borne pathogens and TB control to OSHA, etc.).

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	appropriate Federal agency. If CMS is notified or becomes aware of another Federal agency's final *enforcement action, action will be taken only if the final enforcement action remains in effect.*	
LD.13.01.01, EP 1: See above	**§485.608(b) Standard: Compliance With State and Local Laws and Regulations** All patient care services are furnished in accordance with applicable State and local laws and regulations.	**Interview** □ Ask organization representatives about State practice act requirements and how they maintain compliance. **Observation** □ Review the organization's website prior to going on the survey, determine what professional specialists provide patient care services at the CAH.
LD.13.01.01, EP 2: The critical access hospital is licensed in accordance with law and regulation, to provide the care, treatment, or services for which the critical access hospital is seeking accreditation from Joint Commission. Note: For rehabilitation or psychiatric distinct part units in critical access hospitals: The critical access hospital is licensed or approved as meeting the standards for licensing established by the state or responsible locality.	**§485.608(c) Standard: Licensure of CAH** The CAH is licensed in accordance with applicable Federal, State and local laws and regulations.	**Document Review** **General** □ Prior to the survey, determine whether the CAH is subject to licensure requirements and verify that the licensing agency has approved the CAH as meeting the standards for licensure as set forth by the agency of the State or locality responsible for licensing CAHs.
HR.11.01.03, EP 1: All staff who provide patient care, treatment, and services are qualified and possess a current license, certification, or registration, in accordance with law and regulation.	**§485.608(d) Standard: Licensure, Certification or Registration of Personnel**	**Document Review** **General** □ Verify for those personnel required to be licensed by the State, that the CAH has established, and follows, procedures for determining that personnel providing patient care services are properly licensed.

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MS.17.01.03, EP 3: The credentialing process requires that the critical access hospital verifies in writing and from the primary source whenever feasible, or from a credentials verification organization (CVO), the following information for the applicant: - Current licensure at the time of initial granting, renewal, and revision of privileges, and at the time of license expiration - Relevant training - Current competence **MS.17.02.01, EP 9:** All physicians and other licensed practitioners that provide care, treatment, and services possess a current license, certification, or registration, as required by law and regulation.		□ Review CAH policies regarding certification, licensure, and registration of personnel. Are the CAH policies compliant with State and local laws? Are the personnel in compliance with CAH policy? **Personnel File Review** □ Check a sample of personnel files to verify that licensure information is up to date. Verify that appropriate categories of staff and personnel are licensed in accordance with State requirements. Verify state licensure compliance of the direct care personnel, as well as administrators and supervisory personnel, and any contracted personnel. □ Confirm there are procedures in place to guarantee licensure of employees working at the CAH under contract or agreement.

Critical Access Hospital Patient Rights Evaluation Module (485.614)

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RI.11.01.01, EP 1: The critical access hospital develops and implements written policies to protect and promote patient rights. **RI.11.01.01, EP 2:** The critical access hospital informs each patient, or when appropriate, the patient's representative (as allowed, under state law) of the patient's rights in advance of providing or discontinuing care, treatment, or services whenever possible.	**§ 485.614** Condition of participation: Patient's rights. **§485.614(a)** Standard: Notice of rights. §485.614(a)(1) (1) A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.	**Interview** ☐ Ask staff how the hospital communicates information about patient rights to diverse patients, including individuals who need assistive devices or translation services. o Does the hospital have alternative means, such as written materials, signs, or interpreters (when necessary), to communicate patients' rights? ☐ Ask staff and patients or patients' representatives (as appropriate) to examine how the hospital determines whether the patient has a representative, who that representative is, and whether notice of patient rights is provided as required to patients' representatives. o Ask patients to describe what the hospital has told them about their rights.
LD.11.01.01, EP 2: The governing body does the following: - Approves and is responsible for the effective operation of the grievance process - Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body also does the following: - Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff - Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff	**§485.614(a)(2)** (2) The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's governing body must approve and be responsible for the effective operation of the grievance process and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. At a minimum:	**Interview** ☐ Ask Medicare patients if they are aware of their right to appeal premature discharge. ☐ Ask a sample of patients or their legal representative if they know how to file a complaint (grievance) and who to contact if they have a complaint (grievance). ☐ Confirm that patients or their representative know they have the right to file a complaint with the state agency as well as or instead of using the hospital's grievance process. ☐ Confirm that the hospital provided the telephone number for the state agency to patients or their patient representatives. ☐ Ask if beneficiaries are aware of their right to seek review by the QIO for quality of care issues and

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- Makes certain that the medical staff has bylaws - Approves medical staff bylaws and other medical staff rules and regulations - Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients - Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment - Makes certain that under no circumstances is the accordance of staff membership or professional privileges in the critical access hospital dependent solely upon certification, fellowship, or membership in a specialty body or society - Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the locations without emergency services when emergency services are not provided at the critical access hospital, or are provided at the critical access hospital but not at one or more off-campus locations **RI.14.01.01, EP 1:** The process for resolving grievances includes a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. **RI.14.01.01, EP 2:** The critical access hospital develops and implements policies and procedures for the prompt resolution of patient		coverage decisions and to appeal a premature discharge. **Document Review** **General** ☐ Confirm that the hospital has a process for prompt resolution of patient grievances and informs each patient whom to contact to file a grievance. ☐ Confirm that the grievance process includes a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate utilization and quality control quality improvement organization (QIO). ☐ Verify that the hospital's governing body approved the grievance process. ☐ Verify that the governing body is responsible for the effective operation of the grievance process and reviews and resolves grievances unless delegated in writing to a grievance committee. ☐ Review patient discharge materials. o Is the hospital in compliance with 42 CFR §489.27 (beneficiary notice of discharge rights)? o Does the hospital grievance process include a mechanism for timely referral of Medicare patient concerns to the QIO? What time frames are established? ☐ Determine how effectively the grievance process works. o Are patient's or the patient representative's concerns addressed in a timely manner? o Are patients informed of any resolution to their grievances? o Does the hospital apply what it learns from the grievance as part of its continuous quality improvement activities?

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grievances. The policies clearly explain the procedure for patients to submit written or verbal grievances and specify timeframes for the review of and response to the grievance.		☐ Verify that the grievance process is reviewed and analyzed through the hospital's quality assurance/performance improvement or some other mechanism that provides oversight of the grievance process ☐ Review the hospital's policies and procedures to confirm that its grievance process encourages all personnel to alert appropriate staff concerning any patient grievance. **Note:** *A "patient grievance" is a formal or informal written or verbal complaint that is made to the hospital by the patient or the patient's representative about the patient's care (when the complaint is not resolved at the time of the complaint by staff present), abuse or neglect, issues related to the hospital's compliance with the CMS Hospital Conditions of Participation, or a Medicare beneficiary billing issue related to rights and limitations provided by 42 CFR §489.* ☐ Confirm that the hospital adheres to its policy or procedure established for grievances. ☐ Verify that the hospital's process assures that grievances involving situations or practices that place the patient in immediate danger are resolved in a timely manner.
RI.11.02.01, EP 1: The critical access hospital provides information, including but not limited to the patient's total health status, in a manner tailored to the patient's age, language, and ability to understand. Note: The critical access hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs. **RI.14.01.01, EP 2:** The critical access hospital develops and implements policies and	**§485.614(a)(2)(i)** (i) The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital.	**Interview** ☐ Ask a sample of patients or their representatives (if they are incapacitated) if they know about the grievance process and how to submit a grievance. **Document Review** **General** Confirm that the information provided to patients about the hospital's grievance procedures clearly explains how they submit either a verbal or written grievance.

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procedures for the prompt resolution of patient grievances. The policies clearly explain the procedure for patients to submit written or verbal grievances and specify timeframes for the review of and response to the grievance.		
RI.14.01.01 EP 2: The critical access hospital develops and implements policies and procedures for the prompt resolution of patient grievances. The policies clearly explain the procedure for patients to submit written or verbal grievances and specify timeframes for the review of and response to the grievance	**§485.614(a)(2)(ii)** (ii) The grievance process must specify time frames for review of the grievance and the provision of a response.	**Document Review** **General** ☐ Confirm that the time frames established to review and respond to patient grievances are clearly explained in the information provided to patients explaining the hospital's grievance process. ☐ Verify that, on average, the hospital provides a written response to most of its grievances within the time frame specified in its policy. **Note:** *On average, a time frame of 7 days for the provision of the response would be considered appropriate. Not every grievance must be resolved during the specified time frame, although most should be resolved.*
RI.14.01.01, EP 3: In its resolution of grievances, the critical access hospital provides the patient with a written notice of its decision, which contains the following: -Name of the critical access hospital contact person -Steps taken on behalf of the individual to investigate the grievances -Results of the process -Date of completion of the grievance process	**§485.614(a)(2)(iii)** (iii) In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.	**Document Review** **General** ☐ Review the hospital's copies of written notices of its decision (responses to grievances) to patients to confirm that all patients are provided a written notice and that the notices comply with the requirements of §482.13(a)(2)(iii). **Note:** *The written notice of the hospital's determination regarding a grievance must be communicated to the patient or their representative in a language and manner the patient or their legal representative understands.*
PC.11.03.01, EP 2: The critical access hospital involves the patient in the development and implementation of their plan of care. Note: For swing beds in critical access hospitals: The resident has the right to be informed, in advance, of changes to their plan of care.	**§485.614 (b) Standard: Exercise of rights** **§485.614(b)(1)** (1) The patient has the right to participate in the development and implementation of their plan of care.	**Interview** ☐ Ask staff and patients or patients' representatives (as appropriate) if the hospital involves the patient or their representative (as appropriate) in the development and implementation of the plan of care.

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		☐ Verify that revisions in the plan of care were explained to the patient and/or their representative (when appropriate). **Document Review** **General** ☐ Confirm that the hospital has policies and procedures to involve the patient or their representative (as appropriate) in the development and implementation of their inpatient treatment/care plan, outpatient treatment/care plan, discharge plan, and pain management plan. ☐ Verify that the hospital's policies and procedures provide for determining when a patient has a representative who may exercise the patient's right to participate in developing and implementing their plan of care, as well as who that representative is, consistent with this guidance and state law. **Patient Health Record** ☐ Review a sample of patient health records to determine how the hospital involves the patient or their representative (as appropriate) in the development and implementation of their plan of care. ☐ Confirm that there is evidence that the patient or their representative was included or proactively involved in the development and implementation of their plan of care.
RI.12.01.01, EP 1: The patient or their representative (as allowed, in accordance with state law) has the right to make informed decisions regarding their care. The patient's rights include being informed of their health status, being involved in care planning and treatment, and being able to request or refuse treatment. This does not mean the patient has the right to demand the provision of treatment	**§485.614(b)(2)** (2) The patient or their representative (as allowed under State law) has the right to make informed decisions regarding their care. The patient's rights include being informed of their health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the	**Interview** ☐ Ask current patients and/or hospital personnel to determine their understanding of the hospital's informed decision-making policies and how they are implemented. ☐ Determine whether patients or their representatives are provided adequate information about the patient's medical status, diagnosis, and prognosis

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or services deemed medically unnecessary or inappropriate.	provision of treatment or services deemed medically unnecessary or inappropriate.	and then are allowed to make informed decisions about their care planning and treatment. **Document Review** General ☐ Confirm that there is a hospital policy addressing the patient's or the patient representative's (as appropriate) right to make informed decisions. ☐ Verify that the hospital's policy provides for determining when a patient has a representative who may exercise the patient's right to make informed decisions, as well as who that representative is, consistent with this guidance and state law. Note: *Hospitals are expected to take reasonable steps to determine the patient's wishes concerning designation of a representative.* ☐ Confirm that there is a hospital policy addressing the patient's right to have information on their medical status, diagnosis, and prognosis that articulates the hospital's process for ensuring that patients have this information. ☐ Review the hospital policy addressing how the patient will be involved in their care planning and treatment. **Patient Health Record** ☐ Review a sample of patient health records to determine whether patients or their representatives are provided adequate information about the patient's medical status, diagnosis, and prognosis and then are allowed to make informed decisions about their care planning and treatment. **<u>Assessing Required Disclosures: Physician Ownership</u>** **Interview** ☐ Ask staff whether the hospital furnishes its list of physician owners and investors at the time a patient or patient's representative requests it.

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		☐ Ask staff whether a physician-owned hospital's medical staff membership and admitting privileging requirements include a requirement that, as a condition of continued membership or admitting privileges, physician owners who refer patients to the hospital agree to provide written disclosure of their own or any immediate family member's ownership or investment interest to all patients at the time of the referral to the hospital. **Document Review** **General** ☐ *If the hospital is physician owned but not exempt from the physician ownership disclosure requirements:* o Verify that appropriate policies and procedures are in place to ensure that necessary written notices are provided to all patients at the beginning of an inpatient or outpatient stay. o Review the notice the hospital issues to each patient to verify that it discloses, in a manner reasonably designed to be understood by all patients, that the hospital meets the federal definition of "physician owned," that a list of owners and investors who are physicians or immediate family members of physicians is available upon request, and that such a list is provided to the patient at the time the request is made by or on behalf of the patient. o Review policies, procedures, and staff records to determine whether a physician-owned hospital's medical staff membership and admitting privileging requirements include a requirement that, as a condition of continued membership or admitting privileges, physician owners who refer

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		patients to the hospital agree to provide written disclosure of their own or any immediate family member's ownership or investment interest to all patients at the time of the referral to the hospital. **Observation** ☐ Observe whether the hospital furnishes its list of physician owners and investors at the time a patient or patient's representative requests it. **<u>MD/DO 24/7 On-Site Presence</u>** **Interview** *For each required location where an MD/DO is not present:* ☐ Ask a sample of inpatients and affected outpatients whether they were provided notice about an MD/DO not being present at all times in the hospital. **Document Review** **General** ☐ *For each required location where a doctor of medicine or osteopathy (MD/DO) is not present:* o Verify that the hospital has policies and procedures to ensure that a written notice stating an MD/DO is not present at all times is provided at the beginning of an inpatient stay or outpatient stay to all inpatients and all outpatients receiving observation services, surgery, or another procedure requiring anesthesia. o Review the written notice to verify that it indicates how the hospital will meet the medical needs of any patient who develops an emergency medical condition at a time when no physician is present at that hospital, including any remote location or satellite.

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		Patient Health Record ☐ Verify that there is signed acknowledgment by patients of receiving the written notice obtained by the hospital prior to the patient's admission or before applicable outpatient services were provided. **Observation** ☐ Observe whether an MD/DO is present in the hospital at each campus or satellite location providing inpatient services 24 hours a day, seven days a week. ☐ *For each required location where an MD/DO is not present:* Verify that the hospital's emergency department has signage with the appropriate disclosure information about an MD/DO not being present at all times in the hospital.
RI.12.01.01, EP 5: Staff and licensed practitioners who provide care, treatment, or services in the critical access hospital honor the patient's right to formulate advance directives and comply with these directives, in accordance with law and regulation. Note: Law and regulation includes, at a minimum, 42 CFR 489.100, 489.102, and 489.104.	**§485.614(b)(3)** (3) The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with §§ 489.100 of this part (Definition), 489.102 of this part (Requirements for providers), and 489.104 of this part (Effective dates).	**Interview** ☐ Ask staff about their knowledge of the advance directives of the patients in their care. ☐ Ask patients about the hospital's process to allow them to formulate an advance directive or to update their current advance directive. ☐ Confirm that the hospital is promoting and protecting each patient's right to formulate an advance directive. **Document Review** **General** ☐ Review the hospital's advance directive notice to confirm that it advises inpatients or applicable outpatients, or their representatives, of the patient's right to formulate an advance directive and to have hospital staff comply with the advance directive (in accordance with state law).

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		☐ Confirm that the notice includes a clear, precise, and valid statement of limitation if the hospital cannot implement an advance directive on the basis of conscience. At a minimum, a statement of limitation should do the following: • Clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians or other practitioners. • Identify the state legal authority permitting such an objection. • Describe the range of medical conditions or procedures affected by the conscience objection. ☐ Review the hospital's process to allow patients to formulate an advance directive or update their current advance directive. ☐ Confirm that the hospital is promoting and protecting each patient's right to formulate an advance directive. ☐ Determine to what extent the hospital complies, as permitted under state law, with patient advance directives that delegate decisions about the patient's care to a designated individual. **Patient Health Record** ☐ Review a sample of patient health records for evidence of hospital compliance with advance directive notice requirements. ☐ Verify that every inpatient or applicable outpatient record contains documentation that notice of the hospital's advance directives policy was provided at the time of admission or registration and there is documentation of whether or not each patient has an advance directive. ☐ For those patients who have reported an advance directive, verify that a copy of the patient's advance directive been placed in the medical record.

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RI.12.01.01, EP 2: The critical access hospital asks the patient whether they want a family member, representative, or physician or other licensed practitioner notified of their admission to the critical access hospital. The critical access hospital promptly notifies the identified individual(s). Note: The patient is informed, prior to the notification occurring, of any process to automatically notify the patient's established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well as all applicable post–acute care services providers and suppliers. The critical access hospital has a process for documenting a patient's refusal to permit notification of registration to the emergency department, admission to an inpatient unit, or discharge or transfer from the emergency department or inpatient unit. Notifications with primary care practitioners and entities are in accordance with all applicable federal and state laws and regulations.	**§485.614(b)(4)** (4) The patient has the right to have a family member or representative of their choice and their own physician notified promptly of their admission to the hospital.	**Interview** ☐ Interview staff who is responsible for providing notification of a patient's family or representative and physician when the patient is admitted as an inpatient. ☐ Ask them how they identify the persons to be notified and the means of notification and what they do in the case of an incapacitated person to identify a family member or representative and the patient's physician. **Document Review** **General** ☐ Verify that the hospital has policies that address notification of a patient's family or representative and physician when the patient is admitted as an inpatient. **Patient Health Record** ☐ Review a sample of inpatient medical records to confirm the following: 1. Evidence that the patient was asked about notifying a family member or representative and their physician 2. Record of when and how notice was provided 3. Evidence that the notice was provided promptly 4. Record of the patient declining to have notice provided to a family member or representative and their physician 5. Documentation of whether the patient was incapacitated at the time of admission and, if so, what steps were taken to identify a family member or representative and the patient's physician

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RI.11.01.01, EP 5: The critical access hospital respects the patient's right to personal privacy. Note 1: This element of performance (EP) addresses a patient's personal privacy. For EPs addressing the privacy of a patient's health information, refer to Standard IM.12.01.01. Note 2: For swing beds in critical access hospitals: Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	**§485.614(c)(1)** (1) The patient has the right to personal privacy.	**Interview** ☐ Ask patients or their representatives if they are provided reasonable privacy during examinations or treatments, personal hygiene activities and discussions about their health status or care, and other appropriate situations. ☐ Ask staff about their understanding of the use of patient information in the facility directory. o Confirm with staff that the policy addresses the opportunity for the patient or patient's representative to restrict or prohibit use of patient information in emergent and nonemergent situations. o Ask staff if reasonable safeguards are used to reduce incidental disclosures of patient information. **Document Review** **General** ☐ Review hospital policy about the use of patient information in the facility directory. o Confirm that the policy addresses the opportunity for the patient or patient's representative to restrict or prohibit use of patient information in emergent and nonemergent situations. o Determine if reasonable safeguards are used to reduce incidental disclosures of patient information. **Observation** ☐ Observe whether patients are provided reasonable privacy during examinations or treatments, personal hygiene activities and discussions about their health status or care, and other appropriate situations. ☐ Observe whether reasonable safeguards are used to reduce incidental disclosures of patient information.

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		☐ If audio and/or visual monitoring is used in the medical-surgical or intensive care unit setting, observe whether monitor screens and/or speakers are not readily visible or audible to visitors or the public. **Note:** *Audio/video monitoring (not include recording) of patients in medical-surgical or intensive care type units would not be considered violating the patient's privacy, as long as a clinical need exists, the patient or patient's representative is aware of the monitoring, and the monitors or speakers are located so that the monitor screens are not readily visible and speakers are not readily audible to visitors or the public. Video recording of patients undergoing medical treatment requires the consent of the patient or their representative.*
PE.01.01.01, EP 1: The critical access hospital's building is constructed, arranged, and maintained to allow safe access and to protect the safety and well-being of patients. Note 1: Diagnostic and therapeutic facilities are located in areas appropriate for the services provided. Note 2: When planning for new, altered, or renovated space, the critical access hospital uses state rules and regulations, or the current Guidelines for Design and Construction of Hospitals published by the Facility Guidelines Institute. If the state rules and regulations or the Guidelines do not address the design needs of the critical access hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria.	**§485.614(c)(2)** (2) The patient has the right to receive care in a safe setting.	**Interview** ☐ Ask staff in patient care areas about their training to identify risks in the care environment. If risks are found, how does staff report those findings? ☐ Ask staff how the hospital defines continuous visual observation or 1:1 observation in which a staff member is assigned to observe only one patient at all times. ☐ In units where infants and children are inpatients, ask staff whether there are appropriate security protections (such as alarms, arm banding systems) in place, and confirm that they are functioning. **Document Review** **General** ☐ Review and analyze patient and staff incident and accident reports to identify any incidents or patterns of incidents concerning a safe environment. Expand the review if a problem with safe environment in the hospitals is suspected. ☐ Verify that the hospital has a policy or procedure for defining continuous visual observation or 1:1

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		observation in which a staff member is assigned to observe only one patient at all times. ☐ Verify that the hospital has a policy or procedure for curtailing unwanted visitors, contaminated materials, or unsafe items that pose a safety risk to patients and staff. ☐ Access the hospital's security efforts to protect vulnerable patients, including newborns, children, and patients at risk of suicide or intentional harm to self or others. Confirm that the hospital is providing appropriate security to protect patients and that appropriate security mechanisms are in place and being followed to protect patients. ☐ Confirm that security mechanisms are based on nationally recognized standards of practice. **Observation** ☐ Observe patient care environments for unattended items, such as utility or housekeeping carts, that contain hazardous items that may pose a safety risk to patients, visitors, and staff. **Note:** *Examples of hazardous items include cleaning agents, disinfectant solutions, mops, brooms, and tools.* ☐ Observe units where infants and children are inpatients to determine whether appropriate security protections (such as alarms, arm banding systems) are in place and functioning.
RI.13.01.01, EP 1: The critical access hospital protects the patient from harassment, neglect, exploitation, corporal punishment, involuntary seclusion, and verbal, mental, sexual, or physical abuse that could occur while the patient is receiving care, treatment, and services. For swing beds in critical access hospitals: The	**§485.614(c)(3)** (3) The patient has the right to be free from all forms of abuse or harassment.	**Document Review** **General** ☐ Verify that the hospital has a system in place to protect patients from abuse, neglect, and harassment of all forms, whether from staff, other patients, visitors, or other persons. In particular, determine the extent to which the hospital does the following:

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critical access hospital also protects the resident from misappropriation of property.		○ Staffing levels across all shifts are sufficient to care for individual patient's needs. ○ The hospital has a written procedure for investigating allegations of abuse and neglect, including methods to protect patients from abuse during investigations of allegations. How does the hospital substantiate allegations of abuse and neglect? • Incidents of substantiated abuse and neglect result in appropriate action. • The hospital has implemented an abuse protection program that it is effective and complies with federal, state, and local law and regulation. • Appropriate agencies are notified in accordance with state and federal laws regarding incidents of substantiated abuse and neglect. ○ Allegations of abuse and neglect are thoroughly investigated. - The hospital conducts criminal background checks as allowed by state law for all potential new hires. - The hospital does not employ people with a history of abuse, neglect, or harassment. **Interview** ☐ Ask staff to identify various forms of abuse or neglect. ☐ Ask staff if they know what to do if they witness abuse or neglect.
IM.12.01.01, EP 1: The critical access hospital develops and implements policies and	**§482.13(d) Standard: Confidentiality of Patient Records**	**Interview**

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procedures addressing the privacy and confidentiality of health information. Note: For swing beds in critical access hospitals: Policies and procedures also address the resident's personal records.	§485.614(d)(1) The patient has the right to the confidentiality of their clinical records.	☐ Ask staff to about their understanding of and compliance with the hospital's policies and procedures for protecting medical record information. **Document Review** **General** ☐ Verify that the hospital has policies and procedures addressing the protection of information in patients' medical records from unauthorized disclosures. **Observation** ☐ Observe locations where medical records are stored to determine whether appropriate safeguards are in place to protect medical record information.
RI.11.01.01, EP 6: The critical access hospital provides the patient, upon an oral or written request, with access to medical records, including past and current records, in the form and format requested (including in electronic form or format when available). If electronic is unavailable, the medical record is provided in hard copy form or another form agreed to by the critical access hospital and patient. The critical access hospital does not impede the legitimate efforts of individuals to gain access to their own medical records and fulfills these electronic or hard-copy requests within a reasonable time frame (that is, as quickly as its recordkeeping system permits).	§485.614(d)(2) (2) The patient has the right to access their medical records, including current medical records, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such medical records are maintained electronically); or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, and within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits.	**Document Review** **General** ☐ Confirm that the hospital promotes and protects the patient's right to access information contained in their clinical record. ☐ Confirm that the hospital has a procedure for providing records to patients within a reasonable time frame. ☐ Determine whether the hospital's system frustrates the legitimate efforts of individuals to gain access to their own medical record. ☐ Verify that the procedure for providing records to patients includes a method to identify what documents were not provided and the reason.

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PC.13.02.01, EP 1: The critical access hospital does not use restraint or seclusion of any form as a means of coercion, discipline, convenience, or staff retaliation. Restraint or seclusion is only used to protect the immediate physical safety of the patient, staff, or others when less restrictive interventions have been ineffective and is discontinued at the earliest possible time, regardless of the length of time specified in the order. **RI.13.01.01, EP 1:** The critical access hospital protects the patient from harassment, neglect, exploitation, corporal punishment, involuntary seclusion, and verbal, mental, sexual, or physical abuse that could occur while the patient is receiving care, treatment, and services. For swing beds in critical access hospitals: The critical access hospital also protects the resident from misappropriation of property.	**§485.614(e)** (e) Standard: Restraint or seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.	**Document Review** **General** ☐ Review the restraint and seclusion policies and procedures to determine if they address, at a minimum the following: o Who has the authority to discontinue the use of restraint or seclusion (based on state law and hospital policies) o Circumstances under which restraint or seclusion should be discontinued. ☐ Review incident and accident reports to determine whether patient injuries occurred proximal to or during a restraint or seclusion intervention. Are incidents and accidents occurring more frequently with restrained or secluded patients? ☐ If record review indicates that restrained or secluded patients sustained injuries, determine what the hospital did to prevent additional injury. Did the hospital investigate possible changes to its restraint or seclusion policies? ☐ Review data on the use of restraint and seclusion for a specified time period (for example, 3 months) to determine any patterns in their use for specific units, shifts, days of the week, and so on. Did the number of patients who were restrained or secluded increase on weekends, on holidays, at night, on certain shifts, where contract nurses were used, or in one unit more than other units? **Note:** *Such patterns of restraint or seclusion use may suggest that the intervention is not based on the patient's need but on issues such as convenience, inadequate staffing, or lack of staff training. Obtain nursing staffing schedules during the time periods in question to determine if staffing levels impact the use of restraint or seclusion.*

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		Patient Health Record ☐ Review a sample of medical records of patients for whom restraints were used to manage nonviolent, non-self-destructive behavior, as well as a sample of medical records of patients for whom restraint or seclusion was used to manage violent or self-destructive behavior. o Include in the review patients who are currently in restraint or seclusion, as well as those who have been in restraint or seclusion during their hospital stay (include both violent or self-destructive patients and nonviolent, non-self-destructive patients). o Determine if there is evidence that hospital staff identified the reason for the restraint or seclusion and that other less restrictive measures would not be effective before applying the restraint. **Interview** ☐ Ask staff who work directly with patients to determine their understanding of the restraint and seclusion policies. If any patients are currently in restraint or seclusion, determine the rationale for use and when the patient was last monitored and assessed. ☐ Confirm that the actual use of restraints or seclusion was consistent with hospital restraint and seclusion policies and procedures, as well as CMS requirements. ☐ Interview a sample of patients who were restrained to manage nonviolent, non-self-destructive behavior to determine whether the reasons for the use of a restraint to manage such behavior were explained to the patient in understandable terms.

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		☐ Confirm that the patient could articulate their understanding of the reasons for the use of restraint.
	§485.614(e)(1) (1) Definitions. §485.614(e)(1)(i) (i) A restraint is—	
PC.13.02.01, EP 4: The critical access hospital restraint policies are followed when any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or when a drug or medication is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. Note: A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).	§485.614(e)(1)(i)(A) (A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move their arms, legs, body, or head freely; or	**Document Review** **General** ☐ Determine whether the hospital's policy and procedures employ a definition or description of what constitutes a restraint that is consistent with the CMS regulation. **Interview** ☐ Ask hospital staff whether they know the definition of a restraint. **Observation** ☐ While touring hospital units, look for restraints in use. Where a restraint is in use, check the medical record for appropriate documentation.
PC.13.02.01, EP 4: See above	§485.614(e)(1)(i)(B) (B) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.	**Document Review** **General** ☐ Verify that the hospital's policies and procedures include a definition or description of what constitutes the use of drugs or medications as a restraint that is consistent with the CMS regulation. **Interview**

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		☐ Ask hospital staff if they can identify when the use of a drug or medication is considered a chemical restraint.
PC.13.02.01, EP 4: See above	**§485.614(e)(1)(i)(C)** (C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).	**Document Review** **General** ☐ Verify that the hospital's policies and procedures include a definition or description of what constitutes a restraint that is consistent with the regulation. **Interview** ☐ Ask hospital staff if they know the definition of a restraint, particularly with respect to use of bedside rails. **Observation** ☐ While touring hospital units, look for bedside rail use to determine whether it is consistent with the definition of a restraint. Where bed side rails are being used as a restraint, check the medical record for appropriate documentation.
PC.13.02.01, EP 5: The critical access hospital seclusion policies are followed when a patient is involuntarily confined alone in a room or area from which the patient is physically prevented from leaving. Note: Seclusion is only used for the management of violent or self-destructive behavior.	**§485.614(e)(1)(ii)** (ii) Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.	**Interview** ☐ Ask hospital staff if they know the definition of seclusion. **Document Review** **General** ☐ Verify that the hospital's policy and procedures include a definition or description of what constitutes seclusion that is consistent with the CMS regulation. **Observation** ☐ While touring hospital units, look for cases where a patient is in seclusion.
PC.13.02.01, EP 1: The critical access hospital does not use restraint or seclusion of any form as a means of coercion, discipline,	**§485.614(e)(2)** (2) Restraint or seclusion may only be used when less restrictive interventions have been	**Document Review** **Patient Health Record**

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convenience, or staff retaliation. Restraint or seclusion is only used to protect the immediate physical safety of the patient, staff, or others when less restrictive interventions have been ineffective and is discontinued at the earliest possible time, regardless of the length of time specified in the order.	determined to be ineffective to protect the patient, a staff member, or others from harm.	☐ Review a sample of health records for patients for whom restraint or seclusion was used. o Confirm that the physician's or other practitioner's orders specify the reason for restraint or seclusion, the type of restraint, and the duration of restraint or seclusion. o Verify that the severity of the patient's behavior justifies seclusion or restraint usage by identifying an immediate and serious danger to the physical safety of the patient or others. o Confirm that the hospital considers factors other than the individual patient in determining causes for the need for restraints or seclusion (that is, environmental factors). ☐ Review the medical record for documentation of an individual patient assessment and a revision of the plan of care. o Confirm that the medical record reflects changes in behavior and staff concerns regarding safety risks to the patient, staff, or others, prompting use of seclusion or restraints. o Verify that the patient's behavior placed the patient or others at risk for harm and that the patient's behavior was violent or self-destructive. o Determine if other, less restrictive interventions were tried and documented. Or is there evidence that alternatives were considered and determined to be insufficient?
PC.13.02.01, EP 2: The critical access hospital uses the least restrictive form of restraint or	**§485.614(e)(3)** (3) The type or technique of restraint or seclusion used must be the least restrictive	**Document Review** **General**

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seclusion that will be effective to protect the patient, a staff member, or others from harm.	intervention that will be effective to protect the patient, a staff member, or others from harm.	☐ Review a sample of health records for patients for whom restraint or seclusion was used. ○ Is there documentation in the record describing the steps or interventions used prior to the use of the needed restraint or seclusion? That is, what documentation is in the record to explain the rationale for the use of restraint or seclusion? ○ Confirm that there is documentation in the record showing that less restrictive measures were tried or considered. ○ Verify that the restraint or seclusion intervention was the least restrictive intervention to meet the patient's clinical needs and protect the safety of the patient, staff, or others. ○ Confirm that staff determined that less restrictive alternatives would not meet the patient's clinical needs or protect the patient's safety or the safety of others. ○ Verify that ongoing documented assessments demonstrate that the restraint or seclusion intervention was needed at that time (or at a time in the past) and that the restraint or seclusion intervention remained the least restrictive way to protect the patient's safety. ○ If the time of restraint or seclusion use was lengthy, look for evidence that the symptoms necessitating the use of restraint or seclusion persisted. Look for evidence indicating that staff evaluated whether the restraint or seclusion could be safely discontinued.

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PC.13.02.09, EP 1: The critical access hospital's policies and procedures regarding the use of restraint or seclusion that are consistent with current standards of practice. For rehabilitation and psychiatric distinct part units in critical access hospitals: The policies and procedures include the following: - Definitions for restraint and seclusion that are consistent with state and federal law and regulation - Physician and other licensed practitioner training requirements - Staff training requirements - Who has authority to order restraint or seclusion - Who has authority to discontinue the use of restraint or seclusion - Who can initiate the use of restraint or seclusion - Circumstances under which restraint or seclusion is discontinued - Requirement that restraint or seclusion is discontinued as soon as is safely possible - Who can assess and monitor patients in restraint or seclusion - Time frames for assessing and monitoring patients in restraint or seclusion	**§485.614(e)(4)** (4) The CAH must have written policies and procedures regarding the use of restraint and seclusion that are consistent with current standards of practice.	**Document Review** **General** ☐ Verify that the hospital's policies and procedures for the use of restraint and seclusion are consistent with current standards of practice.
PC.13.02.03, EP 1: The critical access hospital's use of restraint or seclusion meets the following requirements: - In accordance with a written modification to the patient's plan of care - Implemented by trained staff using safe techniques identified by the critical access hospital's policies and procedures in accordance with law and regulation	**§485.614(f)** (f) Standard: Restraint or seclusion: Staff training requirements. The patient has the right to safe implementation of restraint or seclusion by trained staff.	**Document Review** **General** ☐ Verify that the hospital has a staff training and education program that protects the patient's right to safe implementation of restraint or seclusion. **Observation** ☐ Observe patients in restraint or seclusion to verify safe application of the restraint or seclusion.

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PC.13.02.17, EP 2: Staff education and training include the following: - Patient-centered, trauma-informed, competency-based training and education on the use of restraint and seclusion for staff, including medical staff and, as applicable, staff providing contract services - Alternatives to the use of restraint or seclusion	**§485.614(f)(1)** (1) The CAH must provide patient-centered, trauma informed competency-based training and education of CAH personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the CAH, on the use of restraint and seclusion.	**Document Review** **General** ☐ Confirm that the hospital has a documented patient-centered, trauma informed competency-based training program for the use of restraint and seclusion interventions employed by staff at the hospital. ☐ Verify that the hospital has documented evidence that all levels of CAH personnel and staff, including medical staff, and as applicable, personnel providing contracted services in the CAH. **Personnel/Credential File** ☐ Review a sample of personnel files to verify restraint and seclusion education staff training documentation for all levels of CAH personnel and staff, including medical staff, and as applicable, personnel providing contracted services in the CAH.
PC.13.02.17, EP 2: See above	**§485.614(f)(2)** (2) The training must include alternatives to the use of restraint/seclusion.	**Document Review** **General** Confirm that the hospital's educational program includes alternatives to the use of restraint/seclusion.
PC.13.02.19, EP 1: The critical access hospital reports the following information to the Centers for Medicare & Medicaid Services (CMS) regarding deaths related to restraint or seclusion: - Each death that occurs while a patient is in restraint or seclusion - Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion - Each death known to the critical access hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the	**§485.614(g)** (g) Standard: Death reporting requirements. Hospitals must report deaths associated with the use of seclusion or restraint.	**Document Review** **General** ☐ Confirm that the hospital has a death reporting policy that addresses the requirements of §485.614(g). ☐ Review data related to patient deaths while the patients were in restraint or seclusion to determine if the hospital followed the requirements related to death reporting for the following: o Each death that occurred while the patient was in restraints (whether physical or drugs used as a restraint) or seclusion

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restraint or seclusion contributed directly or indirectly to the patient's death. Note 1: This reporting requirement includes all restraints except soft wrist restraints. For more information on deaths related to the use of soft wrist restraints, refer to EP 3 in this standard. Note 2: In this element of performance "reasonable to assume" includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time or deaths related to chest compression, restriction of breathing, or asphyxiation.		○ Each death that occurred within 24 hours after the patient had been removed from restraint or seclusion ○ Each death that occurred within one week after restraint or seclusion where it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to a patient's death **Patient Health Record** ☐ Review medical records of patients who died associated with the use of restraint or seclusion to determine if the deaths were reported to CMS. Does documentation include the date and time the death was reported to CMS? **Interview** ☐ Ask staff about their knowledge of the hospital's death reporting policy.
PC.13.02.19, EP 2: The deaths addressed in PC.13.02.19, EP 1, are reported to the Centers for Medicare & Medicaid Services by telephone, by facsimile, or electronically no later than the close of the next business day following knowledge of the patient's death. The date and time that the patient's death was reported is documented in the patient's medical record. **PC.13.02.19, EP 1:** The critical access hospital reports the following information to the Centers for Medicare & Medicaid Services regarding deaths related to restraint or seclusion: - Each death that occurs while a patient is in restraint or seclusion - Each death that occurs within 24 hours after	**§485.614(g)(1)** (1) With the exception of deaths described under paragraph (g)(2) of this section, the hospital must report the following information to CMS by telephone, facsimile, or electronically, as determined by CMS, no later than the close of business on the next business day following knowledge of the patient's death. **§485.614(g)(1)(i)** Each death that occurs while a patient is in restraint or seclusion.	**Document Review** **General** ☐ Confirm that the hospital has restraint and seclusion death reporting policies and procedures that address responsibilities and systems for identifying restraint- or seclusion-associated deaths reportable to CMS and for implementing the reporting and recordkeeping requirements. ☐ Can the hospital provide examples of restraint- or seclusion-associated deaths that were reported to CMS? ○ If yes, review the report and medical records to determine whether the following occurred: • The reports met the criteria for reporting to CMS. • The reports were submitted in a timely fashion to CMS. • The reports were complete.

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the patient has been removed from restraint or seclusion - Each death known to the critical access hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death Note 1: This reporting requirement includes all restraints except soft wrist restraints. For more information on deaths related to the use of soft wrist restraints, refer to EP 3 in this standard. Note 2: In this element of performance "reasonable to assume" includes but is not limited to deaths related to restrictions of movement for prolonged periods of time or deaths related to chest compression, restriction of breathing, or asphyxiation.		• The date and time the death reported to CMS was entered into the patient's medical record. o If no, do the following: • Ask how the hospital ensures that there were no reportable restraint- or seclusion-associated deaths. • If the hospital's system relies on staff identification of reportable deaths, interview several applicable staff members to determine if they are aware of the hospital's policy and know when and where to internally report a restraint- or seclusion-associated death. Ask if there have been any patient deaths that met the reporting requirements. **Interview** ☐ Ask staff in various types of inpatient units, including a psychiatric unit if applicable, if they are aware of any patients who died while in restraints or seclusion or within one day of restraint or seclusion discontinuation, excluding cases involving only the use of two-point soft wrist restraints and no seclusion. If yes, determine whether the hospital has any evidence that these cases were reported to CMS.
PC.13.02.19, EP 1: The critical access hospital reports the following information to the Centers for Medicare & Medicaid Services (CMS) regarding deaths related to restraint or seclusion: - Each death that occurs while a patient is in restraint or seclusion - Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion - Each death known to the critical access	**§485.614(g)(1)(ii)** **(ii) Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.**	**Document Review** **General** ☐ Confirm that the hospital has a death reporting policy that addresses the requirements of §85.614(g). ☐ Review data related to patient deaths while the patients were in restraint or seclusion to determine if the hospital followed the requirements related to death reporting for the following:

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hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death. The types of restraints included in this reporting requirement are all restraints except soft wrist restraints. Note 1: This reporting requirement includes all restraints except soft wrist restraints. For more information on deaths related to the use of soft wrist restraints, refer to EP 3 in this standard. Note 2: In this element of performance "reasonable to assume" includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time or deaths related to chest compression, restriction of breathing, or asphyxiation.		○ Each death that occurred while the patient was in restraints (whether physical or drugs used as a restraint) or seclusion ○ Each death that occurred within 24 hours after the patient had been removed from restraint or seclusion ○ Each death that occurred within one week after restraint or seclusion where it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to a patient's death **Patient Health Record** ☐ Review medical records of patients who died associated with the use of restraint or seclusion to determine if the deaths were reported to CMS. Does documentation include the date and time the death was reported to CMS? **Interview** ☐ Ask staff about their knowledge of the hospital's death reporting policy.
PC.13.02.19, EP 1: See above	§485.614(g)(1)(iii) **(iii) Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death, regardless of the type(s) of restraint used on the patient during this time. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing, or asphyxiation.**	**Document Review** **General** ☐ Confirm that the hospital has a death reporting policy that addresses the requirements of §485.614(g). ☐ Review data related to patient deaths while the patients were in restraint or seclusion to determine if the hospital followed the requirements related to death reporting for the following: ○ Each death that occurred while the patient was in restraints (whether physical or drugs used as a restraint) or seclusion ○ Each death that occurred within 24 hours after the patient had been removed from restraint or seclusion

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		○ Each death that occurred within one week after restraint or seclusion where it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to a patient's death **Patient Health Record** ☐ Review medical records of patients who died associated with the use of restraint or seclusion to determine if the deaths were reported to CMS. Does documentation include the date and time the death was reported to CMS? **Interview** ☐ Ask staff about their knowledge of the hospital's death reporting policy.
PC.13.02.19, EP 3: When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, non-rigid, cloth-like material, the critical access hospital does the following: - Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. - Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. - Documents in the patient record the date and time that the death was recorded in the log or other system. - Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the care of the patient, medical record number, and primary	**§485.614(g)(2)** When no seclusion has been used and when the only restraints used on the patient are those applied exclusively to the patient's wrist(s), and which are composed solely of soft, non-rigid, cloth-like materials, the hospital staff must record in an internal log or other system, the following information**:** **§485.614(g)(2)(i)** **(i) Any death that occurs while a patient is in such restraints.** **§485.614(g)(2)(ii)** **(ii) Any death that occurs within 24 hours after a patient has been removed from such restraints**	**Document Review** **General** ☐ Confirm that the hospital has restraint and seclusion death reporting policies and procedures that address responsibilities and systems for identifying restraint- or seclusion-associated deaths that must be recorded in an internal hospital log or tracking system and for implementing the reporting and recordkeeping requirements. ☐ Verify how the hospital ensures that each death that must be captured in the log or tracking system is identified and entered. ☐ Review the log/tracking system for patient deaths associated with use of only 2-point soft wrist restraints to determine if the following requirements were met: ○ Each entry was made within 7 days of the patient's death. ○ Each entry contains all the information required under the regulation.

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diagnosis(es). - Makes the information in the log or other system available to the Centers for Medicare & Medicaid Services, either electronically or in writing, immediately upon request.		○ Confirm that the hospital is able to make the log or tracking system available immediately on request. **Patient Health Record** ☐ Review a sample of medical records of patients whose deaths were entered in the log or tracking system. ○ Confirm that the medical record indicates that only soft, 2-point wrist restraints were used. ○ Verify that there is documentation in the medical record of the entry into the log or tracking system. **Interview** ☐ Ask inpatient unit staff if they have had patients die while 2-point soft wrist restraints are being used without seclusion or within 24 hours of their discontinuance. If yes, ask the hospital to demonstrate that it has recorded such deaths. ☐ If the hospital's log or tracking system relies on staff identification of reportable deaths, interview several applicable staff members to determine if they are aware of the hospital's policy and know when and where to report internally a restraint- or seclusion-associated death.
	§485.614(g)(3) **(3) The staff must document in the patient's medical record the date and time the death was:**	**Document Review** **General** ☐ Confirm that the hospital has a death reporting policy that addresses the requirements of §485.614(g). ☐ Review data related to patient deaths while the patients were in restraint or seclusion to determine if the hospital followed the requirements related to death reporting for the following: ○ Each death that occurred while the patient was in restraints (whether physical or drugs used as a restraint) or seclusion

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		○ Each death that occurred within 24 hours after the patient had been removed from restraint or seclusion ○ Each death that occurred within one week after restraint or seclusion where it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to a patient's death **Patient Health Record** ☐ Review medical records of patients who died associated with the use of restraint or seclusion to determine if the deaths were reported to CMS. Does documentation include the date and time the death was reported to CMS? **Interview** ☐ Ask staff about their knowledge of the hospital's death reporting policy.
PC.13.02.19, EP 2: The deaths addressed in PC.13.02.19, EP 1, are reported to the Centers for Medicare & Medicaid Services by telephone, by facsimile, or electronically no later than the close of the next business day following knowledge of the patient's death. The date and time that the patient's death was reported is documented in the patient's medical record.	**§485.614(g)(3)(i)** (i) Reported to CMS for deaths described in paragraph (g)(1) of this section; or	**See above survey procedures**
PC.13.02.19, EP 3: When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, non-rigid, cloth-like material, the critical access hospital does the following: - Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient.	**§485.614(g)(3)(ii)** (ii) Recorded in the internal log or other systems for deaths described in paragraph (g)(2) of this section.	**Document Review** **General** ☐ Confirm that the hospital has restraint and seclusion death reporting policies and procedures that address responsibilities and systems for identifying restraint- or seclusion-associated deaths that must be recorded in an internal hospital log or tracking system and for implementing the reporting and recordkeeping requirements.

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- Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. - Documents in the patient record the date and time that the death was recorded in the log or other system. - Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the care of the patient, medical record number, and primary diagnosis(es). - Makes the information in the log or other system available to the Centers for Medicare & Medicaid Services, either electronically or in writing, immediately upon request.		☐ Determine how the hospital ensures that each death that must be captured in the log or tracking system is identified and entered. ☐ Review the log or tracking system for patient deaths associated with use of only 2-point soft wrist restraints to determine if the following requirements were met: o Each entry was made within 7 days of the patient's death. o Each entry contains all the information required under §485.614(g). o Confirm that the hospital is able to make the log or tracking system available immediately on request. **Patient Health Record** ☐ Review a sample of medical records of patients whose deaths were entered in the log or tracking system. o Confirm that the medical record indicates that only 2-point soft wrist restraints were used. o Determine whether there is documentation in the medical record of the entry into the log or tracking system. **Interview** ☐ Ask inpatient unit staff to determine whether they have had patients die while 2-point soft wrist restraints are being used without seclusion or within 24 hours of their discontinuance. If yes, ask the hospital to demonstrate that it has recorded such deaths. ☐ If the hospital's log or tracking system relies on staff identification of reportable deaths, interview several applicable staff members to determine whether they are aware of the hospital's policy and know when and where to report internally a restraint- or seclusion-associated death.

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	§485.614(g)(4) For deaths described in paragraph (g)(2) of this section, entries into the internal log or other system must be documented as follows:	**Document Review** **General** ☐ Confirm that the hospital has restraint and seclusion death reporting policies and procedures that address responsibilities and systems for identifying restraint- or seclusion-associated deaths that must be recorded in an internal hospital log or tracking system and for implementing the reporting and recordkeeping requirements. ☐ Verify that the hospital ensures that each death that must be captured in the log or tracking system is identified and entered. ☐ Review the log or tracking system for patient deaths associated with use of only 2-point soft wrist restraints to determine if the following requirements were met: o Each entry was made within 7 days of the patient's death. o Each entry contains all the information required under the regulation. ☐ Confirm that the hospital is able to make the log or tracking system available immediately on request. **Patient Health Record** ☐ Review a sample of medical records of patients whose deaths were entered in the log or tracking system. ☐ Confirm that the medical record indicates that only 2-point soft wrist restraints were used. ☐ Determine whether there is documentation in the medical record of the entry into the log or tracking system. **Interview** ☐ Ask inpatient unit staff whether they have had patients die while 2-point soft wrist restraints are

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		being used without seclusion or within 24 hours of their discontinuance. If yes, ask the hospital to demonstrate that it has recorded such deaths. ☐ If the hospital's log or tracking system relies on staff identification of reportable deaths, interview several applicable staff members to determine whether they are aware of the hospital's policy and know when and where to report internally a restraint- or seclusion-associated death.
PC.13.02.19, EP 3: When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, non-rigid, cloth-like material, the critical access hospital does the following: - Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. - Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. - Documents in the patient record the date and time that the death was recorded in the log or other system. - Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the care of the patient, medical record number, and primary diagnosis(es). - Makes the information in the log or other system available to the Centers for Medicare & Medicaid Services, either electronically or in writing, immediately upon request.	**§485.614(g)(4)(i)** **(i) Each entry must be made not later than seven days after the date of death of the patient.**	**Document Review** **Patient Health Record** ☐ Confirm that each entry in the patient's medical record related to any death that occurs while a patient in is restraints or any death that occurs within 24 hours after a patient has been removed from such restraints was made no later than 7 days after the date of death of the patient.

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PC.13.02.19, EP 3: See above	**§485.614(g)(4)(ii)** **(ii) Each entry must document the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner who is responsible for the care of the patient, medical record number, and primary diagnosis(es).**	**Document Review** **Patient Health Record** ☐ Confirm that each entry in the patient's medical record related to any death that occurs while a patient in is restraints or any death that occurs within 24 hours after a patient has been removed from such restraints documents the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner who is responsible for the care of the patient, medical record number, and primary diagnosis(es).
PC.13.02.19, EP 3: See above	**§485.614(g)(4)(iii)** (iii) The information must be made available in either written or electronic form to CMS immediately upon request.	**Document Review** **Patient Health Record** ☐ Verify that information about any death that occurs while a patient in is restraints or any death that occurs within 24 hours after a patient has been removed from such restraints is made available in either written or electronic form to CMS immediately upon request.
RI.11.01.01, EP 7: The critical access hospital develops and implements policies and procedures for patient visitation rights. Visitation rights include the right to receive the visitors designated by the patient, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. The patient also has the right to withdraw or deny such consent at any time. Note 1: The critical access hospital's written policies and procedures include any restrictions or limitations that are clinically necessary or reasonable that need to be placed on visitation rights and the reasons for the restriction or limitation. Note 2: The critical access hospital informs the patient (or support person, where	**§485.614(h)** (h) Standard: Patient visitation rights. A CAH must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the CAH may need to place on such rights and the reasons for the clinical restriction or limitation. A CAH must meet the following requirements:	**Document Review** **General** ☐ Verify that the hospital has written policies and procedures that address the right of patients to have visitors. ☐ Review the policy to determine if there are limitations or restrictions on visitation. If so, confirm that the policy explains the clinical rationale for the restrictions or limitations and that the rationale is clear and reasonably related to clinical concerns. ☐ Confirm that there is documentation of how the hospital identifies and trains staff who play a role in facilitating or controlling access of visitors to patients. **Interview**

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appropriate) of the patient's visitation rights, including any clinical restriction or limitation on such rights.		☐ Determine whether hospital staff are aware of the hospital's visitation policies and procedures and confirm that staff on a given unit can correctly describe the policies for that unit.
RI.11.01.01, EP 7: See above	**§485.614(h)(1)** (1) Inform each patient (or support person, where appropriate) of his or her visitation rights, including any clinical restriction or limitation on such rights, in advance of furnishing patient care whenever possible.	**Document Review** **General** ☐ Determine whether the hospital's visitation policies and procedures require providing notice of the patient's visitation rights to each patient or, if appropriate, to the patient's support person and/or, as applicable, the patient's representative. **Note:** *A patient's "support person" does not necessarily have to be the same person as the patient's representative who is legally responsible for making medical decisions on the patient's behalf. A support person could be a family member, a friend, or another individual who supports the patient during the course of the hospital stay. Hospitals must accept a patient's designation, orally or in writing, of an individual as the patient's support person.* ☐ Review the hospital's standard notice of visitation rights to confirm that it clearly explains the following: o Hospital's visitation policy, including any limitations or restrictions, such as visiting hours, numbers of visitors, or unit-specific restrictions, and the clinical rationale for such limitations or restrictions o Right of the patient to have designated visitors, including but not limited to a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and the right to withdraw or deny consent to visitation **Patient Health Record**

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		☐ Review a sample of medical records to determine if there is documentation that the required notice of the patient's visitation rights was provided. How was the notice provided? **Interview** ☐ Ask staff responsible for providing the required notice of the patient's visitation rights how they accomplish this. Ask staff if they are familiar with the concept of a patient's "support person" and what it means. ☐ Ask a sample of current hospital patients or patients' support persons (where appropriate) whether they were provided notice of their right to have visitors. Ask if they were able to have visitors when they wanted to. If not, verify that the restriction or limitation on visitors was addressed in the hospital's visitation policies and notice and does not violate the regulations at §485.614(h)(3&(4). (See interpretive guidelines for the latter provisions.) ☐ Ask a sample of current hospital patients or patients' support persons (where appropriate) if the hospital failed to limit some or all visitors, contrary to the patient's wishes.
RI.11.01.01, EP 7: See above	**§485.614(h)(2)** (2) Inform each patient (or support person, where appropriate) of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.	**Document Review** **General** ☐ Determine whether the hospital's visitation policies and procedures require providing notice of the patient's visitation rights to each patient or, if appropriate, to a patient's support person and/or, as applicable, the patient's representative. ☐ Review the hospital's standard notice of visitation rights to confirm that it clearly explains the following: ○ Hospital's visitation policy, including any limitations or restrictions, such as visiting hours, numbers of visitors, or unit-specific restrictions,

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		and the clinical rationale for such limitations or restrictions ○ Right of the patient to have designated visitors, including but not limited to a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and the right to withdraw or deny consent to visitation **Patient Health Record** ☐ Review a sample of medical records to determine if there is documentation that the required notice of the patient's visitation rights was provided. How was the notice provided? **Interview** ☐ Ask staff responsible for providing the notice of the patient's visitation rights how they accomplish this. Ask the staff if they are familiar with the concept of a patient's "support person" and what it means. ☐ Ask a sample of current hospital patients or patients' support persons (where appropriate) if they were provided notice of their right to have visitors. Ask if they were able to have visitors when they wanted to. If not, verify that the restriction or limitation on visitors was addressed in the hospital's visitation policies and notice and does not violate the regulations at §485.614(h)(3)&(4). (See interpretive guidelines for the latter provisions.) ☐ • Ask a sample of current hospital patients or patients' support persons (where appropriate) if the hospital failed to limit some or all visitors, contrary to the patient's wishes.
RI.11.01.01, EP 4: The critical access hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex,	**§485.614(h)(3)** (3) Not restrict, limit , or otherwise deny visitation privileges on the basis of race, color,	**Document Review** **General** ☐ Review the hospital's visitation policies and procedures to determine whether they restrict, limit,

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sexual orientation, and gender identity or expression. Note: This includes prohibiting discrimination through restricting, limiting, or otherwise denying visitation privileges. The critical access hospital allows all visitors to have full and equal visitation privileges consistent with patient preferences.	national origin, religion, sex, gender identity, sexual orientation, or disability.	or otherwise deny visitation to individuals on a prohibited basis. **Interview** ☐ Ask the hospital how it educates staff to ensure that visitation policies are implemented in a nondiscriminatory manner. ☐ Ask hospital staff who play a role in facilitating or controlling visitors to discuss their understanding of the circumstances under which visitors may be subject to restrictions or limitations and whether the restrictions or limitations are appropriately based on the hospital's clinically based policies. ☐ Ask hospital patients (or patients' support persons, where appropriate) whether the hospital has restricted or limited visitors against their wishes. If yes, verify whether the restriction or limitation on visitors was addressed in the hospital's visitation policies and in the patient notice and whether it was appropriately based on a clinical rationale rather than impermissible discrimination.
RI.11.01.01, EP 4: See above	**§485.614(h)(4)** (4) Ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences.	**Document Review** **General** ☐ Review the hospital's visitation policies and procedures to determine whether they restrict, limit, or otherwise deny visitation to individuals on a prohibited basis. **Interview** ☐ Ask staff how about the education they received to ensure that visitation policies are implemented in a nondiscriminatory manner. ☐ Ask hospital staff who play a role in facilitating or controlling visitors to discuss their understanding of the circumstances under which visitors may be subject to restrictions or limitations and whether the

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		restrictions or limitations are appropriately based on the hospital's clinically based policies. □ Ask hospital patients (or patients' support persons, where appropriate) whether the hospital has restricted or limited visitors against their wishes. If yes, verify whether the restriction or limitation on visitors was addressed in the hospital's visitation policies and in the patient notice and whether it was appropriately based on a clinical rationale rather than impermissible discrimination.

Critical Access Hospital Agreements Evaluation Module (485.616)

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	§485.616 Condition of Participation: Agreements	
	§485.616(a) Standard: Agreements With Network Hospitals In the case of a CAH that is a member of a rural health network as defined in §485.603 of this chapter, the CAH has in effect an agreement with at least one hospital that is a member of the network for:	**Interview** ☐ How does the CAH participate with other hospitals and facilities in the network communications system? Is a communications log kept at the facility? o Ask staff if there have been difficulties in contacting network members. If so, ask how the CAH deals with communication delays. o How does the network's communications system compare with any available communications equipment in the CAH? ☐ When the network communications system is not in operation, how does the CAH communicate and share patient data with other network members? ☐ How is the CAH staff educated on the use of any communication system utilized in the facility? **Document Review** **General** ☐ If the CAH is a member of a rural health network having a communications system, ask to see the agreement. ☐ Review any policies and procedures related to the operation of any communications system. ☐ Review any written agreements with the local EMS service.
LD.13.03.03, EP 8: If the critical access hospital is a member of a rural health network, it has an agreement with at least one hospital that is a member of the network to address the following: - Patient referral and transfer	**§485.616(a)(1)** Patient referral and transfer;	See above survey process **§485.616(a)**

- Development and use of network communications systems, including electronic sharing of patient data, telemetry, and medical records, if the network has in operation such a system - Provision of emergency and nonemergency transportation between the facility and the hospital		
LD.13.03.03, EP 8: See above	**§485.616(a)(2)** The development and use of communications systems of the network, including the network's system for the electronic sharing of patient data, and telemetry and medical records, if the network has in operation such a system; and	See above survey process **§485.616(a)**
LD.13.03.03, EP 8: See above	**§485.616(a)(3)** The provision of emergency and non-emergency transportation between the facility and the hospital.	See above survey process **§485.616(a)**
LD.13.03.03, EP 9: If the critical access hospital is a member of a rural health network, it has an agreement with respect to credentialing and quality assurance with at least one of the following organizations: - Hospital that is a member of the network - Quality improvement organization (QIO) or equivalent entity - Other appropriate and qualified entity in the state rural health care plan	**§485.616(b) Standard: Agreements for Credentialing and Quality Assurance** Each CAH that is a member of a rural health network shall have an agreement with respect to credentialing and quality assurance with at least-- (1) One hospital that is a member of the network; (2) One QIO or equivalent entity; or (3) One other appropriate and qualified entity identified in the State rural health care plan.	**Document Review** ☐ Review any agreements related to credentialing or quality assurance to determine the level of assistance to be provided and the responsibilities of the CAH. • Review policies and procedures to determine how information is to be obtained, utilized, and how confidentiality of information will be maintained.
LD.13.03.03, EP 4: When telemedicine services are provided to the critical access hospital's patients through an agreement with a distant-site hospital, the critical access hospital's governing body makes certain that	**§485.616(c) Standard: Agreements for credentialing and privileging of telemedicine physicians and practitioners.** (1) The governing body of the CAH must ensure that, when telemedicine services are	**Interview** • Ask the CAH's leadership whether it uses telemedicine services. If yes, • Ask to see a copy of the written agreement(s) with the distant-site hospital(s).

the written agreement specifies that it is the responsibility of the governing body of the distant-site hospital to do the following with regard to its physicians or other licensed practitioners providing telemedicine services: - Determine, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff - Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff - Assure that the medical staff has bylaws - Approve medical staff bylaws and other medical staff rules and regulations - Make certain that the medical staff is accountable to the governing body for the quality of care provided to patients - Make certain that the criteria for selection are individual character, competence, training, experience, and judgment - Make certain that under no circumstances is the accordance of staff membership or professional privileges in the critical access hospital dependent solely upon certification, fellowship or membership in a specialty body or society **MS.20.01.01, EP 1:** When telemedicine services are furnished to the critical access hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating critical access hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing	furnished to the CAH's patients through an agreement with a distant site hospital, the agreement is written and specifies that it is the responsibility of the governing body of the distant-site hospital to meet the following requirements with regard to its physicians or practitioners providing telemedicine services: (i) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff. (ii) Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff. (iii) Assure that the medical staff has bylaws. (iv) Approve medical staff bylaws and other medical staff rules and regulations. (v) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients. (vi) Ensure the criteria for selection are individual character, competence, training, experience, and judgment. (vii) Ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship or membership in a specialty body or society. (2) When telemedicine services are furnished to the CAH's patients through an agreement with a distant-site hospital, the CAH's governing body or responsible individual may choose to rely upon the credentialing and privileging decisions made by the governing body of the distant-site hospital regarding individual distant-site physicians or practitioners. The CAH's governing body or responsible individual	• Does each agreement include the required elements concerning credentialing and privileging of the telemedicine physicians and practitioners by the distant-site hospital? • Does the CAH have documentation indicating that it granted privileges to each telemedicine physician and practitioner? • Does the documentation indicate that the CAH's governing body or responsible individual made the privileging decision based on the privileging decisions of the distant-site hospital? If yes: • Does the agreement address the required elements concerning the distant-site hospital's Medicare participation, appropriate licensure of telemedicine physicians and practitioners, current list of telemedicine physicians and practitioners with privileges, and review by the CAH of the telemedicine physicians' and practitioners' services? • Ask to see the list provided by the distant-site hospital of the telemedicine physicians and practitioners, including their privileges and pertinent licensure information. • Ask for evidence that the CAH conducts the required review of the telemedicine services provided by the telemedicine physicians and practitioners, including any associated adverse events and complaints, and that it provides the required feedback to the distant-site hospital.

such services if the critical access hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity: - The distant site telemedicine entity provides services in accordance with contract service requirements. - The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the critical access hospital's process and standards, at a minimum. - The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. - The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity. - The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the critical access hospital whose patients are receiving the telemedicine services is located. - For distant-site physicians or other licensed practitioners privileged by the originating critical access hospital, the originating critical access hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services	must ensure, through its written agreement with the distant-site hospital, that the following provisions are met: (i) The distant-site hospital providing telemedicine services is a Medicare-participating hospital. (ii) The individual distant-site physician or practitioner is privileged at the distant-site hospital providing the telemedicine services, which provides a current list of the distant-site physician's or practitioner's privileges; (iii) The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the CAH is located; and (iv) With respect to a distant-site physician or practitioner, who holds current privileges at the CAH whose patients are receiving the telemedicine services, the CAH has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site hospital such information for use in the periodic appraisal of the individual distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the CAH's patients and all complaints the CAH has received about the distant-site physician or practitioner.	

provided by the distant-site physician or other licensed practitioner to the critical access hospital's patients and complaints the critical access hospital has received about the distant-site physician or other licensed practitioner. Note 1: In the case of distant-site physicians and licensed practitioners providing telemedicine services to the critical access hospital's patients under a written agreement between the critical access hospital and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare-participating provider or supplier. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2).		
LD.11.01.03, EP 1: The person responsible for the operation of the critical access hospital under 42 CFR 485.627(b)(2) is also responsible for the following: - Services provided in the critical access hospital whether or not they are furnished under arrangements or agreements - Ensuring that contractors of services (including contractors for shared services and joint ventures) provide services that enable the critical access hospital to comply with all applicable Centers for Medicare & Medicaid (CMS) Conditions of Participation and standards for the contracted services	**§485.616(c)(3)** The governing body of the CAH must ensure that when telemedicine services are furnished to the CAH's patients through an agreement with a distant site telemedicine entity, the agreement is written and specifies that the distant-site telemedicine entity is a contractor of services to the CAH and as such, in accordance with §485.635(c)(4)(ii), furnishes the contracted services in a manner that enables the CAH to comply with all applicable conditions of participation for the contracted services, including, but not limited to, the requirements in this section with regard to its physicians and practitioners providing telemedicine services.	See below process for **§485.616(c)(4)**

LD.13.03.03, EP 3: When telemedicine services are furnished to the critical access hospital's patients, the originating site has a written agreement with the distant site that specifies the following: - The distant site is a contractor of services to the critical access hospital. - The distant site furnishes services in a manner that permits the originating site to be in compliance with the Medicare Conditions of Participation, in accordance with 42 CFR 485.635(c)(4)(ii). - The originating site makes certain through the written agreement that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 485.616(c)(1)(i) through (c)(1)(vii). Note: For the language of the Medicare Conditions of Participation pertaining to telemedicine, refer to https://www.ecfr.gov. If the originating site chooses to use the credentialing and privileging decision of the distant-site telemedicine provider, then the following requirements apply: - The governing body of the distant site is responsible for having a process that is consistent with the credentialing and privileging requirements in the "Medical Staff" (MS) chapter (Standards MS.17.01.01 through MS.17.04.01). - The governing body of the originating site grants privileges to a distant-site physician or other licensed practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site. The written agreement includes that it is the responsibility of the governing body of the		

distant-site hospital to meet the requirements of this EP.		
MS.20.01.01, EP 1: See above	**§485.616(c)(4)** When telemedicine services are furnished to the CAH's patients through an agreement with a distant-site telemedicine entity, the CAH's governing body or responsible individual may choose to rely upon the credentialing and privileging decisions made by the governing body of the distant-site telemedicine entity regarding individual distant-site physicians or practitioners. The CAH's governing body or responsible individual must ensure, through its written agreement with the distant-site telemedicine entity, that the following provisions are met: (i) The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at (c)(1)(i) through (c)(1)(vii). (ii) The individual distant-site physician or practitioner is privileged at the distant-site telemedicine entity providing the telemedicine services, which provides a current list to the CAH of the distant-site physician's or practitioner's privileges at the distant-site telemedicine entity. (iii) The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the CAH whose patients are receiving the telemedicine services is located. (iv) With respect to a distant-site physician or practitioner, who holds current privileges at the CAH whose patients are receiving the telemedicine services, the CAH has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends	**Interview** ☐ Ask the CAH's leadership whether it uses telemedicine services. If yes, ☐ Ask to see a copy of the written agreement(s) with the distant-site telemedicine entity(ies). ○ Does each agreement explicitly state that the distant-site telemedicine entity will provide telemedicine services in a manner that enables the CAH to comply with all applicable CoPs? ○ Does the CAH have documentation indicating that it granted privileges to each telemedicine physician and practitioner? ○ Does the documentation indicate that the CAH's governing body or responsible individual made the privileging decision based on the privileging decisions of the distant-site telemedicine entity? If yes: ○ Does the written agreement with the distant-site telemedicine entity address the required elements concerning the distant-site telemedicine entity's utilization of a medical staff credentialing and privileging process that meets the requirements of the hospital CoPs, licensure of telemedicine physicians and practitioners, current list of telemedicine physicians and practitioners with privileges at the distant-site telemedicine entity, and written review by the CAH of the telemedicine physicians' and practitioners' services? ○ Is there a list provided by the distant-site telemedicine entity of the telemedicine physicians and practitioners covered by the agreement, including their privileges and pertinent licensure information? ○ Is there evidence that the CAH reviews the services provided by the telemedicine

	the distant-site telemedicine entity such information for use in periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the CAH's patients and all complaints the CAH has received about the distant-site physician or practitioner.	physicians and practitioners, including any adverse events and complaints, and provides written feedback to the distant-site telemedicine entity? ○ Ask the CAH how it verifies that the telemedicine entity fulfills the terms of the agreement with respect to its credentialing and privileging process and otherwise assures that services are provided in a manner that enables the CAH to meet all applicable CAH requirements? *Note: Surveyors do not attempt to independently verify whether or not the distant-site telemedicine entity's credentialing and privileging process fulfills the regulatory requirements. Surveyors focus only on what actions the CAH takes to ensure that the distant-site telemedicine entity complies with the terms of the agreement.*

Critical Access Hospital Emergency Services Evaluation Module (485.618)

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LD.13.03.01, EP 6: The critical access hospital provides emergency medical services that meet the needs of its inpatients and outpatients as a first response to common life-threatening injuries and acute illnesses. Note: Emergency services are available 24-hours a day, 7 days a week.	**§485.618 Condition of Participation: Emergency Services** The CAH provides emergency care necessary to meet the needs of its inpatients and outpatients.	**Interview** ☐ Ask leaders and emergency services director how they determine the categories and numbers of MDs/DOs, specialists, RNs, EMTs, and ED support staff the CAH needs to meet its anticipated emergency care services needs. ☐ Ask staff to verify how the CAH provides emergency care to meet the needs of its inpatients and outpatients in accordance with acceptable standards of practice and as per applicable law and regulation. Note: *All emergency services must be provided as a direct service in the CAH. The ED cannot be a provider-based off-site location.* ☐ Ask staff to verify how the CAH conducts ongoing assessments of its emergency needs to anticipate the policies, procedures, staffing, training, and other resources needed to address likely demands. ☐ Based on their level of participation in emergency care, ask staff to describe how they maintain knowledge of the following: o Parenteral administration of electrolytes, fluids, blood, and blood components o Care and management of injuries to extremities and the central nervous system o Prevention of contamination and cross infection o Provision of emergency respiratory services

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		Document Review **General** ☐ Verify that emergency services are organized under the direction of a qualified member of the medical staff. o Has the medical staff established criteria for the qualifications of the emergency services director in accordance with state law and acceptable standards of practice? ☐ Verify that the hospital's medical staff has established criteria for the qualifications a medical staff member must possess to be granted privileges for the provision of emergency care services. Qualifications include necessary education, experience, and specialized training, consistent with state law and acceptable standards of practice. ☐ Verify that emergency services are provided in accordance with State law and acceptable standards of practice. ☐ Verify that the CAH's medical staff has established written policies and procedures for the medical care provided in the emergency services or emergency department. o Are they revised as necessary based on the ongoing monitoring conducted by the medical staff and the emergency service or department QA activities? Note: *These must be developed and approved by the medical staff and include the participation of any mid-level practitioners working in the ED.* ☐ Review emergency services policies and procedures for the following:

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		○ The categories and numbers of MD/DOs, specialists, RNs, EMTs, and emergency department support staff needed to meet its anticipated emergency needs. ○ Medical staff criteria that is in accordance with state law and regulation and acceptable standards of practice delineating the qualifications required for each category of emergency services staff (for example, emergency physicians, specialist MDs/DOs, RNs, EMTs, midlevel practitioners). □ If the CAH provides any degree of respiratory care services, determine the following: ○ The scope of diagnostic and/or therapeutic respiratory services offered by the CAH are defined in writing and approved by the medical staff. ○ Does the type and amount of respiratory care provided meet the needs of the patients? ○ Is respiratory care delivered in accordance with acceptable standards of practice? Is there a current CLIA certificate for blood gases or other laboratory tests performed as part of the delivery of respiratory services? □ Verify that the CAH has the appropriate equipment and sufficient and qualified medical and nursing personnel to respond to the emergency medical needs and care of the patient population being served and to furnish all services offered in a safe manner in accordance with acceptable standards of practice. ○ Review staffing schedules to make certain they reflect the number and type of staff available

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		and that it is appropriate to the volume and types of treatments provided. ☐ Look for evidence that the CAH's emergency services are integrated into the QA program. **Patient Health Record** ☐ Review a sample of medical records for patients treated in the ED to see if the CAH followed its own policies and procedures.
LD.13.03.01, EP 6: The critical access hospital provides emergency medical services that meet the needs of its inpatients and outpatients as a first response to common life-threatening injuries and acute illnesses. Note: Emergency services are available 24-hours a day, 7 days a week.	**§485.618(a)** Standard: Availability Emergency services are available on a 24-hours a day basis.	**Interview** ☐ Ask staff how the CAH ensures that emergency services are made available 24-hours a day. ☐ Interview staff, patients, and families to verify that ED services are made available to patients presenting on a 24-hour basis. **Document Review** **General** ☐ Verify that the CAH's emergency services are available 24-hours a day Note: *A CAH does not have to remain open 24 hours a day when it does not have inpatients (including swing-bed patients); however, it must make available 24-hour emergency services.* ☐ Verify that the CAH has a procedure to make certain that a practitioner with training and experience in emergency care is on call and is immediately available by telephone or radio and available on site within 30 minutes (or 1 hour in certain frontier areas), 24 hours a day. ☐ Verify that the CAH's emergency services maintain the types, quality, and numbers of supplies, drugs and biologicals, blood and blood products, and

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		equipment required by state and local law and in accordance with accepted standards of practice. **Patient Health Record** ☐ Verify through record review of patients admitted through the ED that ED services were made available to patients presenting on a 24-hour basis. **Observation** ☐ Observe how ED services are made available to patients presenting on a 24-hour a day basis.
PC.12.01.07, EP 1: The critical access hospital maintains equipment, supplies, and drugs and biologicals commonly used in life-saving procedures. These items are kept at the critical access hospital and are available for treating emergency cases. Note 1: The drugs and biologicals commonly used in life-saving procedures, include, but are not limited to analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids, antiarrythmics, cardiac glycosides, antihypertensives, diuretics, and electrolytes and replacement solutions. Note 2: Equipment and supplies commonly used life-saving procedures, include, but are not limited to, airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters.	**§485.618(b)** Standard: Equipment, Supplies, and Medication Equipment, supplies, and medication used in treating emergency cases are kept at the CAH and are readily available for treating emergency cases. The items available must include the following:	**Interview** ☐ Interview staff and tour the ED to determine compliance and the CAH's ability to provide emergency services. ☐ Ask leaders and staff how the required equipment, supplies and medications are always readily available. **Document Review** **General** ☐ Verify that the CAH maintains and has readily available the types, quality, and number of supplies, drugs and biologicals, blood and blood products, and equipment as required by state and local law and in accordance with accepted standards of practice.
PC.12.01.07, EP 1: See above	**§485.618(b)(1)** Drugs and biologicals commonly used in life-saving procedures, including analgesics, local anesthetics,	**Interview** ☐ Interview staff about: o Where are drugs and biologicals kept?

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	antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids, antiarrythmics, cardiac glycosides, antihypertensives, diuretics, and electrolytes and replacement solutions.	○ How is inventory of drugs and biologicals maintained? ○ Who is responsible for monitoring drugs and biologicals? ○ How are drugs and biologicals replaced?
PC.12.01.07, EP 1: See above	**§485.618(b)(2)** Equipment and supplies commonly used in life-saving procedures, including airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters.	**Interview** ☐ Interview staff about: ○ Where are emergency and life-saving equipment and supplies kept? ○ Are the required equipment and supplies readily available to staff? ○ How are supply inventories maintained and replaced? Who is responsible for monitoring supplies? ○ When was the last time emergency supplies were used? Did any equipment not work when needed? **Document Review** **General** ☐ Verify that the CAH has an equipment maintenance schedule (for example, for the defibrillator) for equipment used for emergency services and other life-saving procedures. **Observation** ☐ Examine sterilized equipment (for example, tracheostomy sets) for expiration dates, when applicable. ☐ Examine the oxygen supply system to determine functional capabilities.

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		☐ Check the force of the vacuum (suction) equipment to see that it is in operating condition.
LD.13.03.01, EP 16: The critical access hospital provides services directly or by arrangement, for the procurement, safekeeping, and transfusion of blood and provides services for making blood products available for emergencies on a 24-hour basis.	**§485.618(c)** Standard: Blood and Blood Products The facility provides, either directly or under arrangements, the following-- (1) Services for the procurement, safekeeping, and transfusion of blood, including the availability of blood products needed for emergencies on a 24-hours a day basis.	**Interview** ☐ Ask staff to demonstrate the capability (i.e., an effective system is in place regardless of whether, in actual practice, it has been utilized) of making blood products available to emergency patients 24-hours a day. Note: *Blood and blood products must be available and accessible to CAH staff in time to effectively treat emergency patients at the CAH.* ☐ For CAHs that elect to store units of O-negative packed red blood cells, ask staff how they arrange for the provision of such units (for example, with the Red Cross or other similar product provider). **Document Review** **General** ☐ Verify that the CAH has procedures for providing, either directly or under arrangements, the procurement, safekeeping, and transfusion of blood, including the availability of blood products needed for emergencies on a 24-hour basis. *Note: If blood and blood products services are being provided by a testing laboratory, there should be a written agreement or arrangement between the two.* ☐ If the CAH chooses to store O-negative blood on site, verify that it has procedures to properly store 4 units of O-negative packed red blood cells (the universal donor type) and that the blood is always available for emergencies only.

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		Note: *There is no requirement in the regulation for a CAH to store blood on site, although it may choose to do so.* ☐ For emergency release of uncrossmatched blood, verify that the CAH has procedures for a release form to be signed by a doctor, prior to transfusion, acknowledging that the blood has not been crossmatched for the patient. ☐ If a CAH performs on-site CLIA tests on blood, verify that it has a CLIA certificate and is subject to survey under CLIA. Note: *A CAH that is only storing blood for transfusion and refers all related testing out to another laboratory is not performing testing as defined by CLIA.* ☐ If the CAH is collecting blood, verify that it is registered with the Food and Drug Administration. **Observation** ☐ If the CAH is storing blood on site, verify that the blood is appropriately stored to prevent deterioration and that refrigerator temperatures are documented. ☐ If the CAH performs blood type and compatibility testing, verify that it has the necessary equipment (that is, serofuge and heat block), as well as typing and crossmatching reagents (some of which have a 30-day expiration date).
LD.13.03.01, EP 17: The critical access hospital provides blood storage facilities, either directly or by arrangement, that meet the requirements of 42 CFR part 493, subpart K, and are under the control and supervision	**§485.618(c)(2)** Blood storage facilities that meet the requirements of 42 CFR part 493, subpart K, and are under the control and supervision of a pathologist or other qualified doctor of medicine or osteopathy.	**Interview** Ask leaders

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of a pathologist or other qualified doctor of medicine or osteopathy. Note: If blood banking services are provided under an arrangement, the arrangement is approved by the critical access hospital's medical staff and by the persons directly responsible for the operation of the critical access hospitals.	If blood banking services are provided under an arrangement, the arrangement is approved by the facility's medical staff and by the persons directly responsible for the operation of the facility.	☐ If blood-banking services are provided on site. Who has control and supervision of the blood facility? Note: *Blood storage facilities that meet 42 CFR part 493, subpart K, must be under the control and supervision of a pathologist or other qualified MD/DO.* ☐ If blood-banking services are provided under arrangement, is there evidence of the medical staff and the person responsible for operations have approved this arrangement
NPG.12.01.01, EP 5: A doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist with training or experience in emergency care is on call and immediately available by telephone or radio contact, and they are available on-site within 30 minutes, 24 hours a day, 7 days a week. Note: If all of the following criteria are met, these practitioners are available on site within 60 minutes: - The critical access hospital is located in an area designated as a frontier (that is, an area with fewer than six residents per square mile based on the latest population data published by the US Census Bureau) or in an area that meets the criteria for a remote location adopted by the state in its rural health care plan and approved by Centers for Medicare & Medicaid Services (CMS) under section 1820(b) of the Social Security Act. - The state has determined under criteria in its rural health plan that allowing an emergency response time longer than 30	**§485.618(d)** Standard: Personnel (1) Except as specified in paragraph (d)(3) of this section, there must be a doctor of medicine or osteopathy, a physician assistant, a nurse practitioner or a clinical nurse specialist with training or experience in emergency care on call and immediately available by telephone or radio contact, and available on site within the following timeframes: **(i)** Within 30 minutes, on a 24-hour a day basis, if the CAH is located in an area other than an area described in paragraph (d)(1)(ii) of this section; or **(ii)** Within 60 minutes, on a 24-hour a day basis, if all of the following requirements are met: **(A)** The CAH is located in an area designated as a frontier area (that is, an area with fewer than six residents per square mile based on	**Interview** ☐ Ask staff if they know who is currently on call. **Document Review** **General** ☐ Review on-call schedules to determine how the CAH ensures that a qualified staff member is on call 24 hours a day and available on site at the CAH within 30 minutes or 60 minutes in certain frontier areas. Note: *When state law is more stringent and requires more stringent staffing or expanded operational hours, the CAH must staff its ED in accordance with state law. For example, if state law requires that the CAH ED be open and staffed with a MD/DO 24 hours a day, 7 days a week, then the CAH must comply.* ☐ Review supporting documentation that demonstrates that an MD/DO, a nurse practitioner, a physician assistant, a clinical nurse specialist, or a registered nurse with emergency training or experience has been on call and was

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minutes is the only feasible method of providing emergency care to residents of the area served by the critical access hospital. - The state maintains documentation showing that the response time of up to 60 minutes at a particular designated critical access hospital is justified because other available alternatives would increase the time needed to stabilize a patient in an emergency. **HR.11.01.01, EP 2:** A registered nurse with training and experience in emergency care can be used to conduct specific medical screening examinations only if both of the following conditions are met: - The registered nurse is on site and immediately available at the critical access hospital when a patient requests medical care. - The patient's request for medical care is within the scope of practice of a registered nurse and consistent with applicable state laws and the critical access hospital's bylaws and rules and regulations **NPG.12.02.01, EP 8:** A registered nurse satisfies the personnel requirements in 42 CFR 485.618(d)(1) for a temporary period if all of the following conditions are met: - The critical access hospital has no more than 10 beds. - The critical access hospital is located in an area designated as a frontier area or remote location as described in 42 CFR 485.618(d)(1)(ii)(A). - The state in which the critical access hospital is located submits a letter to the	the latest population data published by the Bureau of the Census) or in an area that meets criteria for a remote location adopted by the State in its rural health care plan, and approved by CMS, under section 1820(b) of the Act. **(B)** The State has determined under criteria in its rural health care plan, that allowing an emergency response time longer than 30 minutes is the only feasible method of providing emergency care to residents of the area served by the CAH. **(C)** The State maintains documentation showing that the response time of up to 60 minutes at a particular CAH it designates is justified because other available alternatives would increase the time needed to stabilize a patient in an emergency. (2) A registered nurse with training and experience in emergency care can be utilized to conduct specific medical screening examinations only if— **(i)** The registered nurse is on site and immediately available at the CAH when a patient requests medical care; and **(ii)** The nature of the patient's request for medical care is within the scope of practice of a registered nurse and consistent with applicable State laws and the CAH's bylaws or rules and regulations.	available on site at the CAH within 30 or 60 minutes, as appropriate.

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Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation on the issue of using registered nurses on a temporary basis as part of its state rural health care plan with the State Boards of Medicine and Nursing, and in accordance with state law, requesting that a registered nurse with training and experience in emergency care be included in the list of personnel specified in 42 CFR 485.618(d)(1). The letter from the governor must attest that they have consulted with the State Boards of Medicine and Nursing about issues related to access to and the quality of emergency services in the state. The letter from the governor also describes the circumstances and duration of the temporary request to include the registered nurses on the list of personnel specified in 42 CFR 485.618(d)(1). - Once a governor submits a letter,, the critical access hospital submits documentation to the state survey agency demonstrating that it has been unable, due to the shortage of such personnel in the area, to provide adequate coverage as specified in 42 CFR 485.618(d). Note: The critical access hospital's request for using RNs on a temporary basis or its withdrawal of this request can be submitted to CMS at any time and is effective upon submission.	(3) A registered nurse satisfies the personnel requirement specified in paragraph (d)(1) of this section for a temporary period if-- **(i)** The CAH has no greater than 10 beds; **(ii)** The CAH is located in an area designated as a frontier area or remote location as described in paragraph (d)(1)(ii)(A) of this section; **(iii)** The State in which the CAH is located submits a letter to CMS signed by the Governor, following consultation on the issue of using RNs on a temporary basis as part of their State rural health care plan with the State Boards of Medicine and Nursing, and in accordance with State law, requesting that a registered nurse with training and experience in emergency care be included in the list of personnel specified in paragraph (d)(1) of this section. The letter from the Governor must attest that he or she has consulted with State Boards of Medicine and Nursing about issues related to access to and the quality of emergency services in the States. The letter from the Governor must also describe the circumstances and duration of the temporary request to include the registered nurses on the list of personnel specified in paragraph (d)(1) of this section; (iv) Once a Governor submits a letter, as specified in paragraph (d)(3)(iii) of this section, a CAH must submit documentation to the State survey agency demonstrating that it has been unable, due to the shortage of such personnel in the area, to provide	

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	adequate coverage as specified in this paragraph (d). (4) The request, as specified in paragraph (d)(3)(iii) of this section, and the withdrawal of the request, may be submitted to us at any time, and are effective upon submission.	
LD.13.03.01, EP 20: In accordance with the complexity and scope of services offered, the critical access hospital has adequate provisions (as required under 42 CFR 485.618 (b) and (c)) and protocols to meet the emergency needs of patients. Note: For 485.618(b) and (c), refer to https://www.ecfr.gov/current/title-42/section-485.618.	**485.618(e)** ***Standard: Emergency services readiness.*** Effective July 1, 2025, in accordance with the complexity and scope of services offered, there must be adequate provisions (as required under paragraphs (b) and (c) of this section) and protocols to meet the emergency needs of patients.	**CMS Guidance Pending**
LD.13.03.01, EP 21: In accordance with the complexity and scope of services offered, the critical access hospital protocols are consistent with nationally recognized and evidence-based guidelines for the care of patients with emergency conditions, including but not limited to patients with obstetrical emergencies, complications, and immediate postdelivery care.	**485.618(e)(1)** ***Standard: Protocols.*** Protocols must be consistent with nationally recognized and evidence-based guidelines for the care of patients with emergency conditions, including but not limited to patients with obstetrical emergencies, complications, and immediate post-delivery care.	**CMS Guidance Pending**
HR.11.03.01, EP 2: Applicable staff, as identified by the critical access hospital, are trained annually on the protocols and provisions implemented for emergency services readiness pursuant to 42 CFR 485.618(e).	**485.618(e)(2)** **Standard: Staff training.** Applicable staff, as identified by the CAH, must be trained annually on the protocols and provisions implemented pursuant to this section. (i) The governing body must identify and document which staff must complete such training.	**CMS Guidance Pending**

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Note 1: For 485.618(e), refer to https://www.ecfr.gov/current/title-42/part-485/section-485.618#p-485.618(e). Note 2: The critical access hospital must document in staff personnel records that the annual training was successfully completed. **HR.11.03.01, EP 3:** The governing body identifies and documents which staff must complete the annual emergency services readiness training. **HR.11.03.01, EP 4:** The critical access hospital is able to demonstrate staff knowledge of emergency services readiness protocols and provisions training. **HR.11.03.01, EP 5:** The critical access hospital uses findings from its quality assessment and performance improvement (QAPI) program, as required at 42 CFR 485.641, to inform staff training needs and any additions, revisions, or updates to training topics on an ongoing basis. Note: For 485.641, refer to https://www.ecfr.gov/current/title-42/section-485.641.	(ii) The CAH must document in the staff personnel records that the training was successfully completed. (iii) The CAH must be able to demonstrate staff knowledge on such training. (iv) The CAH must use findings from its QAPI program, as required at § 485.641, to inform staff training needs and any additions, revisions, or updates to training topics on an ongoing basis.	
LD.13.01.09, EP 8: In coordination with area emergency response systems, the critical access hospital establishes procedures under which a doctor of medicine or osteopathy is immediately available by telephone or radio contact on a 24-hour-a-day, 7 days a week, to receive emergency calls, provide information on treatment of emergency patients, and refer patients to the critical access hospital or other appropriate locations for treatment.	**§485.618(f)** Standard: Coordination With Emergency Response Systems The CAH must, in coordination with emergency response systems in the area, establish procedures under which a doctor of medicine or osteopathy is immediately available by telephone or radio contact on a 24-hours a day basis to receive emergency calls, provide information on treatment of emergency patients, and refer patients to	**Interview** ☐ Ask staff how an MD/DO is contacted when emergency instructions are needed. **Document Review** **General** ☐ Verify that the CAH has policies and procedures to ensure an MD/DO is available by telephone or radio on a 24-hour basis to receive emergency

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	the CAH or other appropriate locations for treatment.	calls and provide medical direction in emergency situations. **Observation** □ What evidence demonstrates that the procedures are followed and evaluated for effectiveness?

Critical Access Hospital Number of Beds (485.620 (a) and (b))

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LD.13.01.01, EP 3: Except as permitted for critical access hospitals having distinct part units under 42 CFR 485.647, the critical access hospital maintains no more than 25 inpatient beds that can be used for either inpatient or swing bed services. Note: Any bed in a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility applies to the state for designation as a critical access hospital is not counted in this 25-bed count.	**§485.620(a) Standard: Number of Beds** Except as permitted for CAHs having distinct part units under §485.647, the CAH maintains no more than 25 inpatient beds. Inpatient beds may be used for either inpatient or swing-bed services.	**Observation** ☐ Count the number of inpatient beds the CAH maintains, excluding any DPU beds. ☐ Ask the CAH leaders how frequently it uses observation services, and for its policies and procedures governing use of observation services. ☐ Verify that patients are never pre-registered for observation services; there should be no scheduled observation stays. ☐ Check to see if the CAH has specific clinical criteria for placement in and discharge from observation status, and that these clinical criteria are clearly distinguishable from those used for inpatient admission and discharge. ☐ If there is a separate unit of observation beds, ask the CAH leaders for evidence of how its criteria for placement in the observation unit differ from admission criteria for an inpatient bed. Count the number of beds in the observation unit and compare them to the number of inpatient beds. The higher the proportion of observation beds, the greater is the CAH's burden to prove these are not being used as inpatient beds. Ask for the occupancy rates for the observation unit; the higher the occupancy rate, particularly if there are more than a couple of beds, the greater is the CAH's burden to prove these are not being used as inpatient beds.

		Patient Health Record Review ☐ Select a sample of closed medical records for patients who were in an observation status. Verify that the medical record includes an order to place the patient in observation status, as well as a later order to admit, discharge, or transfer the patient. ☐ Review the medical records for patients who are in observation status at the time of survey. Verify that the medical record includes an order to place the patient in observation status, including the clinical reason for observation, e.g., as "Place patient in observation to rule out possible myocardial infarction (MI)." ☐ Verify through medical record review that observation services are not ordered as a standing order following outpatient surgery or prior to admission from the emergency department.
LD.13.01.01, EP 5: The critical access hospital provides acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient.	**§485.620(b) Standard: Length of Stay** The CAH provides acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient.	**Interview** ☐ The critical access hospital leaders to confirm the acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient. **Note:** The Fiscal Intermediary (FI) will determine compliance with this CoP. The FI will calculate the CAH'S length of stay based on patient census data. If a CAH exceeds the length of stay limit, the FI will send a report to the CMS-RO as well as a copy of the report to the SA. The CAH will be required to develop and implement a plan of correction (POC) acceptable to the CMS Regional Office or provide adequate information to demonstrate compliance.

Critical Access Hospital Physical Environment Evaluation Module (485.623)

(Requires use of K-tag/CoP/EP review tool to evaluate compliance with the Life Safety Code.)

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	§485.623 Condition of Participation: Physical Plant and Environment	**Observation** ☐ Verify that all locations (such as inpatient and outpatient) meet this CoP. **Interview** ☐ Confirm that the department/service responsible for building and equipment maintenance are incorporated into the CAH's performance improvement program.
PE.01.01.01, EP 1: The critical access hospital's building is constructed, arranged, and maintained to allow safe access and to protect the safety and well-being of patients. Note 1: Diagnostic and therapeutic facilities are located in areas appropriate for the services provided. Note 2: When planning for new, altered, or renovated space, the critical access hospital uses state rules and regulations, or the current Guidelines for Design and Construction of Hospitals published by the Facility Guidelines Institute. If the state rules and regulations or the Guidelines do not address the design needs of the critical access hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria. **PE.01.01.01, EP 2:** The critical access hospital has adequate space and facilities for the services it provides, including facilities for the diagnosis and treatment of patients and for any special services offered to meet the	**§485.623(a) Standard: Construction** The CAH is constructed, arranged, and maintained to ensure access to and safety of patients, and provides adequate space for the provision of services.	**Observation** ☐ Verify through observation that the physical facilities are large enough for the scope of services the CAH is required to provide on-site, as well as any additional services it offers on-site or at a provider-based, off-site location. Appropriate size of facility should be based on state rules and regulations and the current FGI guidelines. The adequacy of the space depends on both the nature of the services provided and the number of patients to whom the CAH typically provides those services. ☐ Verify through observation that the CAH's building(s) is/are maintained in a manner to ensure the safety and well-being of patients (e.g., condition of ceilings, walls, and floors, presence of patient hazards, etc.). ☐ Verify through observation that the design of the CAH assures that staff can reach patients readily.

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needs of the community served. Note: The extent and complexity of facilities is determined by the services offered.		
PE.04.01.01, EP 2: The critical access hospital maintains essential mechanical, electrical, and patient care equipment in safe operating condition. **PE.04.01.05, EP 1:** The water management program has an individual or a team responsible for the oversight and implementation of the program, including but not limited to development, management, and maintenance activities. **PE.04.01.05, EP 2:** The individual or team responsible for the water management program develops the following: - A basic diagram that maps all water supply sources, treatment systems, processing steps, control measures, and end-use points Note: An example would be a flow chart with symbols showing sinks, showers, water fountains, ice machines, and so forth. - A water risk management plan based on the diagram that includes an evaluation of the physical and chemical conditions of each step of the water flow diagram to identify any areas where potentially hazardous conditions may occur (these conditions are most likely to occur in areas with slow or stagnant water) Note: Refer to the Centers for Disease Control and Prevention's "Water Infection Control Risk Assessment (WICRA) for Healthcare Settings" tool as an example for conducting a water-related risk assessment. - A plan for addressing the use of water in	**§485.623(b) Standard: Maintenance** The CAH has housekeeping and preventive maintenance programs to ensure that— **§485.623(b)(1)** All essential mechanical, electrical, and patient-care equipment is maintained in safe operating condition;	**Interview** Interview personnel/staff in charge of equipment maintenance to determine: - If the CAH has identified equipment that is essential for both regular operations and in an emergency situation. - If the CAH has made adequate provisions to ensure the availability of those and equipment when needed. Interview equipment users on units/departments to determine: - If equipment failures are occurring and causing problems for patient health or safety. **Document Review** Review equipment inventory to verify the following: - The inventory is complete and includes equipment required to meet patient needs regardless of ownership. - Critical equipment is readily identified - If AEM program is used, equipment in the program is readily identified Review equipment maintenance documentation to verify the following: - All equipment is inspected and tested for performance and safety before initial use and after major repairs or upgrades - All equipment is inspected, tested, and maintained to ensure its safety, availability and reliability in accordance with established maintenance activities based on manufacturer's

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areas of buildings where water may have been stagnant for a period of time (for example, unoccupied or temporarily closed areas) - An evaluation of the patient populations served to identify patients who are immunocompromised - Monitoring protocols and acceptable ranges for control measures Note: Critical access hospitals should consider incorporating basic practices for water monitoring within their water management programs that include monitoring of water temperature, residual disinfectant, and pH. In addition, protocols should include specificity around the parameters measured, locations where measurements are made, and appropriate corrective actions taken when parameters are out of range. (See also IC.04.01.01 EP2) **PE.04.01.05, EP 3:** The individual or team responsible for the water management program manages the following: - Documenting results of all monitoring activities - Corrective actions and procedures to follow if a test result outside of acceptable limits is obtained, including when a probable or confirmed waterborne pathogen(s) indicates action is necessary - Documenting corrective actions taken when control limits are not maintained Note: See PE.07.01.01, EP 1 for the process of monitoring, reporting, and investigating utility system issues.		recommendations or alternative equipment maintenance program Review documentation to verify: □ Individual(s) responsible for overseeing the development, implementation, and management of equipment maintenance programs and activities (including contractors) are qualified. Examples include training certificates or certifications. **If the CAH is following the manufacturer-recommended equipment maintenance activities and frequencies:** **Document Review** In addition to reviewing maintenance records on equipment observed while inspecting various CAH locations for multiple compliance assessment purposes, select a sample of equipment from the CAH's equipment inventory to determine whether the CAH is following the manufacturer's recommendations. Critical equipment which poses a higher risk to patient safety if it were to fail, such as ventilators, defibrillators, robotic surgery devices, etc. should make up the sample majority. For the sample selected, determine if: □ The CAH has available manufacturer's recommendations (e.g., manufacturer's operation and maintenance manual, standards, studies, guidance, recall information, service records, etc.); □ Maintenance is being performed in accordance with manufacturer's recommendations **If a CAH is using an AEM for some equipment:** **Document Review**

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PE.04.01.05, EP 4: The individual or team responsible for the water management program reviews the program annually and when the following occurs: - Changes have been made to the water system that would add additional risk. - New equipment or an at-risk water system(s) has been added that could generate aerosols or be a potential source for Legionella. This includes the commissioning of a new wing or building. Note 1: Joint Commission and the Centers for Medicare & Medicaid Services (CMS) do not require culturing for Legionella or other waterborne pathogens. Testing protocols are at the discretion of the critical access hospital unless required by law or regulation. Note 2: Refer to ASHRAE Standard 188-2018 "Legionellosis: Risk Management for Building Water Systems" and the Centers for Disease Control and Prevention Toolkit "Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings" for guidance on creating a water management plan. For additional guidance, consult ANSI/ASHRAE Guideline 12-2020 "Managing the Risk of Legionellosis Associated with Building Water Systems."		□ Verify that the CAH's inventory does not include equipment ineligible for AEM, for example, any diagnostic imaging or therapeutic radiologic equipment? □ Verify for each type of equipment subject to the AEM program, that there is documentation indicating: ○ The pertinent types and level of risks to patient or staff health and safety ○ Alternate maintenance activities, and the maintenance strategy and any other rationale used to determine those activities ○ Alternate maintenance frequencies to be used, if any, and the maintenance strategy and any other rationale used to determine those frequencies ○ The date when AEM program maintenance activities were performed and, if applicable, further actions required/taken ○ If any equipment failures (not including failures due to operator error) occurred, including whether there was resulting harm to an individual. □ Verify the CAH has policies and procedures which address the effectiveness of its AEM program. □ Verify the CAH is evaluating the safety and effectiveness of the AEM program. □ If there is equipment on the inventory the CAH has identified as having such a very low level of risk that it has determined it can use a broad interval range or departmental "sweeps," ask the CAH for the evidence used to make this determination. Does it seem reasonable?

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		Interview Select a sample of equipment in the AEM program. The majority of the sample must include critical equipment which poses a higher risk to patient safety if it were to fail, such as ventilators, defibrillators, robotic surgery devices, etc. For the sample selected: • Ask the responsible personnel to explain how the decision was made to place the equipment in an AEM program. Does the methodology used consider risk factors and make use of available evidence? • Ask the responsible personnel to describe the methodology for applying maintenance strategies and determining alternative maintenance activities or frequencies for the sampled equipment. Can they readily provide an explanation and point to sources of information (accepted standards of practice for facility or medical equipment) they relied upon? • Determine if maintenance is being performed in accordance with the maintenance activities and frequencies defined in the AEM program in accordance with established policies and procedures. • Verify the CAH is evaluating the safety and effectiveness of the AEM maintenance activities for this equipment and taking corrective actions when needed.
PE.02.01.01, EP 6: The critical access hospital has procedures for the proper routine storage and prompt disposal of trash and regulated medical waste.	**§485.623(b)(2)** There is proper routine storage and prompt disposal of trash;	**Observation** • Verify that the hospital follows its process for storage and disposal of trash and medical waste.
MM.13.01.01, EP 2: The critical access hospital stores all medications and biologicals, including controlled (scheduled)	**§485.623(b)(3)** Drugs and biologicals are appropriately stored;	**Interview** • Discuss with staff what standards, guidelines, State and Federal law the CAH is following to

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medications, in a secured area and locked when necessary to prevent diversion in accordance with law and regulation. Note 1: Scheduled medications include those listed in Schedules II–V of the Comprehensive Drug Abuse Prevention and Control Act of 1970. Note 2: This element of performance is also applicable to sample medications. Note 3: Only authorized staff have access to locked areas.		ensure that drugs and biologicals are appropriately stored (e.g., properly locked) in all storage areas?
PE.01.01.01, EP 3: The critical access hospital's premises are clean and orderly. Note: Clean and orderly means an uncluttered physical environment where patients and staff can function. This includes but is not limited to storing equipment and supplies in their proper spaces, attending to spills, and keeping areas neat.	**§485.623(b)(4)** The premises are clean and orderly; and "***Clean and orderly***" *means an uncluttered physical environment where patients and staff can function safely.* Equipment and supplies are stored in proper spaces, not in corridors. Spills are not left unattended. There are no floor obstructions. The area is neat and well kept. There is no evidence of peeling paint, visible water leaks, or plumbing problems.	**Observation** ☐ Verify that equipment and supplies are stored in proper spaces, not in corridors ☐ Verify there are no floor obstructions ☐ Verify spills are not left unattended ☐ Verify areas are clean and well kept (no evidence of peeling paint, water leaks, plumbing problems, etc.)
PE.04.01.01, EP 3: The critical access hospital has proper ventilation, lighting, and temperature control in all pharmaceutical, patient care, and food preparation areas.	**§485.623(b)(5)** There is proper ventilation, lighting, and temperature control in all pharmaceutical, patient care, and food preparation areas.	**Observation** ☐ Verify that food and medication preparation areas are well lit ☐ Verify the hospital is in compliance with ventilation requirements ☐ Verify that food products are stored under appropriate conditions based on nationally accepted sources ☐ Verify pharmaceuticals are stored in accordance with manufacturer's recommendations **Document Review**

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		☐ Review monitoring records for temperature to make certain that appropriate levels are maintained
PE.03.01.01, EP 3: The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients.	**§485.623(c) Standard: Life Safety from Fire** (1) Except as otherwise provided in this section, (i) the CAH must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4.) (ii)Notwithstanding paragraph (d)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors.	**Observation** ☐ Use the K-tag/CoP/EP Review tool to evaluate compliance with the Life Safety Code.

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Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity. **PE.03.01.01, EP 6:** Regardless of the provisions of the Life Safety Code, corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited on these doors.		
PE.03.01.01, EP 3: The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which	§485.623(*c*)(2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a CAH, but only if the waiver will not adversely affect the health and safety of the patients. **Note: Waivers can only be granted by CMS**	**Refer to Joint Commission's website for additional guidance on waivers.**

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would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.		
PE.03.01.01, EP 3: The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion	**§485.623(c)(3)** After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the CAH, but only if the waiver does not adversely affect the health and safety of patients. **Note: Waivers can only be granted by CMS**	**Refer to Joint Commission's website for additional guidance on waivers.**

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of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.		
PE.03.01.01, EP 5: The critical access hospital maintains written evidence of regular inspection and approval by state or local fire control agencies.	**§485.623(*c*)(4)** The CAH maintains written evidence of regular inspection and approval by State or local fire control agencies.	**Document Review** ☐ Review copies of inspection and approval reports from state or local fire control agencies.
PE.03.01.01, EP 7: When the critical access hospital installs alcohol-based hand rub dispensers, it installs the dispensers in a manner that protects against inappropriate access.	**§485.623(*c*)(5)** A CAH may install alcohol-based hand rub dispensers in its facility if the dispensers are installed in a manner that adequately protects against inappropriate access.	**Observation** ☐ Verify that ABHR dispensers are installed in accordance with Life Safety Code requirements (see K-tag/CoP/EP Review tool) and maintained in accordance with manufacturer recommendations or established policies and procedures.

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PE.03.01.01, EP 8: When a sprinkler system is shut down for more than 10 hours, the critical access hospital either evacuates the building or portion of the building affected by the system outage until the system is back in service or establishes a fire watch until the system is back in service.	*§*485.623(c)(6) When a sprinkler system is shut down for more than 10 hours, the CAH must: (i) Evacuate the building or portion of the building affected by the system outage until the system is back in service, or (ii) Establish a fire watch until the system is back in service.	**Interview** ☐ Discuss with staff how they would handle a situation where a sprinkler system is shut down for more than 10 hours.
PE.03.01.01, EP 9: Buildings have an outside window or outside door in every sleeping room, and for any building constructed after July 5, 2016, the sill height does not exceed 36 inches above the floor. Note 1: Windows in atrium walls are considered outside windows for the purposes of this requirement. Note 2: The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours. Note 3: The sill height in special nursing care areas of new occupancies does not exceed 60 inches.	§485.623(c)(7) Buildings must have an outside window or outside door in every sleeping room, and for any building constructed after July 5, 2016, the sill height must not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows for the purposes of this requirement. (i) The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours. (ii) Special nursing care areas of new occupancies shall not exceed 60 inches.	**Observation** ☐ Use the K-tag/CoP/EP Review tool to evaluate compliance with the outside window or door requirements.
PE.04.01.01, EP 1: The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5 and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services	**§485.623(d) Standard: Building safety.** Except as otherwise provided in this section, the CAH must meet the applicable provisions and must proceed in accordance with 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). (1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to a CAH.	**Observation** ☐ Use the K-tag/CoP/EP Review tool to evaluate compliance with the Health Care Facilities Code. **Document Review** ☐ Review plans, policies and procedures, and documentation to determine compliance with Health Care Facilities Code requirements.

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may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.	(2) If application of the Health Care Facilities Code required under paragraph (d) of this section would result in unreasonable hardship for the CAH, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients.	
PE.04.01.01, EP 1 The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5 and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.	**§485.632(e)(1)(i)-(e)(1)(xi)** 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 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_federalregulations/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, Standards for Health Care Facilities Code of the National Fire	**Document Review** Review plans, policies and procedures, and documentation to determine compliance with Health Care Facilities Code requirements. Note: PE.04.01.01, EP 1 is mapped to (482.41(e)(1)(vii) through (e)(1)(xi)) PE.03.01.01, EP 3 is mapped to (482.41(e)(1)(i) through (e)(1)(vi)) **Observation** ☐ Use the K-tag/CoP/EP Review tool to evaluate compliance with the Health Care Facilities Code.

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PE.03.01.01, EP 3 The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA	Protection Association 99, 2012 edition, issued August 11, 2011. (ii) 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.	

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standard(s) referenced for the activity; and results of the activity.		

Critical Access Hospital Emergency Management Evaluation Module (485.625)

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EM.09.01.01, EP 1: The critical access hospital has a written comprehensive emergency management program that utilizes an all-hazards approach. The program includes, but is not limited to, the following: - Leadership structure and program accountability - Hazard vulnerability analysis - Mitigation and preparedness activities - Emergency operations plan and policies and procedures - Education and training - Exercises and testing - Continuity of operations plan - Disaster recovery - Program evaluation **EM.09.01.01, EP 3:** The critical access hospital complies with all applicable federal, state, and local emergency preparedness laws and regulations.	**§485.625 Condition of Participation: Emergency Preparedness** The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH **must develop and maintain a comprehensive emergency preparedness program** that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:	**Interview** □ Ask leaders to describe the CAH's emergency preparedness program. □ Ask leaders to describe how the CAH used an all-hazards approach when developing its program. **Document Review** **General** □ Verify that the CAH has a written policy on its the emergency preparedness program. ***Note:*** *CMS does not require any particular system for meeting the requirements. It is up to each CAH to be able to demonstrate in writing its emergency preparedness program.*
EM.12.01.01, EP 1: The critical access hospital has a written all-hazards emergency operations plan (EOP) with supporting policies and procedures that provides guidance to staff and volunteers on actions to take during emergency or disaster incidents. The EOP and policies and procedures include, but are not limited to, the following: - Mobilizing incident command - Communications plan - Maintaining, expanding, curtailing, or closing operations - Protecting critical systems and infrastructure - Conserving and/or supplementing resources	**§485.625(a) Emergency Plan.** The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.	**Interview** □ Ask CAH leaders to identify the hazards (for example, natural, humanmade, facility, geographic) that were identified in the CAH's risk assessment and how the risk assessment was conducted. **Document Review** □ Verify that the CAH has an emergency preparedness plan that is reviewed and updated at least every 2 years and the plan contains all the required elements that includes: ▪ Hazard vulnerability analysis ▪ Emergency operation plan and policies and procedures

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- Surge plans (such as flu or pandemic plans) - Identifying alternate treatment areas or locations - Sheltering in place - Evacuating (partial or complete) or relocating services - Safety and security - Securing information and records **EM.17.01.01, EP 3:** The critical access hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program		▪ Communications plan ▪ Continuity of operations ▪ Education and training ▪ Exercises and testing ▪ Program evaluation (after-action/improvement plans) ▪ Unified and integrated EM program (if applicable) ***Note:*** *Ask for documentation of the date of the last review and updates that were made to the plan based on the review.*
EM.11.01.01, EP 1: The critical access hospital conducts a facility-based hazard vulnerability analysis (HVA) using an all-hazards approach that includes the following: - Hazards that are likely to impact the critical access hospital's geographic region, community, facility, and patient population - A community-based risk assessment (such as those developed by external emergency management agencies) - Separate HVAs for its other accredited facilities if they significantly differ from the main site The findings are documented. Note: A separate HVA is only required if the accredited facilities are in different geographic locations, experience different hazards or	**§485.625(a)(1)-(2)** **(a) Emergency Plan.** 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.	**Interview** □ Ask CAH leaders which hazards (for example, natural, humanmade, facility, geographic) were included in the CAH's risk assessment, why they were included, and how the risk assessment was conducted. **Document Review** □ Ask to see written documentation on the CAH's risk assessments and associated strategies. o Verify that the risk assessment is based on the CAH and the community. o Ensure that the risk assessment takes an all-hazards approach specific to the geographic location of the CAH and encompasses potential hazards, such as emerging infectious diseases.

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threats, or the patient population and services offered are unique to this facility. **EM.11.01.01, EP 2:** The critical access hospital's hazard vulnerability analysis includes the following: - Natural hazards (such as flooding, wildfires) - Human-caused hazards (such as bomb threats or cyber/information technology crimes) - Technological hazards (such as utility or information technology outages) - Hazardous materials (such as radiological, nuclear, chemical) - Emerging infectious diseases (such as the Ebola, Zika, or SARS-CoV-2 viruses) **EM.11.01.01, EP 3:** The critical access hospital evaluates and prioritizes the findings of the hazard vulnerability analysis to determine what presents the highest likelihood of occurring and the impacts those hazards will have on the operating status of the critical access hospital and its ability to provide services. The findings are documented. **EM.11.01.01, EP 4:** The critical access hospital uses its prioritized hazards from the hazard vulnerability analysis to identify and implement mitigation and preparedness actions to increase the resilience of the critical access hospital and helps reduce disruption of essential services or functions.		**Note:** *Surveyors are not expected to analyze a CAH's risk assessment to determine whether the identified risks are appropriate. Surveyors may consider the geographic location and review the remaining standards to determine that the CAH has addressed the hazards within their risk assessment through their policies and procedures.*
EM.12.01.01, EP 2: The critical access hospital's emergency operations plan identifies the patient population(s) that it will serve, including at-risk populations, and the types of services it would have the ability to provide in an emergency or disaster event.	**§485.625(a)(3) [(a) Emergency Plan.** [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	**Interview** □ Ask leaders to describe the following: ○ The CAH's patient populations that would be at risk during an emergency event

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Note: At-risk populations such as the elderly, dialysis patients, or persons with physical or mental disabilities may have additional needs to be addressed during an emergency or disaster incident such as medical care, communication, transportation, supervision, and maintaining independence. **EM.13.01.01, EP 1:** The critical access hospital has a written continuity of operations plan (COOP) that is developed with the participation of key executive leaders, business and finance leaders, and other department leaders as determined by the critical access hospital. These key leaders identify and prioritize the services and functions that are considered essential or critical for maintaining operations. Note: The COOP provides guidance on how the critical access hospital will continue to perform its essential business functions to deliver essential or critical services. Essential business functions to consider include administrative/vital records, information technology, financial services, security systems, communications/telecommunications, and building operations to support essential and critical services that cannot be deferred during an emergency; these activities must be performed continuously or resumed quickly following a disruption. **EM.13.01.01, EP 2:** The critical access hospital's continuity of operations plan identifies in writing how and where it will continue to provide its essential business functions when the location of the essential or critical service has been compromised due to an emergency or disaster incident.	continuity of operations, including delegations of authority and succession plans.	○ Services that the CAH would be able to provide during an emergency and any plans to address services needed that cannot be provided by the CAH during an emergency as part of continuity of operations and services ○ How the CAH plans to continue operations during an emergency ○ How the CAH delegates authority and implements succession plans □ Ask leaders if the CAH has delegations and succession plans that use roles and responsibilities instead of staff names (for example, Safety Officer = Emergency Department Charge Nurse or Pharmacy Department Lead), identify an individual who would be designated in one of the roles and ask them to describe their role based on the CAH's emergency preparedness program. **Document Review** **General** □ Verify that the written emergency plan includes the following: ○ Addresses the patient population, including, but not limited to, persons at-risk ○ The type of services the CAH has the ability to provide in an emergency ○ Continuity of operations, including delegations of authority and succession plans

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Note: Example of options to consider for providing essential services include use of off-site locations, space maintained by another organization, existing facilities or space, telework (remote work), or telehealth. **EM.13.01.01, EP 3:** The critical access hospital has a written order of succession plan that identifies who is authorized to assume a particular leadership or management role when that person(s) is unable to fulfill their function or perform their duties. **EM.13.01.01, EP 4:** The critical access hospital has a written delegation of authority plan that provides the individual(s) with the legal authorization to act on behalf of the critical access hospital for specified purposes and to carry out specific duties. Note: Delegations of authority are an essential part of an organization's continuity program and should be sufficiently detailed to make certain the critical access hospital can perform its essential functions. Delegations of authority will specify a particular function that an individual is authorized to perform and includes restrictions and limitations associated with that authority.		
EM.12.01.01, EP 6: The critical access hospital's emergency operations plan includes a process for cooperating and collaborating with other health care facilities; health care coalitions; and local, tribal, regional, state, and federal emergency preparedness officials' efforts to leverage support and resources and to provide an integrated response during an emergency or disaster incident.	**§485.625(a)(4)** [(a) **Emergency Plan.** 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.	**Interview** □ Ask CAH leaders to describe their process for ensuring cooperation and collaboration with local, tribal, regional, state, and federal emergency preparedness officials during a disaster or emergency situation.
EM.12.01.01, EP 1: The critical access hospital has a written all-hazards emergency operations	**§485.625(b)**	**Document Review** **General**

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plan (EOP) with supporting policies and procedures that provides guidance to staff and volunteers on actions to take during emergency or disaster incidents. The EOP and policies and procedures include, but are not limited to, the following: - Mobilizing incident command - Communications plan - Maintaining, expanding, curtailing, or closing operations - Protecting critical systems and infrastructure - Conserving and/or supplementing resources - Surge plans (such as flu or pandemic plans) - Identifying alternate treatment areas or locations - Sheltering in place - Evacuating (partial or complete) or relocating services - Safety and security - Securing information and records **EM.17.01.01, EP 3:** The critical access hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program	(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.	□ Verify that the CAH has written emergency preparedness policies and procedures that are based on the emergency plan. ○ Ensure that the policies and procedures were developed with a facility- and community-based risk assessment and communication plan, using an all-hazards approach. **Note:** *Policies and procedures must be reviewed and updated at least every 2 years*.
EM.12.01.01, EP 4: The emergency operations plan includes written procedures for how the critical access hospital will provide essential needs for its staff, volunteers, and patients,	**§485.625(b)(1) [(b) Policies and procedures. The policies and procedures must be reviewed and updated at least every 2 years.**	**Document Review** **General**

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whether they shelter in place or evacuate, that includes, but is not limited to, the following: - Food and other nutritional supplies - Medications and related supplies - Medical/surgical supplies - Medical oxygen and supplies - Potable or bottled water **EM.12.02.11, EP 4:** The critical access hospital's plan for managing utilities includes alternate sources for maintaining energy to the following: - Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions - Emergency lighting - Fire detection, extinguishing, and alarm systems - Sewage and waste disposal Note: It is important for critical access hospitals to consider alternative means for maintaining temperatures at a level that protects the health and safety of all persons within the facility. For example, when safe temperature levels cannot be maintained, the critical access hospital considers partial or full evacuation or closure.	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 that the CAH's emergency preparedness policies and procedures include: ○ Provision of subsistence needs, including but not limited to food, water, and pharmaceutical supplies for patients and staff ○ Alternate sources of energy, including emergency power necessary to maintain the following: ▪ Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions ▪ Emergency lighting ▪ Fire detection, extinguishing, and alarm systems ▪ Sewage and waste disposal **Note:** *Policies and procedures must be reviewed and updated at least every 2 years.*
EM.12.02.07, EP 2: The critical access hospital's plan for safety and security measures includes a system to track the location of its on-duty staff and volunteers and patients when sheltered in place, relocated, or evacuated. If on-duty staff and volunteers and patients are relocated during an emergency, the critical access hospital documents the specific name and location of the receiving facility or evacuation location. Note: Examples of systems used for tracking purposes include the use of established technology or tracking systems or taking head counts at defined intervals.	§485.625(b)(2) Policies and Procedures. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following: (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.	**Interview** □ Ask staff to describe and/or demonstrate the tracking system used to document locations of patients and staff. **Document Review** **General** □ Verify that the CAH's emergency preparedness policies and procedures include a tracking system to be used during emergencies that includes:

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		○ A system to track the location of on-duty staff and sheltered patients in the CAH's care during an emergency. ○ If on-duty staff and sheltered patients are relocated during the emergency, the CAH must document the specific name and location of the receiving facility or other location. **Note:** *Policies and procedures must be reviewed and updated at least every 2 years.*
EM.12.01.01, EP 3: The critical access hospital's emergency operations plan includes written procedures for when and how it will shelter in place or evacuate (partial or complete) its staff, volunteers, and patients. Note 1: Shelter-in-place plans may vary by department and facility and may vary based on the type of emergency or situation. Note 2: Safe evacuation from the critical access hospital includes consideration of care, treatment, and service needs of evacuees, staff responsibilities, and transportation. **EM.12.02.01, EP 5:** The critical access hospital's communications plan identifies its primary and alternate means for communicating with staff and relevant authorities (such as federal, state, tribal, regional, and local emergency preparedness staff). The plan includes procedures for the following: - How and when alternate/backup communication methods are used - Verifying that its communications systems are compatible with those of community partners and relevant authorities the critical access hospital plans to communicate with	**§485.625(b)(3)** [(b) Policies and procedures… The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following: **(3)** 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.	**Interview** □ Ask staff to describe how they would handle a situation in which a patient refused to evacuate **Document Review** **General** □ Verify that the CAH's emergency preparedness policies and procedures include safe evacuation from the CAH, including the following: ○ Consideration of care and treatment needs of evacuees ○ Staff responsibilities ○ Transportation ○ Identification of evacuation location(s) ○ Primary and alternate means of communication with external sources of assistance **Note:** *Policies and procedures must be reviewed and updated at least every 2 years.*

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- Testing the functionality of the critical access hospital's alternate/backup communication systems or equipment Note: Examples of alternate/backup communication systems include amateur radios, portable radios, text-based notifications, cell and satellite phones, and reverse 911 notification systems.		
EM.12.01.01, EP 3: The critical access hospital's emergency operations plan includes written procedures for when and how it will shelter in place or evacuate (partial or complete) its staff, volunteers, and patients. Note 1: Shelter-in-place plans may vary by department and facility and may vary based on the type of emergency or situation. Note 2: Safe evacuation from the critical access hospital includes consideration of care, treatment, and service needs of evacuees, staff responsibilities, and transportation.	**§485.625(b)(4)** (b) Policies and procedures… The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following: **(4)** A means to shelter in place for patients, staff, and volunteers who remain in the [facility].	**Document Review** **General** □ Verify that the CAH's emergency preparedness policies and procedures include how the CAH will provide a means to shelter in place for patients, staff, and volunteers who on remain in the CAH. □ Verify that the CAH's policies and procedures for sheltering in place align with its emergency plan and risk assessment. **Note:** *Policies and procedures must be reviewed and updated at least every 2 years.*
IM.11.01.01, EP 1: The critical access hospital develops and implements policies and procedures regarding medical documentation and patient information during emergencies, including security and availability of patient records to support continuity of care. Note: These policies and procedures are based on the emergency plan, risk assessment, and emergency communication plan and are reviewed and updated at least every 2 years.	**§485.625(b)(5) ([(b)** Policies and Procedures…. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following: **(5)** A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.	**Document Review** **General** □ Verify that the CAH's emergency preparedness policies and procedures include a medical record documentation system that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records. **Note:** *Policies and procedures must be reviewed and updated at least every 2 years.*
EM.12.02.03, EP 1: The critical access hospital develops a staffing plan for managing all staff and volunteers to meet patient care needs during the duration of an emergency or disaster incident or during a patient surge. The plan	**§485.625(b)(6) (b)** Policies and procedures… The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:	**Interview** □ Ask CAH leaders to explain their staffing strategies. o Do they use volunteers?

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includes the following: - Methods for contacting off-duty staff - Acquiring staff from its other health care facilities - Use of volunteer staffing, such as staffing agencies, health care coalition support, and those deployed as part of the disaster medical assistance teams Note: If the critical access hospital determines that it will never use volunteers during disasters, this is documented in its plan. **EM.12.02.03, EP 2:** The critical access hospital's staffing plan addresses the management of all staff and volunteers as follows: - Reporting processes - Roles and responsibilities for essential functions - Integrating staffing agencies, volunteer staffing, or deployed medical assistance teams into assigned roles and responsibilities	**(6)** 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.	○ Do they have other emergency staffing strategies if no volunteers are used? **Document Review** **General** □ Verify that the CAH's emergency preparedness policies and procedures include: ○ Use of volunteers and other emergency staffing strategies during an emergency ○ Addressing surge needs during an emergency **Note:** *Policies and procedures must be reviewed and updated at least every 2 years.*
EM.12.02.05, EP 1: The critical access hospital's plan for providing patient care and clinical support includes written procedures and arrangements with other hospitals and providers for how it will share patient care information and medical documentation and how it will transfer patients to other health care facilities to maintain continuity of care.	**§485.625(b)(7)** (b) Policies and procedures… The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following: **(7)** 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.	**Interview** □ Ask CAH leaders to explain the arrangements in place for transportation in the event of an evacuation. **Document Review** **General** □ Verify that the CAH's emergency preparedness policies and procedures include written arrangements and/or agreements the CAH has with other facilities to receive patients in the event the CAH is not able to care for them during an emergency. **Note:** *Policies and procedures must be reviewed and updated at least every 2 years.*

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EM.12.01.01, EP 7: The critical access hospital must develop and implement emergency preparedness policies and procedures that address the role of the critical access hospital under a waiver declared by the Secretary, in accordance with section 1135 of the Social Security Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. Note 1: This element of performance is applicable only to critical access hospitals that receive Medicare, Medicaid, or Children's Health Insurance Program reimbursement. Note 2: For more information on 1135 waivers, visit https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Resources/Waivers-and-flexibilities and https://www.cms.gov/about-cms/agency-information/emergency/downloads/consolidated_medicare_ffs_emergency_qsas.pdf.	**§485.625(b)(8) (b)** Policies and procedures… The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following: **(8)** 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.	**Document Review** **General** □ Verify that the CAH's emergency preparedness policies and procedures include the CAH's role in providing care and treatment at alternate care sites under an 1135 waiver. **Note:** *This policy and procedure requirement does not require a CAH to have an 1135 waiver on hand at the time of the survey, as such waivers are established or granted by CMS only during a declared emergency period. Section 1135 waivers by nature are time limited.* **Note:** *Policies and procedures must be reviewed and updated at least every 2 years.*
EM.09.01.01, EP 3: The critical access hospital complies with all applicable federal, state, and local emergency preparedness laws and regulations. **EM.12.01.01, EP 1:** The critical access hospital has a written all-hazards emergency operations plan (EOP) with supporting policies and procedures that provides guidance to staff and volunteers on actions to take during emergency or disaster incidents. The EOP and policies and procedures include, but are not limited to, the following: - Mobilizing incident command - Communications plan - Maintaining, expanding, curtailing, or closing operations - Protecting critical systems and infrastructure	**§485.625(c)** The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years.	**Interview** □ Ask CAH leaders or the designee responsible for the emergency program to explain how they collaborate with federal, state, and local officials to ensure their communication plan complies with federal, state and local requirements. **Document Review** **General** □ Verify that the CAH has a written emergency preparedness communication plan, that complies with Federal, State and local laws. **Note:** *The communication plan must be reviewed and updated at least every 2 years.*

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- Conserving and/or supplementing resources - Surge plans (such as flu or pandemic plans) - Identifying alternate treatment areas or locations - Sheltering in place - Evacuating (partial or complete) or relocating services - Safety and security - Securing information and records **EM.17.01.01, EP 3:** The critical access hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program		
EM.12.02.01, EP 1: The critical access hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes the following: - Staff - Physicians and other licensed practitioners - Volunteers - Other health care organizations - Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies - Relevant community partners (such as fire, police, local incident command, public health departments)	**§485.625(c)(1) [(c) The communication plan…** must be reviewed and updated at least every 2 years. The communication plan must include all of the following: **(1)** Names and contact information for the following: **(i)** Staff. **(ii)** Entities providing services under arrangement. **(iii)** Patients' physicians **(iv)** Other [hospitals and CAHs]. **(v)** Volunteers.	**Document Review** **General** □ Verify that the CAH's emergency preparedness communication plan includes names and contact information for staff, entities under arrangement, physicians, other hospitals and CAHs, and volunteers **Note:** *CAHs that use electronic data storage should be able to provide evidence of data backup with hard copies or by demonstrating the ability to reproduce contact lists or access these data during emergencies.*

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- Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) - Other sources of assistance (such as health care coalitions) Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident.		**Note:** *The communication plan and contact information must be reviewed and updated at least every 2 years.*
EM.12.02.01, EP 1: See above	**§485.625(c)(2) [(c) The communication plan**… must be reviewed and updated at least every 2 years. 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.**	**Document Review** **General** □ Verify that the CAH's emergency preparedness communication plan includes contact information for federal, state, tribal, regional, and local emergency preparedness officials and other sources of assistance. □ Verify that the CAH has contact information for the State Survey Agency and/or public health departments. **Note:** *The communication plan and contact information must be reviewed and updated at least every 2 years.*
EM.12.02.01, EP 5: The critical access hospital's communications plan identifies its primary and alternate means for communicating with staff and relevant authorities (such as federal, state, tribal, regional, and local emergency preparedness staff). The plan includes procedures for the following: - How and when alternate/backup communication methods are used - Verifying that its communications systems are compatible with those of community partners and relevant authorities the critical access hospital plans to communicate with - Testing the functionality of the critical access	**§485.625(c)(3) The communication plan**… must be reviewed and updated at least every 2 years. 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.**	**Document Review** **General** □ Verify that the CAH's emergency preparedness communication plan includes primary and alternate means for communicating with facility staff and federal, state, tribal, regional, and local emergency management agencies. **Note:** *CAHs have the discretion to use alternate communication systems that best meet their needs.* **Note:** *The communication plan must be reviewed and updated at least every 2 years.*

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hospital's alternate/backup communication systems or equipment Note: Examples of alternate/backup communication systems include amateur radios, portable radios, text-based notifications, cell and satellite phones, and reverse 911 notification systems.		□ Verify that the CAH's communication plan includes the types of communication equipment and/or communication systems that will be used for primary and alternate means of communicating. **Note:** *CAHs may use pagers, cell phones, radio transceivers (that is, walkie-talkies), and various other radio devices (such as Ham Radio systems, as well as satellite telephone communications systems. However, those in rural or remote areas may have difficulty using some communications systems, which should be outlined with their risk assessment.* □ Verify that the CAH's communication plan includes procedures for when and how alternate communication methods will be used and who uses them. **Observation** □ Ask to see the communications equipment or communication systems listed in the plan
EM.12.02.01, EP 4: In the event of an emergency or evacuation, the critical access hospital's communications plan includes a method for sharing and/or releasing location information and medical documentation for patients under the hospital's care to the following individuals or entities, in accordance with law and regulation: - Patient's family, representative, or others involved in the care of the patient - Disaster relief organizations and relevant authorities - Other health care providers	**§485.625(c)(4)-(6) The communication plan…** must be reviewed and updated at least every 2 years. 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).	**Document Review** **General** □ Verify that the CAH's emergency preparedness communication plan includes a method for sharing information and medical documentation for patients under its care, as necessary, with other health providers to maintain the continuity of care. □ Verify that the CAH has policies and procedures addressing the means it will use to

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Note: Sharing and releasing of patient information is consistent with 45 CFR 164.510(b)(1)(ii) and (b)(4). **EM.12.02.05, EP 1:** The critical access hospital's plan for providing patient care and clinical support includes written procedures and arrangements with other hospitals and providers for how it will share patient care information and medical documentation and how it will transfer patients to other health care facilities to maintain continuity of care.	**(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).	release patient information, including the general condition and location of patients. **Note:** *The communication plan must be reviewed and updated at least every 2 years*
EM.12.02.01, EP 3: The critical access hospital's communication plan describes how the critical access hospital will communicate with and report information about its organizational needs, available occupancy, and ability to provide assistance to relevant authorities. Note: Examples of critical access hospital needs include shortages in personal protective equipment, staffing shortages, evacuation or transfer of patients, and temporary loss of part or all organization function.	**§485.625(c)(7) The communication plan**… must be reviewed and updated at least every 2 years. The communication plan must include all of the following: **(7)** 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.	**Document Review** **General** □ Verify that the CAH's emergency preparedness communication plan includes a means of providing information about the CAH's needs and its ability to provide assistance to the authority having jurisdiction, the Incident Command Center, or a designee. □ Verify that the CAH's communication plan includes a means of providing information about its occupancy. **Note:** *The communication plan must be reviewed and updated at least every 2 years.*
EM.15.01.01, EP 1: The critical access hospital has a written education and training program in emergency management that is based on the critical access hospital's prioritized risks identified as part of its hazard vulnerability analysis, the emergency operations plan, communications plan, and policies and procedures. Note: If the critical access hospital has developed multiple hazard vulnerability analyses	**§485.625(d) Training and testing.** The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.	**Document Review** **General** □ Verify that the CAH has a written training and testing program that is based on the CAH's risk assessment, has incorporated its policies and procedures, as well as its communication plan within training required for staff. **Note:** *Refer to the CAH's risk assessment when determining if the training and testing program*

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based on the location of other services offered, the education and training for those facilities are specific to their needs. **EM.16.01.01, EP 1:** The critical access hospital describes in writing a plan for when and how it will conduct annual testing of its emergency operations plan (EOP). The planned exercises are based on the following: - Likely emergencies or disaster scenarios - EOP and policies and procedures - After-action reports (AAR) and improvement plans - The six critical areas (communications, staffing, patient care and clinical support, safety and security, resources and assets, utilities) Note 1: The planned exercises should attempt to stress the limits of its emergency response procedures in order to assess how prepared the critical access hospital may be if a real event or disaster were to occur based on past experiences. Note 2: An AAR is a detailed critical summary or analysis of an emergency or disaster incident, including both planned and unplanned events. The report summarizes what took place during the event, analyzes the actions taken by participants, and provides areas needing improvement. **EM.17.01.01, EP 3:** The critical access hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and		*reflects the risks and hazards identified within the CAH's program.* **Note:** *Training and testing program must be reviewed and updated at least every 2 years.*

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procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program		
EM.15.01.01, EP 2: The critical access hospital provides initial education and training in emergency management to all new and existing staff, individuals providing services under arrangement, and volunteers that is consistent with their roles and responsibilities in an emergency. The initial education and training include the following: - Activation and deactivation of the emergency operations plan - Communications plan - Emergency response policies and procedures - Evacuation, shelter-in-place, lockdown, and surge procedures - Where and how to obtain resources and supplies for emergencies (such as procedure manuals or equipment) Documentation is required. **EM.15.01.01, EP 3:** The critical access hospital provides ongoing education and training to all staff, individuals providing services under arrangement, and volunteers that is consistent with their roles and responsibilities in an emergency. The education and training occur at the following times: - At least every two years - When roles or responsibilities change - When there are significant revisions to the emergency operations plan, policies, and/or procedures - When procedural changes are made during an emergency or disaster incident requiring just-in-	**FOR CAHs §485.625(d)(1) Training program.** The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.	**Interview** □ Ask various staff about the CAH's initial and subsequent (at least every 2 years) training courses to verify staff knowledge of emergency procedures. **Note:** *Training is intended for all new and existing staff, individuals providing services under arrangement, and volunteers. It is up to the CAH to decide what level of training each staff member will be required to complete based on an individual's involvement or expected role during an emergency.* **Document Review** **General** □ Verify that the CAH's training program provides initial and subsequent (at least every 2 years) emergency preparedness training that is consistent with staff roles during an emergency and is based on the CAH's risk assessment, policies, and procedures, as well as the communication plan. **Personnel/Credential File** □ Review a sample of staff training files to verify that staff have received initial and subsequent (at least every 2 years) emergency preparedness training. **Note:** *For ease of demonstrating compliance that the CAH has updated its training program at*

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time education and training. Documentation is required. Note 1: Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization. Note 2: Critical access hospitals are not required to retrain staff on the entire emergency operations plan but can choose to provide education and training specific to the new or revised elements of the emergency management program. **PE.03.01.01, EP 4:** The critical access hospital has written fire control plans that include provisions for prompt reporting of fires; extinguishing fires; protection of patients, staff, and guests; evacuation; and cooperation with firefighting authorities.		*least every 2 years, CAHs should retain, at a minimum, the past 2 cycles (generally 4 years) of emergency training documentation for both training and exercises.*
EM.16.01.01, EP 2: The critical access hospital is required to conduct two exercises per year to test the emergency operations plan. - One of the annual exercises must consist of an operations-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise when a community-based exercise is not possible - The other annual exercise must consist of either an operations-based or discussion-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise; or - Mock disaster drill; or - Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion	**§485.625(d)(2) Testing.** The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.	**Interview** □ Ask CAH leaders to describe the participation of managers and staff during scheduled exercises. **Document Review** **General** □ Verify that the CAH has conducted at least 2 annual exercises to test the emergency plan. The CAH is required to conduct a minimum of 2 exercises per year as follows: ○ One annual exercise must be a full-scale community- or facility-based functional exercise.

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using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. Exercises and actual emergency or disaster incidents are documented (after-action reports). Note 1: The critical access hospital would be exempt from conducting its next annual operations-based exercise if it experiences an actual emergency or disaster incident (discussion-based exercises are excluded from exemption). An exemption only applies if the critical access hospital provides documentation that it activated its emergency operations plan. Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises. **EM.17.01.01, EP 1:** The multidisciplinary committee that oversees the emergency management program reviews and evaluates all exercises and actual emergency or disaster incidents. The committee reviews after-action reports (AARs), identifies opportunities for improvement, and recommends actions to take to improve the emergency management program. The AARs and improvement plans are documented. Note 1: The review and evaluation address the effectiveness of its emergency response procedure, continuity of operations plans (if activated), training and exercise programs, evacuation procedures, surge response procedures, and activities related to communications, resources and assets, security, staff, utilities, and patients. Note 2: An AAR provides a detailed critical summary or analysis of a planned exercise or	(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.	○ The other annual exercise can be of choice, which may be a full-scale community based or a facility-based functional exercise, or the exercise may be a mock drill, tabletop exercise, or workshop. **Note:** *If the CAH experiences a real emergency that requires activation of its emergency plan, the CAH is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.* □ Ask to see documentation of the exercises conducted by the CAH which may include but is not limited to the exercise plan, the after-action report, and any additional documentation used by the CAH to support the exercise. **Note:** *CAHs are to retain, at a minimum, the past 2 cycles (generally 2 years for inpatient providers) of emergency testing exercise documentation.* □ Ask to see documentation of the CAH's efforts to identify a full-scale community-based exercise if it did not participate in one (that is, date, staff and agencies contacted, and reasons for the inability to participate). □ Verify documentation of the CAH's analysis and response to the annual exercises and how the CAH updated its emergency program based on this analysis.

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actual emergency or disaster incident. The report summarizes what took place during the event, analyzes the actions taken by participants, and provides areas needing improvement. **EM.17.01.01, EP 3:** The critical access hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program		
EM.12.02.09, EP 1: The critical access hospital's plan for managing its resources and assets describes in writing how it will document, track, monitor, and locate the following resources (on-site and off-site inventories) and assets during and after an emergency or disaster incident: - Medications and related supplies - Medical/surgical supplies - Medical gases including oxygen and supplies - Potable or bottled water and nutrition - Non-potable water - Laboratory equipment and supplies - Personal protective equipment - Fuel for operations - Equipment and nonmedical supplies to sustain operations Note: The critical access hospital should be aware of the resources and assets it has readily available and what resources and assets may be	§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. §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.	**Document Review** **General** □ Verify that the CAH has the required emergency and standby power systems to meet the requirements of its emergency plan and corresponding policies and procedures. □ Verify that the CAH's emergency plan for "shelter in place" and evacuation plans include its emergency power supply systems (EPSS) or plans to maintain safe operations while sheltering in place. □ Verify that CAHs under construction or with existing buildings being renovated have a written plan to relocate the emergency power supply systems (EPSS) by the time construction is completed.

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quickly depleted depending on the type of emergency or disaster incident. **EM.12.02.09, EP 2:** The critical access hospital's plan for managing its resources and assets describes in writing how it will obtain, allocate, mobilize, replenish, and conserve its resources and assets during and after an emergency or disaster incident, including the following: - If part of a health care system, coordinating within the system to request resources - Coordinating with local supply chains or vendors - Coordinating with local, state, or federal agencies for additional resources - Coordinating with regional health care coalitions for additional resources - Managing donations (such as food, water, equipment, materials) Note: High priority should be given to resources that are known to deplete quickly and are extremely competitive to acquire and replenish (such as fuel, oxygen, personal protective equipment, ventilators, intravenous fluids, antiviral and antibiotic medications). **EM.12.02.11, EP 1:** The critical access hospital's plan for managing utilities describes in writing the utility systems that it considers as essential or critical to provide care, treatment, and services. Note: Essential or critical utilities to consider may include systems for electrical distribution; emergency power; vertical and horizontal transport; heating, ventilation, and air conditioning; plumbing and steam boilers; medical gas; medical/surgical vacuum; and network or communication systems.	**§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. **§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.	□ Verify that CAHs with permanently attached generators evaluate and maintain their on-site fuel source in accordance with NFPA 110 and have a plan for how to keep the generator operational during an emergency, unless they plan to evacuate.

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EM.12.02.11, EP 2: The critical access hospital's plan for managing utilities describes in writing how it will continue to maintain essential or critical utility systems if one or more are impacted during an emergency or disaster incident. **EM.12.02.11, EP 3:** The critical access hospital's plan for managing utilities describes in writing alternative means for providing essential or critical utilities, such as water supply, emergency power supply systems, fuel storage tanks, and emergency generators. **PE.03.01.01, EP 3:** The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only		

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if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity. **PE.04.01.01, EP 1:** The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5 and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the		

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activity; NFPA standard(s) referenced for the activity; and results of the activity. **PE.04.01.03, EP 3:** The critical access hospital meets the emergency power system and generator requirements found in NFPA 99-2012 Health Care Facilities Code, NFPA 110-2010 Standard for Emergency and Standby Power Systems, and NFPA 101-2012 Life Safety Code requirements.		
EM.09.01.01, EP 2: If the critical access hospital is part of a health care system that has a unified and integrated emergency management program and it chooses to participate in the program, the following must be demonstrated within the coordinated emergency management program: - Each separately certified critical access hospital within the system actively participates in the development of the unified and integrated emergency management program - The program is developed and maintained in a manner that takes into account each separately certified critical access hospital's unique circumstances, patient population, and services offered - Each separately certified critical access hospital is capable of actively using the unified and integrated emergency management program and is in compliance with the program - Documented community-based risk assessment utilizing an all-hazards approach - Documented individual, facility-based risk assessment utilizing an all-hazards approach for each separately certified critical access hospital within the health care system - Unified and integrated emergency plan - Integrated policies and procedures	**§485.625(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	**Interview** □ If the CAH has opted to participate in its health care system's unified and integrated emergency preparedness program, ask CAH leaders to describe how the program is updated based on changes within the health care system, such as when facilities enter or leave the system. **Document Review** **General** □ Verify whether the CAH has opted to be part of its health care system's unified and integrated emergency preparedness program. Note: *This is optional for separately certified CAHs.* □ If the CAH has opted to participate in its health care system's unified and integrated emergency preparedness program, ask to see documentation of its inclusion in the program. ▪ Verify that the CAH was actively involved in the development of the unified emergency preparedness program. ▪ Verify that the CAH was actively involved in the review of program requirements and updates.

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- Coordinated communication plan - Training and testing program **EM.09.01.01, EP 3:** The critical access hospital complies with all applicable federal, state, and local emergency preparedness laws and regulations. **EM.11.01.01, EP 3:** The critical access hospital evaluates and prioritizes the findings of the hazard vulnerability analysis to determine what presents the highest likelihood of occurring and the impacts those hazards will have on the operating status of the critical access hospital and its ability to provide services. The findings are documented. **EM.11.01.01, EP 4:** The critical access hospital uses its prioritized hazards from the hazard vulnerability analysis to identify and implement mitigation and preparedness actions to increase the resilience of the critical access hospital and helps reduce disruption of essential services or functions. **EM.12.01.01, EP 1:** The critical access hospital has a written all-hazards emergency operations plan (EOP) with supporting policies and procedures that provides guidance to staff and volunteers on actions to take during emergency or disaster incidents. The EOP and policies and procedures include, but are not limited to, the following: - Mobilizing incident command - Communications plan - Maintaining, expanding, curtailing, or closing operations - Protecting critical systems and infrastructure	(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.	□ Ask to see a copy of the integrated and unified emergency preparedness program and all required components (emergency plan, policies and procedures, communication plan, training and testing program).

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- Conserving and/or supplementing resources - Surge plans (such as flu or pandemic plans) - Identifying alternate treatment areas or locations - Sheltering in place - Evacuating (partial or complete) or relocating services - Safety and security - Securing information and records **EM.12.01.01, EP 2:** The critical access hospital's emergency operations plan identifies the patient population(s) that it will serve, including at-risk populations, and the types of services it would have the ability to provide in an emergency or disaster event. Note: At-risk populations such as the elderly, dialysis patients, or persons with physical or mental disabilities may have additional needs to be addressed during an emergency or disaster incident such as medical care, communication, transportation, supervision, and maintaining independence. **EM.12.01.01, EP 6:** The critical access hospital's emergency operations plan includes a process for cooperating and collaborating with other health care facilities; health care coalitions; and local, tribal, regional, state, and federal emergency preparedness officials' efforts to leverage support and resources and to provide an integrated response during an emergency or disaster incident. **EM.13.01.01, EP 1:** The critical access hospital has a written continuity of operations plan (COOP) that is developed with the participation of key executive leaders, business and finance		

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leaders, and other department leaders as determined by the critical access hospital. These key leaders identify and prioritize the services and functions that are considered essential or critical for maintaining operations. Note: The COOP provides guidance on how the critical access hospital will continue to perform its essential business functions to deliver essential or critical services. Essential business functions to consider include administrative/vital records, information technology, financial services, security systems, communications/telecommunications, and building operations to support essential and critical services that cannot be deferred during an emergency; these activities must be performed continuously or resumed quickly following a disruption. **EM.13.01.01, EP 2:** The critical access hospital's continuity of operations plan identifies in writing how and where it will continue to provide its essential business functions when the location of the essential or critical service has been compromised due to an emergency or disaster incident. Note: Example of options to consider for providing essential services include use of off-site locations, space maintained by another organization, existing facilities or space, telework (remote work), or telehealth. **EM.13.01.01, EP 3:** The critical access hospital has a written order of succession plan that identifies who is authorized to assume a particular leadership or management role when that person(s) is unable to fulfill their function or perform their duties.		

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EM.13.01.01, EP 4: The critical access hospital has a written delegation of authority plan that provides the individual(s) with the legal authorization to act on behalf of the critical access hospital for specified purposes and to carry out specific duties. Note: Delegations of authority are an essential part of an organization's continuity program and should be sufficiently detailed to make certain the critical access hospital can perform its essential functions. Delegations of authority will specify a particular function that an individual is authorized to perform and includes restrictions and limitations associated with that authority. **EM.15.01.01, EP 1:** The critical access hospital has a written education and training program in emergency management that is based on the critical access hospital's prioritized risks identified as part of its hazard vulnerability analysis, the emergency operations plan, communications plan, and policies and procedures. Note: If the critical access hospital has developed multiple hazard vulnerability analyses based on the location of other services offered, the education and training for those facilities are specific to their needs. **EM.16.01.01, EP 1:** The critical access hospital describes in writing a plan for when and how it will conduct annual testing of its emergency operations plan (EOP). The planned exercises are based on the following: - Likely emergencies or disaster scenarios - EOP and policies and procedures - After-action reports (AAR) and improvement		

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plans - Six critical areas (communications, staffing, patient care and clinical support, safety and security, resources and assets, utilities) Note 1: The planned exercises should attempt to stress the limits of its emergency response procedures in order to assess how prepared the critical access hospital may be if a real event or disaster were to occur based on past experiences. Note 2: An AAR is a detailed critical summary or analysis of an emergency or disaster incident, including both planned and unplanned events. The report summarizes what took place during the event, analyzes the actions taken by participants, and provides areas needing improvement. **EM.17.01.01, EP 3:** The critical access hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program		

Critical Access Hospital Governing Body Evaluation Module (485.627)

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LD.11.01.01, EP 1: The critical access hospital has a governing body or an individual that assumes full legal responsibility for determining, implementing, and monitoring policies governing the critical access hospital's total operation and for administering those policies to provide quality health care in a safe environment.	***§485.627(a) Standard: Governing Body or Responsible Individual*** The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing and monitoring policies governing the CAH's total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment.	**Interview** Medical staff leader and staff responsible for medical staff operations to verify that: ☐ The governing body (or responsible individual) appoints all members to the medical staff, in accordance with established policies, based on the individual practitioner's scope of clinical expertise and according to federal and state law. ☐ Any individual providing patient care services is a member of the medical staff or is accountable to a member of the medical staff qualified to evaluate the quality of services provided. ☐ The medical staff is accountable to the governing body (or responsible individual) for the quality of care provided to patients. ☐ The selection of medical staff for membership, both new and renewal, is based on an individual practitioner's compliance with the medical staff's membership criteria. ☐ At a minimum, criteria for selection of new medical staff members and current medical staff members for continued membership include individual character, competence, training, experience, and judgment. **Document Review** **General** Verify that the CAH ☐ Has an organized governing body or has written documentation that identifies the individual responsible for the conduct of CAH operations. ☐ Governing body (or responsible individual) has determined and stated the categories of practitioners

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		who are eligible candidates for appointment to the medical staff. ☐ Operating policies have been updated to fully reflect its responsibilities as a CAH (for example, physician assistant responsibilities, provision of required CAH direct services). ☐ Governing body or the individual who assumes responsibility for CAH operations is involved in the day-to-day operation of the CAH and is fully responsible for its operations. ☐ Revisions or modifications to the medical staff bylaws, rules, and policies have been approved by the medical staff and the governing body (or responsible individual). ☐ Has written criteria for appointments to the medical staff. ☐ Medical staff operates under current bylaws that are in accordance with federal and state law and regulations. ☐ Medical staff operates under current bylaws, rules, and policies that have been approved by the governing body (or responsible individual). ☐ Governing body (or responsible individual) is periodically apprised of the medical staff evaluation of patient care services provided at every CAH location. **Personnel/Credential File** ☐ Review a sample of records of medical staff appointments to substantiate the governing body's (or responsible individual's) involvement in appointments of medical staff members.

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LD.13.02.01, EP 1: The critical access hospital discloses the names and addresses of the following: - The person principally responsible for the operation of the critical access hospital - The person responsible for medical direction of the critical access hospital	**§485.627(b) Standard: Disclosure** The CAH discloses the names and addresses of— **§485.627(b)(1)** (1) The person principally responsible for the operation of the CAH; and **§485.627(b)(2)** (2) The person responsible for medical direction.	**Interview** CAH leaders and administration staff about processes for reporting to the State agency any changes in the ☐ Person principally responsible for CAH operations. ☐ Medical director.

Critical Access Hospital Governing Body Evaluation Module Continued (Additional Joint Commission Requirements)

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NPG.12.02.01, EP 2: The nurse executive assumes an active leadership role with the critical access hospital's governing body, senior leadership, medical staff, management, and other clinical leaders in the critical access hospital's decision-making structure and process. Note 1: The nurse executive possesses a postgraduate degree in nursing or a related field, the knowledge and skills associated with an advanced degree, or a written plan to obtain these qualifications. Note 2: A related field may include health care administration or business administration.	**Document:** ☐ Review governing body meeting minutes to ensure that the nurse executive assumes an active leadership role and a part of the critical access hospital's decision-making structure and process **Personnel File Review:** ☐ Ensure the nurse executive has a postgraduate degree in nursing or related field, the knowledge and skills associated with an advanced degree, or a written plan to obtain these qualifications.
NPG.12.02.01, EP 9: The nurse executive is responsible for monitoring the effectiveness of the nurse staffing plan.	**Document:** ☐ Verify that the nurse executive is monitoring the nurse staffing plan and making adjustments as needed
LD.11.01.01, EP 3: The governing body provides the organized medical staff with the opportunity to be represented at governing body meetings (through attendance and voice) by one or more of its members, as selected by the organized medical staff. **LD.11.01.01, EP 4:** Organized medical staff members are eligible for full membership in the critical access hospital's governing body, unless legally prohibited.	**Document:** ☐ Review governing body meeting minutes to ensure that the medical staff is eligible for full membership of the governing body and is represented through attendance or voice
MS.17.01.03, EP 1: The governing body approves the credentialing process. **MS.17.01.03, EP 2:** The critical access hospital verifies that the physician or other licensed practitioner requesting approval is the same person identified in the credentialing documents by viewing one of the following: - Current picture hospital ID card - Valid picture ID issued by a state or federal agency (for example, a driver's license or passport)	**Documentation** **General** ☐ Verify the governing body has approved the credentialing process **Credential File Review** ☐ Verify that the physician or other licensed practitioner requesting approval if verified by a photo

MS.17.02.01, EP 3: An applicant submits a statement that no health problems exist that could affect their ability to perform the privileges requested. **MS.17.02.01, EP 4:** The critical access hospital queries the National Practitioner Data Bank (NPDB) in accordance with applicable law and regulation. **MS.17.02.01, EP 5:** Completed applications for privileges are acted on within the time period specified in the medical staff bylaws, rules, and regulations, or in policies and procedures. **MS.17.02.01, EP 8:** The critical access hospital uses participation in continuing education in decisions about reappointment to medical staff membership, or renewal or revision of individual clinical privileges.	**See survey process for 485.627**

Critical Access Hospital Staffing and Staff Responsibilities Evaluation Module (485.631)

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NPG.12.01.01, EP 3: The critical access hospital has a professional health care staff that includes one or more doctors of medicine or osteopathy and may include one or more physician assistants, nurse practitioners, or clinical nurse specialists. **HR.11.01.03, EP 2:** Professional staff supervise ancillary staff. **NPG.12.01.01, EP 1:** Leaders provide for an adequate number and mix of qualified individuals to support safe, quality care, treatment, and services. Note 1: The number and mix of individuals is appropriate to the scope and complexity of the services offered. Services may include but are not limited to the following: - Rehabilitation services - Emergency services - Outpatient services - Respiratory services - Pharmaceutical services, including emergency pharmaceutical services - Diagnostic and therapeutic radiology services Note 2: Emergency services staff are qualified in emergency care. Note 3: For rehabilitation and psychiatric distinct part units in critical access hospitals: As of the first day of the first cost reporting period for which all other exclusion requirements are met, the unit is fully equipped and staffed and is capable of providing hospital inpatient psychiatric or rehabilitation care regardless of whether	**§485.631(a) Standard: Staffing** **(1)** The CAH has a professional health care staff that includes one or more doctors of medicine or osteopathy, and may include one or more physician assistants, nurse practitioners, or clinical nurse specialists. **§485.631(a)(2)** Any ancillary personnel are supervised by the professional staff. **§485.631(a)(3)** The staff is sufficient to provide the services essential to the operation of the CAH. **§485.631(a)(4)** A doctor of medicine or osteopathy, nurse practitioner, clinical nurse specialist, or physician assistant is available to furnish patient care services at all times the CAH operates. **§485.631(a)(5)** A registered nurse, clinical nurse specialist, or licensed practical nurse is on duty whenever the CAH has one or more inpatients.	**Interview** ☐ CAH leaders and administration staff about processes to ensure that staff coverage is sufficient to provide essential services at the facility (e.g., emergency services, direct services, and nursing services). ☐ If the CAH does not have regular announced hours of operation, ask the individual who is principally responsible for the operation of the CAH, when is the CAH is open to the public to provide outpatient services. ☐ What kinds of arrangements have been made by the CAH to ensure that a practitioner is available on site at all times the CAH operates to furnish patient care services? **Document Review** **General** ☐ Review listings or organizational charts showing the names of all staff MD/DOs, nurse practitioners, clinical nurse specialists and physician assistants on the CAH staff. ☐ Review work schedules showing normal CAH hours of operation and coverage by members of the CAH staff. ☐ Use organizational charts and staff interviews to determine how the CAH ensures that the professional staff supervises all ancillary personnel. ☐ Review staffing schedules and daily census records. ☐ Review nursing staff schedules to ensure that a registered nurse, clinical nurse specialist or licensed practical nurse is on duty whenever the CAH has one or more inpatients.

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there are any inpatients in the unit on that date. **NPG.12.01.01, EP 4:** A doctor of medicine or osteopathy, physician's assistant, nurse practitioner, or clinical nurse specialist is available to provide patient care at all times when the critical access hospital is in operation. **NPG.12.02.01, EP 3:** A registered nurse, clinical nurse specialist, or licensed practical nurse is on duty whenever the critical access hospital has one or more inpatients.		
LD.13.01.09, EP 2: The doctor of medicine or osteopathy, in conjunction with the physician assistant, nurse practitioner, or clinical nurse specialist, participates in developing, executing, and periodically reviewing the critical access hospital's written policies governing the services provided. **MS.16.01.03, EP 6:** The doctor of medicine or osteopathy provides medical direction for the critical access hospital's health care activities and consultation for, and medical staff supervision of, the health care staff. **MS.16.01.03, EP 8:** The doctor of medicine or osteopathy, in conjunction with the physician assistant and/or nurse practitioner members of the critical access hospital staff, provides medical orders and medical care services to the critical access hospital's patients. **MS.16.01.03, EP 10:** The doctor of medicine or osteopathy, in conjunction with the physician assistant, the nurse practitioner, and/or clinical nurse specialist members of	**§485.631(b) Standard: Responsibilities of the Doctor of Medicine or Osteopathy** **485.631(b)(1)** The doctor of medicine or osteopathy-- (i) Provides medical direction for the CAH'S health care activities and consultation for, and medical supervision of, the health care staff; **§485.631(b)(1)(ii)** In conjunction with the physician assistant and/or nurse practitioner member(s), participates in developing, executing, and periodically reviewing the CAH'S written policies governing the services it furnishes. **§485.631(b)(1)(iii)** In conjunction with the physician assistant and/or nurse practitioner members, periodically reviews the CAH'S patient records, provides medical orders, and provides medical care services to the patients of the CAH; and **§485.631(b)(1)(iv)** Periodically reviews and signs the records of all inpatients cared for	**Interview** ☐ CAH leaders, administration staff and clinical leaders about who is providing medical direction for the CAH's health care activities. ☐ Confirm that there is an MD/DO on the CAH staff. ☐ Determine if this MD/DO is responsible for all of the CAH's medical oversight functions. ☐ Determine if there is evidence that an MD/DO is providing medical direction for the CAH's health care activities and is available for consultation and supervision of the health care staff. ☐ Determine if there is evidence that demonstrates an MD/DO participates in the development of policies governing CAH services. ☐ Confirm that the CAH has an MD/DO periodically review the policies that govern the services it furnishes. **Document Review** **Patient Health Record** ☐ Determine if an MD/DO periodically reviews CAH patient records in conjunction with staff mid-level practitioners and provides medical care to patients.

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the critical access hospital staff, periodically review the patients' records.
 	
MS.16.01.03, EP 11: The doctor of medicine or osteopathy periodically reviews and signs the records of all inpatients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants.
 	
MS.16.01.03, EP 12: The doctor of medicine or osteopathy periodically reviews and signs a sample of outpatient records of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants.
Note: Outpatient records are reviewed to the extent required by state law where state law requires outpatient record reviews, cosignatures, or both by a collaborating physician.
	by nurse practitioners, clinical nurse specialists, or physician assistants.
	
	§485.631(b)(1)(v) Periodically reviews and signs a sample of outpatient records of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants only to the extent required under State law where State law requires record reviews or co-signatures, or both, by a collaborating physician.
		§485.631(b)(1)(iv)-(v) Select a sample of inpatient and outpatient records, including both open and closed records.
		
		- For inpatient records of patients whose care is/was managed by a non-physician practitioner, verify that:
		  - An MD/DO has reviewed and signed all records that were open at the time of the review, and all inpatient records that were closed since the MD/DO's last review; and
		  - That reviews take place within the timeframe specified by the CAH's policy.
		  - If State law requires a physician to review or co-sign (or both) any outpatient records of patients whose care is/was managed by non-physician practitioner, determine whether an MD or DO has reviewed and/or co-signed a representative sample of these records within the timeframe specified in the CAH's policies.
		  - Ask the CAH how many outpatient encounters are managed by non-physician practitioners, what sample size its policy requires to have an MD/DO review, and what timeframe its policy specifies for reviews.
		  - Ask the CAH to explain how it ensures the sample is representative of the various non-physician practitioners as well as of the various types of outpatient services they provide.
		  - Ask the CAH to describe the method it uses to make sure that reviews are performed in a timely manner on a sample that complies with the CAH's policy.
		  - Review selected records from the CAH's outpatient sample to verify that there is evidence of an MD or DO review and/or signature.

MS.16.01.03, EP 13: A doctor of medicine or osteopathy is present for sufficient periods of	**§485.631(b)(2)** A doctor of medicine or osteopathy is present for sufficient periods of	**Document Review** **General**

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time to provide medical direction, consultation, and supervision for the services provided in the critical access hospital, and is available through direct radio, telephone, or electronic communication for consultation, assistance with medical emergencies, or patient referral.	time to provide medical direction, consultation, and supervision for the services provided in the CAH, and is available through direct radio or telephone communication or electronic communication for consultation, assistance with medical emergencies, or patient referral.	☐ Does the CAH have policies and procedures that address the minimum amount of time and frequency of MD or DO presence on-site at the CAH? Can the CAH demonstrate how its policy reflects the volume and type of services the CAH provides such that there is sufficient MD/DO presence on-site to support the services provided? ☐ Is there documentation showing that an MD or DO is on-site for the frequency and duration specified in the CAH's policies? ☐ Can the CAH demonstrate that an MD or DO is always available by telecommunications contact for consultation, assistance and/or patient referral?
LD.13.01.09, EP 2: The doctor of medicine or osteopathy, in conjunction with the physician assistant, nurse practitioner, or clinical nurse specialist, participates in developing, executing, and periodically reviewing the critical access hospital's written policies governing the services provided. **MS.16.01.03, EP 10:** The doctor of medicine or osteopathy, in conjunction with the physician assistant, the nurse practitioner, and/or clinical nurse specialist members of the critical access hospital staff, periodically review the patients' records.	**§485.631(c)(1)** The physician assistant, the nurse practitioner, or clinical nurse specialist members of the CAH'S staff-- **(i)** Participate in the development, execution and periodic review of the written policies governing the services the CAH furnishes; and **(ii)** Participate with a doctor of medicine or osteopathy in a periodic review of the patients' health records.	**Interview** ☐ Interview any mid-level professional staff to ascertain their level of involvement in CAH policy development, execution, and periodic review. ☐ How does the CAH ensure that mid-level practitioners at the CAH participate with an MD/DO in the review of their patients' health records? **Document review** **General** Does the CAH ensure that policies are updated to remain consistent with State standards of practice requirements for mid-level practitioners?
MS.16.01.03, EP 9: If not being performed by a doctor of medicine or osteopathy, the physician assistant, nurse practitioner, or clinical nurse specialist performs the following functions: - Provides services in accordance with the critical access hospital's policies - Arranges for, or refers patients to, needed services that cannot be furnished at the critical access hospital	**§485.631(c)(2)** The physician assistant, nurse practitioner, or clinical nurse specialist performs the following functions to the extent they are not being performed by a doctor of medicine or osteopathy: **(i)** Provides services in accordance with the CAH'S policies. **(ii)** Arranges for, or refers patients to, needed services that cannot be furnished at the	**Interview** ☐ Interview mid-level practitioners to gauge their knowledge and application of CAH policies. **Document Review** **General** ☐ Review policies and procedures. ☐ Verify that there are policies and procedures for transferring patients to other facilities.

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- Maintains and transfers patient records when patients are referred	CAH, and assures that adequate patient health records are maintained and transferred as required when patients are referred.	
MS.16.01.03, EP 7: Whenever a patient is admitted to the critical access hospital by a nurse practitioner, physician assistant, or clinical nurse specialist, a doctor of medicine or osteopathy on the staff is notified of the admission.	**§485.631(c)(3)** Whenever a patient is admitted to the CAH by a nurse practitioner, physician assistant, or clinical nurse specialist, a doctor of medicine or osteopathy on the staff of the CAH is notified of the admission.	**Interview** ☐ Verify that admitting privileges are limited to those categories of practitioners as allowed by State law. ☐ Verify that patients are admitted only by those practitioners who are currently licensed and have been granted admitting privileges by the governing body (or responsible individual) in accordance with State laws and medical staff bylaws. ☐ Verify that an MD/DO is responsible for and is monitoring the care of each Medicare or Medicaid patient for all medical problems during the hospitalization. ☐ If mid-level practitioners admit patients, verify that every Medicare/Medicaid patient is being monitored by an MD/DO who is responsible for any medical problem outside the scope of practice of the admitting practitioners.
MS.17.01.03, EP 8: The quality and appropriateness of the diagnosis and treatment provided by nurse practitioners, clinical nurse specialists, and physician assistants are evaluated by a member of the critical access hospital's medical staff who is a doctor of medicine or osteopathy or by another doctor of medicine or osteopathy under contract with the organization. **MS.17.01.03, EP 9:** The quality and appropriateness of the diagnosis and treatment provided by doctors of medicine or osteopathy at the critical access hospital are evaluated by one of the following: - A hospital that is a member of the network,	**§485.631(d) Standard: Periodic review of clinical privileges and performance. The CAH requires that -** **§485.631(d)(1)** The quality and appropriateness of the diagnosis and treatment furnished by nurse practitioners, clinical nurse specialist, and physician assistants at the CAH are evaluated by a member of the CAH staff who is a doctor of medicine or osteopathy or by another doctor of medicine or osteopathy under contract with the CAH. **§485.631(d)(2)** The quality and appropriateness of the diagnosis and treatment furnished by	**Survey Procedure Guidance is pending and will be updated in a future release.** **Document Review** **General** ☐ Review listing or organizational chart showing the names of all staff MD/DOs, nurse practitioners, clinical nurse specialists and physicians on the CAH staff ☐ Review policies and procedures on the review of clinical privileges and performance ☐ Determine if the quality and appropriateness of the diagnosis and treatment furnished by non-physician licensed practitioners are evaluated by a doctor of medicine or osteopathy who is on the CAH staff or under contract with the CAH.

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when applicable - A quality improvement organization or equivalent entity - Another appropriate and qualified entity identified in the state's rural health care plan Note: In the case of distant-site physicians and practitioners providing telemedicine services to the critical access hospital's patients under an agreement between the critical access hospital and a distant hospital or between the critical access hospital and a distant-site telemedicine entity, the quality and appropriateness of the diagnosis and treatment provided is evaluated by one of the entities listed in this element of performance.	doctors of medicine or osteopathy at the CAH are evaluated by— **§485.631(d)(2)(i)** One hospital that is a member of the network, when applicable; **§485.631(d)(2)(ii)** One Quality Improvement Organization (QIO) or equivalent entity; **§485.631(d)(2)(iii)** One other appropriate and qualified entity identified in the State rural health care plan;	☐ Determine if the quality and appropriateness of the diagnosis and treatment provided by doctors or medicine or osteopathy at the CAH are evaluated by one of the following: ○ A hospital that is a member of the network (if applicable); ○ A quality improvement organization (QIO) or equivalent entity; or ○ Another appropriate and qualified entity identified in the state's rural health care plan
MS.17.01.03, EP 9: See above	**§485.631(d)(2)(iv)** In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patient under an agreement between the CAH and a distant-site hospital, the distant-site hospital; or **§485.631(d)(2)(v)** In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patients under a written agreement between the CAH and a distant-site telemedicine entity, one of the entities listed in paragraphs (d)(2)(i) through (iii) of this section.	**Document Review** **General** ☐ If the hospital provides telemedicine services to its patients under an agreement with a distant-site hospital or distant-site entity, determine if the quality and appropriateness of the diagnosis and treatment provided by doctors or medicine or osteopathy at the CAH are evaluated by one of the following: ○ A hospital that is a member of the network (if applicable); ○ A quality improvement organization (QIO) or equivalent entity; or ○ Another appropriate and qualified entity identified in the state's rural health care plan
MS.17.01.03, EP 10: The critical access hospital medical staff reviews the findings from the evaluations of doctors of medicine or osteopathy, including any findings or	**§485.631(d)(3)** The CAH staff consider the findings of the evaluation and make the necessary changes	**Interview** Ask how the CAH staff incorporates the feedback from the hospital, QIO, or other appropriate and qualified entity of the diagnosis and treatment provided by doctors of

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recommendations of the quality improvement organization, and makes the necessary changes as specified in 42 CFR 485.631 paragraphs (b) through (d).	as specified in paragraphs (b) through (d) of this section.	medicine or osteopathy when reviewing clinical privileges and performance. **Document Review** **General** ☐ Look for feedback provided by hospitals, QIO or other appropriate and qualified entities on the diagnosis and treatment provided by doctors of medicine or osteopathy.
MS.14.03.01, EP 1: If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals, and the system chooses to establish a unified and integrated medical staff, in accordance with state and local laws, the following occurs: Each separately accredited critical access hospital demonstrates that its medical staff members (that is, all medical staff members who hold privileges to practice at that specific hospital) have voted by majority, in accordance with medical staff bylaws, either to accept the unified and integrated medical staff structure or to opt out of such a structure and maintain a separate and distinct medical staff for their critical access hospital.	**§485.631(e) Standard: Unified and integrated medical staff for a CAH in a multi-facility system.** If a CAH is part of a system consisting of multiple separately certified hospitals, CAHs, and/or REHs, and the system elects to have a unified and integrated medical staff for its member hospitals, CAHs, and/or REHs after determining that such a decision is in accordance with all applicable state and local laws, each separately certified CAH must demonstrate that: **§485.631(e)(1)** The medical staff members of each separately certified CAH in the system (that is, all medical staff members who hold specific privileges to practice at that CAH) have voted by majority, in accordance with medical staff bylaws, either to accept a unified and integrated medical staff structure or to opt out of such a structure and to maintain a separate and distinct medical staff for their respective CAH;	**Interview** ☐ Ask the members of the medical staff whether there has ever been a vote on the question of opting out of using a unified medical staff? ☐ Can the critical access hospital readily identify the medical staff members who are eligible to vote on whether to accept or opt out of a unified medical staff? **Document Review** **General** ☐ Is there documentation that clearly describes a process by which a vote to opt out of using a unified medical staff may be requested and conducted?
MS.14.03.01, EP 4: If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical	**§485.631(e)(2)** The unified and integrated medical staff has bylaws, rules, and requirements that	**Document Review** **General**

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access hospitals, and/or rural emergency hospitals, and the system chooses to establish a unified and integrated medical staff, the united and integrated medical staff bylaws, rules, and requirements include the following: - Process for self-governance, appointment, credentialing, privileging, and oversight, as well as its peer review policies and due process rights guarantees - Description of the process by which medical staff members at each separately accredited hospital (that is, all medical staff members who hold privileges to practice at that specific hospital) are advised of their right to opt out of the unified and integrated medical staff structure after a majority vote by the members to maintain a separate and distinct medical staff for their respective critical access hospital	describe its processes for self-governance, appointment, credentialing, privileging, and oversight, as well as its peer review policies and due process rights guarantees, and which include a process for the members of the medical staff of each separately certified CAH (that is, all medical staff members who hold specific privileges to practice at that CAH) to be advised of their rights to opt out of the unified and integrated medical staff structure after a majority vote by the members to maintain a separate and distinct medical staff for their CAH;	☐ Determine if the unified medical staff bylaws, rules, or requirements clearly describe how and when voting members holding privileges at the hospital are advised of their rights. **Personnel/Credential File** ☐ Review a sample of credentialing and privileging files of members of the medical staff for evidence of their being notified of their right to vote by majority to opt out of using a unified medical staff. **Interview** ☐ Ask how the unified medical staff bylaws define a "majority" for the purpose of an opt-out vote of using a unified medical staff. If the bylaws require a supermajority, ask for evidence that this is consistent with the way "majority" is defined for other amendments to the bylaws. ☐ Interview several members of the medical staff to determine if they recall being notified of their right to vote by majority to opt out of using a unified medical staff.
MS.14.03.01, EP 2: If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals, and the system chooses to establish a unified and integrated medical staff, the following occurs: The unified and integrated medical staff takes into account each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital, critical access hospital, and rural emergency hospital.	**§485.631(e)(3)** The unified and integrated medical staff is established in a manner that takes into account each member CAH's unique circumstances and any significant differences in patient populations and services offered in each hospital, CAH, and REH; and	**Interview** ☐ Ask hospital and medical staff leaders to describe the other types of hospitals, critical access hospitals, or rural emergency hospitals in the system with which it shares a unified medical staff. How are the different types of hospital's unique circumstances addressed?

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MS.14.03.01, EP 3: If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals, and the system chooses to establish a unified and integrated medical staff, the following occurs: The unified and integrated medical staff establishes and implements policies and procedures and mechanisms to make certain that the needs and concerns expressed by members of the medical staff at each of its separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals, regardless of practice or location, are duly considered and addressed.	**§485.631(e)(4)** The unified and integrated medical staff establishes and implements policies and procedures to ensure that the needs and concerns expressed by members of the medical staff, at each of its separately certified hospitals, CAHs, and REHs, regardless of practice or location, are given due consideration, and that the unified and integrated medical staff has mechanisms in place to ensure that issues localized to particular hospitals, CAHs, and REHs are duly considered and addressed.	**Document Review** **General** ☐ Verify that the unified medical staff has policies and procedures addressing how members can raise local concerns and needs. Do the policies and procedures cover the following: ○ The process for raising their local concerns and needs with the unified medical staff's leadership; ○ How members are informed of the process by which they can raise their local concerns and needs; ○ The process for referring the concerns and needs raised to the appropriate committee or other group within the medical staff for due consideration; and ○ The process for documenting the outcome of the medical staff's review of the concerns and needs raised. **Interview** ☐ Ask the critical access hospital and medical staff leaders whether any members practicing at the hospital have raised concerns or needs. **If yes, ask for documentation showing how the concern or need was considered and addressed by the unified medical staff.** ☐ Ask members of the medical staff if they are aware that they can raise local concerns or needs with leaders of the unified medical staff.

Critical Access Hospital Staffing and Staff Responsibilities Evaluation Module Continued (Additional Joint Commission Requirements)

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MS.16.01.01, EP 2: Physician members of the organized medical staff are designated to perform the oversight activities of the organized medical staff. **MS.16.01.01, EP 3:** Physicians and other licensed practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff. **MS.16.01.01, EP 7:** The organized medical staff does the following: - Defines when a medical history and physical examination must be validated and countersigned by a physician with appropriate privileges - Specifies the minimal content and scope of medical histories and physical examinations, which may vary by setting or level of care, treatment, and services, including non-inpatient services	**Interview** ☐ Discuss with staff the oversight activities that the medical staff is responsible for ☐ Discuss how the medical staff ensures that licensed practitioners only practice within the scope of their privileges **Document** **General** ☐ Review meeting minutes for medical staff oversight activities, including the analysis and improvement of patient satisfaction, and history and physical quality ☐ Verify that history and physical minimum content as defined by policy is present in the patient's medical record during medical record review.
MS.17.01.01, EP 1: The critical access hospital has a process to determine whether sufficient space, equipment, staffing, and financial resources are in place or available within a specified time frame to support each requested privilege. **MS.17.01.01, EP 2:** The critical access hospital consistently determines the resources needed for each requested privilege.	**Interview** ☐ Discuss with leadership the process to determine if there is sufficient space, equipment, staffing, and financial resources available to support a new privilege
MS.17.02.03, EP 3: The critical access hospital completes the credentialing and privileging decision process in a timely manner.	**Interview** ☐ Discuss with medical staff leadership how long the privileging process typically takes
MS.17.04.01, EP 1: Temporary privileges are granted to meet an important patient care need for a time period defined in the medical staff bylaws. **MS.17.04.01, EP 2:** When temporary privileges are granted to meet an important care need, the organized medical staff verifies current licensure and current competence.	**Interview:** ☐ Discuss process for granting temporary privileges **Documentation** **General** ☐ During medical staff bylaw review, review the temporary privilege process

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MS.17.04.01, EP 3: Temporary privileges may be granted to applicants for new privileges while awaiting review and approval by the organized medical staff upon verification of the following: - Current licensure - Relevant training or experience - Current competence - Ability to perform the privileges requested - Other criteria required by the medical staff bylaws - A query and evaluation of the National Practitioner Data Bank (NPDB) information - A complete application - No current or previously successful challenge to licensure or registration - No subjection to involuntary termination of medical staff membership at another organization - No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges **MS.17.04.01, EP 4:** All temporary privileges are granted by the chief executive officer or authorized designee. **MS.17.04.01, EP 5:** All temporary privileges are granted on the recommendation of the medical staff president or authorized designee. **MS.17.04.01, EP 6:** Temporary privileges for applicants for new privileges are granted for no more than 120 days.	**Credentialing File** Review at least one of these files to determine if it meets one of the two following criteria: ☐ Temporary privileges may be granted to meet an important patient care need and may be renewed, if permitted by the bylaws. ☐ Review licensure and competency have been verified. ☐ Verify that the temporary privileges are time-limited & not to exceed 120 consecutive days
MS.18.02.01, EP 1: The organized medical staff develops and consistently implements criteria to be used for evaluating the performance of physicians or other licensed practitioners when issues affecting the provision of safe, high quality patient care are identified. **MS.18.02.01, EP 3:** The performance monitoring process is clearly defined and includes each of the following elements:	**Interview** ☐ Discuss the process for implementing a period of focused professional practice evaluation for issues affecting the provisions of safe quality care or for initial privilege request **Document** **General**

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- Criteria for conducting performance monitoring - Method for establishing a monitoring plan specific to the requested privilege - Method for determining the duration of performance monitoring - Circumstances under which monitoring by an external source is required **MS.18.02.01, EP 4:** The triggers that indicate the need for performance monitoring are clearly defined. Note: Triggers can be single incidents or evidence of a clinical practice trend. **MS.18.02.01, EP 5:** Criteria are developed that determine the type of monitoring to be conducted. **MS.18.02.01, EP 6:** The measures employed to resolve performance issues are clearly defined. **MS.18.02.01, EP 7:** The measures employed to resolve performance issues are consistently implemented.	☐ Review the process for conducting a focused professional practice evaluation o Is the process including criteria is approved by the MS (evaluation should be qualitative and not just quantitative)? o Is the process clearly defined *(i.e., written policy-required: criteria for conducting performance monitoring, method for establishing a monitoring plan specific to the requested privilege, method for determining the duration of performance monitoring, circumstances under which monitoring by an external source is required)* o Is the process applied consistently (*follow the same process step and documentation requirements for all evaluations)* ☐ If a for-cause FPPE: o Are the triggers clearly defined? o Are the decisions to initiate FPPE for cause based upon objective measures of current performance reflective of quality and/or safety concerns. o Is there criteria developed for type of monitoring to be conducted o Are the measures/actions to address performance issues defined? o Is there evidence these measures/actions are consistently implemented?
MS.18.02.03, EP 2: The process for the ongoing professional practice evaluation includes the type of data to be collected, which is determined by individual departments and approved by the organized medical staff. **MS.18.02.03, EP 3:** The process for the ongoing professional practice evaluation includes the use of information resulting from the ongoing professional practice evaluation to determine whether to continue, limit, or revoke any existing privilege(s).	**Interview** ☐ Discuss the process for the ongoing professional practice evaluation o What types of data is collected? Who determines which data is collected? **Documentation** **Credentialing File** Review file for evidence that the ongoing professional practice evaluation includes information from the evaluation to determine to continue, limit or revoke any existing privilege(s)
MS.18.03.01 EP 1: The critical access hospital, based on recommendations by the organized medical staff and approval by the governing body, has a	**Documentation** **General**

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clearly defined process for collecting, investigating, and addressing clinical practice concerns. Note: Reported concerns regarding a privileged physician's or other licensed practitioner's professional practice are uniformly investigated and addressed, as defined by the hospital and applicable law.	☐ Review the process for collecting, investigating, and addressing clinical practice concerns **Credentialing File** Review a file in which a concern was reported to validate the process was followed

Critical Access Hospital Storage, Handling, Dispensation, and Administration of Drugs and Biologicals Evaluation Module (485.635 (a)(3) through (a)(3)(v))

(Requires use of Sterile Medication Compounding Evaluation Tool)

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	§ 485.635 (a)(3) The policies include the following:	
LD.13.01.09, EP 1: The critical access hospital develops and implements written policies and procedures that guide health care services. The policies and procedures are consistent with state law and include the following: - Description of the services furnished by the critical access hospital, including those provided through agreement or arrangement - Emergency medical services - Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services provided by the critical access hospital - Rules for the storage, handling, dispensation, and administration of drugs and biologicals - Guidelines for addressing post–acute care needs of the patients receiving critical access hospital services Note: If patients are transferred or discharged to a provider for which there is no agreement or arrangement, the critical access hospital verifies that the patient has been accepted and treated.	**§ 485.635 (a)(3) (i)** A description of the services the CAH furnishes, including those furnished through agreement or arrangement.	**Document Review** **General** ☐ Verify that the CAH's policies identify and describe all health care services offered by the CAH, including services provided under arrangement or by agreement.

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LD.13.01.09, EP 1: See above	**§ 485.635 (a)(3) (ii)** Policies and procedures for emergency medical services.	**Document Review** **General** ☐ Verify that written policies and procedures detail how the CAH plans to comply with the requirements of 42 CFR 485.618, including the following: ○ How the CAH provides 24-hour emergency care to its patients ○ Which equipment, supplies, medications, and blood and blood products are maintained on site and which are readily available for treating emergency cases by agreement at other facilities ○ Which types of staff are available to provide emergency services and what their required on-site response times are ○ How the CAH coordinates with local emergency response systems
LD.13.01.09, EP 1: See above	**§ 485.635 (a)(3) (iii)** Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services furnished by the CAH.	**Document Review** **General** ☐ Verify that the CAH's written patient care policies address the following: ○ Circumstances under which consultation with other CAH professional health care staff, or referral outside the CAH, should occur ○ Maintenance of medical records, in a manner consistent with the requirements at §485.638 ○ Periodic evaluation of the CAH's health care services, in a manner consistent with the requirements at §485.641
LD.13.01.09, EP 1: See above	**§ 485.635 (a)(3)(iv)** Rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must	**Interview**

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MM.13.01.01, EP 1: The critical access hospital maintains current and accurate records of the receipt and disposition of all scheduled drugs. **MM.13.01.01, EP 4:** The critical access hospital removes all expired, damaged, mislabeled, contaminated, or otherwise unusable medications and stores them separately from medications available for patient use. Note: This element of performance is also applicable to sample medications. **MM.15.01.03, EP 1:** Medication containers are labeled whenever medications are prepared but not immediately administered. Note 1: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process. Note 2: This element of performance is also applicable to sample medications.	provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use.	☐ Has the CAH adopted pharmacy rules that were developed with the advice of its professional health care staff? ☐ Has the CAH identified the qualifications of and designated an individual who is responsible for developing and implementing the rules for its pharmacy services, consistent as applicable with state and federal law? ☐ Ask CAH practitioners and nursing and pharmacy staff whether the CAH's pharmacy service dispenses prescribed drugs and biologicals in a timely manner. If there is evidence in medical records reviewed of late administration of prescribed medications, probe to determine whether delays are due to pharmacy dispensing delays. ☐ Ask the individual responsible for CAH pharmacy services what sources of accepted professional principles of pharmacy practice the CAH relies on when developing and implementing its CAH pharmacy rules, policies, and procedures. Is the source(s) nationally recognized? ☐ Interview the person responsible for pharmacy services and other CAH staff to determine their understanding of the CAH's controlled drug policies. ☐ Can the individual responsible for CAH pharmacy services explain the risk level(s) of the compounded sterile products (CSPs) being produced in house and/or obtained from external sources? ☐ If any CSPs are produced in the CAH: o Ask pharmacy staff for one or more examples of situations in which a beyond use date (BUD) had to be determined for a CSP based on the policy.

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		○ Ask if the beyond use date (BUD function was carried out within the CAH or if it was handled by external source(s) of CSPs. ○ Is there evidence that the BUDs are determined consistent with the CAH's rules, policies, and procedures? ☐ Ask staff who engage in sterile and nonsterile compounding if they are knowledgeable about applicable levels of aseptic practices. ☐ Ask the individual responsible for pharmacy services to demonstrate how the following are accomplished to ensure that sterile compounding practices are consistent with standards for the risk level(s) of CSPs being produced for/dispensed to CAH patients: ○ Verification of compounding accuracy and sterility ○ Environmental quality and controls, including environmental sampling, testing and monitoring, and cleaning and disinfection ○ Staff training and competency assessment, including but not limited to accuracy/precision in identifying and measuring ingredients, cleansing and garbing, aseptic manipulation skills, environmental quality and disinfection, appropriate work practices within and adjacent to the direct compounding area, verification/calibration of equipment, sterilization, and postproduction quality checks ☐ Ask pharmacy staff for one or more examples of situations in which a BUD had to be determined for a CSP based on the policy.

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		○ Ask if this function was carried out within the CAH or done by external source(s) of CSPs. ○ Is there evidence that the BUDs were consistent with the CAH's rules, policies, and procedures? ☐ If the CAH obtains CSPs from an external source that is not a registered outsourcing facility by the Food and Drug Administration, can it demonstrate that it systematically evaluates and monitors whether these sources adhere to accepted professional principles for safe compounding? ○ Does the CAH have a process for following up on adverse drug reactions and errors in medication administration reported by CAH staff in accordance with §485.635(a)(3)(v)? ○ If any have been reported, did the CAH thoroughly assess and analyze them? ○ Has the CAH taken effective preventive action to address identified issues? **Document Review** **Personnel/Credential File** ☐ Review the qualifications of the responsible individual to verify that they satisfy the CAH's written criteria. **General** ☐ Review records to see if drugs and biologicals are removed from the pharmacy by unauthorized personnel. ☐ Ensure that the CAH's pharmacy rules address automatic dispensing cabinets (ADCs), if used within the CAH, and that they are being used in the manner prescribed by the CAH's rules. ☐ Verify that concerns, issues or questions pharmacy staff have about any medication order are clarified

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		with the prescribing practitioner or another practitioner responsible for the care of the patient before dispensing.
		- Verify that the individual responsible for pharmacy services, including compounding policies, practices, and quality assurance within the CAH and selecting and overseeing any external sources of compounded medications, has the expertise to conduct effective quality oversight.
		- Review the CAH's procedures for maintaining the quality of CSPs during storage, transport, and dispensing.
		  - Are CSPs packaged in a manner to protect package integrity and sterility?
		  - How are CSP-specific requirements with respect to motion, light exposure, temperature, and potentially hazardous contents addressed?
		  - How does the CAH ensure that such information is effectively conveyed to nonpharmacy health care personnel and/or to patients/caregivers, if applicable?
		- Review the pharmacy rules, policies, and procedures for determining BUDs (for medications compounded in house as well as from external sources).
		  - Can the CAH demonstrate that the policies and procedures are consistent with or more stringent than the applicable nationally accepted standards?
		  - Can it demonstrate that the pharmacy personnel assigned to determining BUDs when manufacturer's instructions are not available have the expertise and technical support needed to properly conduct the assessments needed to make such

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		determinations in a manner consistent with standards and hospital policies?
		Observation
		- Verify that drugs and biologicals stored in a secure manner.
		  - Are drugs stored in areas not accessible to unauthorized personnel?
		  - When drugs or biologicals are kept in a patient care area during hours when patient care is not provided, are they locked up?
		- Conduct a spot check of drug use and other inventory records to ensure that drugs are properly accounted for.
		- Determine if the CAH has a system that tracks movement of all scheduled drugs from the point of entry into the CAH to the point of departure either through administration to the patient, destruction of the drug, or return to the manufacturer.
		  - Does this system provide documentation on scheduled drugs in a readily retrievable manner to facilitate reconciliation of the receipt and disposition of all scheduled drugs?
		- Review records of scheduled drugs over a recent time period. Is there evidence of discrepancies and, if so, of efforts by the CAH to reconcile and address the discrepancies?
		- Verify that only a pharmacist or another staff member authorized in accordance with state and federal law compound, label, and dispense drugs or biologicals, regardless of whether the services are provided by CAH staff or under arrangement.
		  - Interview pharmacy and CAH staff to determine how drugs and biologicals are dispensed.
		  - Observe on-site dispensing operations.

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		☐ Ask the CAH to demonstrate that compounded medications used and/or dispensed by the hospital are being compounded consistent with standard operating procedures and quality assurance practices. ☐ Spot-check the labels of individual drug containers to verify that they contain the following minimal information: o Patient's full name o Strength and quantity of the drug dispensed o Appropriate accessory and cautionary statements o Expiration date and, when applicable, beyond use date (BUD) ☐ Spot-check floor stock containers to ensure labels bear the name and strength of the drug, lot and control number of equivalent, expiration date, and, when applicable, a BUD. ☐ If the unit dose system is used, verify that each single unit dose package bears the name and strength of the drug, lot and control number equivalent, expiration date, and, when applicable, a BUD. ☐ Spot-check patient-specific and floor stock medications to identify expired, mislabeled or unusable medications, including medications that are past their BUD.
MM.17.01.01, EP 1: The critical access hospital develops and implements policies and procedures for reporting transfusion reactions, adverse drug reactions, and errors in administration of drugs. Note: This element of performance is also applicable to sample medications.	**§ 485.635 (a)(3) (v)** Procedures for reporting adverse drug reactions and errors in the administration of drugs.	**Interview** ☐ Assess whether the CAH ensures that medication administration errors and adverse drug reactions (ADRs) are reported to practitioners in a timely manner.

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		○ Ask nursing staff if they are familiar with the concepts of medication errors that do and do not reach the patient, as well as ADRs. ○ Ask nursing staff what they would do in the case of a medication administration error that reaches the patient or an adverse drug event. ○ Ask nursing staff if they can provide examples of cases where they needed to report an ADR. Is the report to the practitioner documented in the medical record? ○ Review records of medication errors and ADRs to determine that they are reported immediately, in accordance with written procedures, and that medications administered and/or drug reactions are promptly recorded in the patient's medical record. □ Interview CAH staff (nursing, pharmacy, and medical) to ascertain awareness of the CAH's policy on reporting medication administration errors and ADRs for quality improvement purposes. ○ Does the CAH rely only on internal staff incident reporting or does it use other methods to identify potential/actual medication errors and ADRs? ○ Ask the individual responsible for the quality assurance (QA) program to demonstrate how the CAH determines if the number of medication administration errors and ADRs reported is consistent with the size and scope of services provided by the CAH. ○ Review QA activities for medication administration errors and ADRs to determine if, upon analyses of the reports,

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		potential corrective actions are identified and implemented, if appropriate. **Document Review** **General** - Verify that the CAH has evidence of training staff on reporting expectations. **Observation** - Ask the CAH to demonstrate that it has a system for reporting/identifying ADRs and medication administration errors for quality assurance/improvement purposes.
PC.12.01.01, EP 1: Prior to providing care, treatment, and services, the critical access hospital obtains or renews orders (verbal or written) from a physician or other licensed practitioner in accordance with professional standards of practice; law and regulation; critical access hospital policies; and medical staff bylaws, rules, and regulations. Note 1: This includes but is not limited to respiratory services, radiology services, rehabilitation services, nuclear medicine services, and dietary services, if provided. Note 2: Patient diets, including therapeutic diets, are ordered by the physician or other licensed practitioner responsible for the patient's care, or by a qualified dietitian or qualified nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals. The requirement of 42 CFR 483.25(i) is met for inpatients receiving care at a skilled nursing facility subsequent to critical access hospital care.	**§485.635(a)(3)(vi)** Procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices. All patient diets, including therapeutic diets, must be ordered by the practitioner responsible for the care of the patients or by a qualified dietitian or qualified nutrition professional as authorized by the medical staff in accordance with State law governing dietitians and nutrition professionals and that the requirement of § 483.25(i) of this chapter is met with respect to inpatients receiving post CAH SNF care.	**Interview** ☐ Ask the dietician for evidence that menus meet the nutritional needs of patients. For example, does the service rely upon DRIs, including RDAs, in developing menus? ☐ Ask the dietician how patients identified as having specialized needs monitored **Document Review** **Patient Health Record** ☐ Verify therapeutic diets are provided as ordered **Observation** - When observing care in inpatient units (or observation units where meals are provided) ask staff how patients are assessed for nutritional needs.

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PC.12.01.9, EP 1: The nutritional needs of the individual patient are met in accordance with clinical practice guidelines and recognized dietary practices. Note 1: Diet menus meet the needs of the patients. Note 2: For swing beds in critical access hospitals: The critical access hospital meets the assisted nutrition and hydration requirement at 42 CFR 483.25(g) with respect to inpatients receiving posthospital skilled nursing facility care.		
LD.13.01.09, EP 1: The critical access hospital develops and implements written policies and procedures that guide health care services. The policies and procedures are consistent with state law and include the following: - Description of the services furnished by the critical access hospital, including those provided through agreement or arrangement - Emergency medical services - Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services provided by the critical access hospital - Rules for the storage, handling, dispensation, and administration of drugs and biologicals - Guidelines for addressing post–acute care needs of the patients receiving critical access hospital services Note: If patients are transferred or discharged to a provider for which there is no agreement or arrangement, the critical access hospital verifies that the patient has been accepted and treated.	**§485.635(a)(3)(viii)** **(viii)** Policies and procedures that address the post-acute care needs of patients receiving CAH services.	**Document Review** **General** ☐ Review policies and procedures developed and implemented to confirm it meets the needs of patients receiving post-acute care.

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LD.13.01.09, EP 4: The critical access hospital's policies are reviewed at least every two years by the group of professional personnel required under LD.13.01.09, EP 3, and updated as necessary.	**§485.635(a)(4)** These policies are reviewed at least biennially by the group of professional personnel required under paragraph (a)(2) of this section, and updated as necessary by the CAH.	**Interview** □ Ask leaders, clinical staff, and professional staff about the processes to review policies at least every two years and how necessary updates are made.

Critical Access Hospital Outpatient Services Evaluation Module (485.635 (b)(1)(i))

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LD.13.03.01, EP 4: The critical access hospital provides basic outpatient services (diagnostic and therapeutic services and supplies that are commonly provided in a physician's office or at another entry point into the health care delivery system, such as low intensity hospital outpatient department or emergency department). These services include medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions.	**485.635(b) Standard: Patient Services** **(1) General** ***(i)*** The CAH provides those diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at another entry point into the health care delivery system, such as a low intensity hospital outpatient department or emergency department. These CAH services include medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions.	**Interview** ☐ CAH individual(s) responsible for outpatient services and observe: ○ Types and number of qualified personnel and staff are appropriate for the scope and complexity of the outpatient services offered. ○ Diagnostic and therapeutic services and supplies are available and provided to outpatients ○ Equipment, staff, and facilities are adequate to provide the outpatient services and are in accordance with acceptable standards of practice. ○ Integration of outpatient services with the appropriate CAH inpatient services in accordance with the needs of the patient care provided. **Document Review** **General** ☐ Review scope of outpatient services. CAH on-site outpatient services provided include services comparable to a physician office or low intensity hospital outpatient or emergency department, including medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions **Personnel File Review (HR/Competency Review Activity)** ☐ Review personnel files and/or contracts to verify current licensure, certifications, and training of staff consistent with applicable State laws.

Critical Access Hospital Laboratory Services Evaluation Module (485.635 (b)(2))

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LD.13.03.01, EP 12: The critical access hospital provides the following basic laboratory services essential to the immediate diagnosis and treatment of the patient: - Chemical examination of urine by the stick method, the tablet method, or both (including urine ketones) - Hemoglobin or hematocrit tests - Blood glucose tests - Examination of stool specimens for occult blood - Pregnancy tests - Primary culturing for transmittal to a certified laboratory Note 1: The laboratory meets the standards imposed under section 353 of the Public Health Service Act (42 U.S.C. 263a). (Refer to the laboratory requirements specified in 42 CFR 493) Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has laboratory services available, either directly or through a contractual agreement with a Clinical Laboratory Improvement Amendments (CLIA)–certified laboratory that meets the requirements of 42 CFR 493.	§**485.635(b)(2)** Laboratory Services The CAH provides basic laboratory services essential to the immediate diagnosis and treatment of the patient that meet the standards imposed under section 353 of the Public Health Service Act (42 U.S.C. 263a). (See the laboratory requirements specified in part 493 of this chapter.) The services provided include the following: (i) - Chemical examination of urine by stick or tablet method or both (including urine ketones); (ii)- Hemoglobin or hematocrit; (iii)- Blood glucose; (iv)- Examination of stool specimens for occult blood; (v)- Pregnancy tests; and (vi)- Primary culturing for transmittal to a certified laboratory Improvement Act (CLIA) certificate or waiver for all tests performed and meet the laboratory requirements specified in Part 493 of this chapter. Compliance with Part	**Interview** ☐ Leaders of the CAH to the basic laboratory services it offers. - Lab services may be provided by the CAH staff or under arrangement or agreement with a laboratory, or through a combination of CAH staff and a laboratory under arrangement. *Note: Laboratory services, whether provided directly by the CAH or under an arrangement with a laboratory contractor, must have a current Clinical Laboratory Improvement Act (CLIA) certificate or waiver for all tests performed and meet the laboratory requirements specified in Part 493 of this chapter. Compliance with Part 493 is not assessed by CAH surveyors evaluating compliance with the CAH conditions of participation, but surveyors are expected to refer potential issues they may identify to the program responsible for CLIA certification.* ☐ Leaders about laboratory services provided on-site at the CAH's main campus are the tests specified in the regulation, which would be considered the minimum necessary for diagnosis and treatment of a patient laboratory must include: - Chemical examination of urine by stick or tablet method or both (including urine ketones); - Hemoglobin or hematocrit; - Blood glucose; - Examination of stool specimens for occult blood; - Pregnancy tests; and - Primary culturing for transmittal to a certified laboratory

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		☐ Leaders how they determine which laboratory services are to be immediately available to meet the emergency needs of patients and how are the services provided. ☐ Staff who furnish emergency services whether these laboratory services are available whenever the CAH provides emergency services. **Observation** ☐ The identified laboratory services are available to support the emergency services the CAH provides Note: Patient laboratory results and all other laboratory clinical patient records are considered patient medical records, and the CAH must comply with the requirements of the clinical records CoP at §485.638(a)(4)(ii). ☐ Review a sample lab results to confirm patient laboratory results and all other laboratory clinical patient records are considered patient medical records, and the CAH must comply with the requirements of the clinical records CoP at §485.638(a)(4)(ii). **Document Review** **General** ☐ Review the CAH's laboratory scope of services. The CAH provides basic laboratory services essential to the immediate diagnosis and treatment of the patient that meet the standards imposed under section 353 of the Public Health Service Act (42 U.S.C. 263a). (See the laboratory requirements specified in part 493.

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		☐ Laboratory services provided on-site at the CAH's main campus are the tests specified in the regulation, which would be considered the minimum necessary for diagnosis and treatment of a patient laboratory must include: - Chemical examination of urine by stick or tablet method or both (including urine ketones); - Hemoglobin or hematocrit; - Blood glucose; - Examination of stool specimens for occult blood; - Pregnancy tests; and - Primary culturing for transmittal to a certified laboratory ☐ The CAH has a CLIA certificate or waiver, as applicable, for all laboratory tests performed in CAH facilities ☐ The laboratory has written policies and procedures for the collection, preservation, transportation, receipt, and reporting of tissue specimen results. ☐ The CAH has a procedure in place for obtaining tests needed but unavailable at the CAH laboratory. ☐ If the CAH refers specimens to another laboratory for testing, the CAH has documentation that the referral laboratory is CLIA certified for the appropriate tests

Critical Access Hospital Radiology Services Evaluation Module (485.635(b)(3))

Joint Commission Standards / EPs	Critical Access Hospital CoP	Critical Access Hospital Survey Process
NPG.12.01.01, EP 1: Leaders provide for an adequate number and mix of qualified individuals to support safe, quality care, treatment, and services. Note 1: The number and mix of individuals is appropriate to the scope and complexity of the services offered. Services may include but are not limited to the following: - Rehabilitation services - Emergency services - Outpatient services - Respiratory services - Pharmaceutical services, including emergency pharmaceutical services - Diagnostic and therapeutic radiology services Note 2: Emergency services staff are qualified in emergency care. Note 3: For rehabilitation and psychiatric distinct part units in critical access hospitals: As of the first day of the first cost reporting period for which all other exclusion requirements are met, the unit is fully equipped and staffed and is capable of providing hospital inpatient psychiatric or rehabilitation care regardless of whether there are any inpatients in the unit on that date. **LD.13.03.01, EP 1:** The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s)	**§485.635(b)(3) Radiology services.** Radiology services furnished by the CAH are provided by personnel qualified under State law, and do not expose CAH patients or personnel to radiation hazards.	**Interview** Interview radiology services leader and staff to determine if □ Diagnostic radiological services are maintained and available to support the services the CAH provides to meet the needs of its patients. □ Diagnostic radiological services are available at all times the CAH provides services, including emergency services. □ Radiological services provided by the CAH, including diagnostic, therapeutic, and nuclear medicine, are provided in accordance with acceptable standards of practice and meet professionally approved standards for safety. □ Radiologists who interpret radiological tests through teleradiology services meet the telemedicine privileging requirements (485.616(c)(3)) **Document Review** **General** □ Verify that scope and complexity of radiological services offered is specified in writing and approved by the governing body (or responsible individual). □ Ensure that written policies approved by the governing body or responsible individual, consistent with state law, designate which personnel are qualified to use the radiological equipment and administer procedures.

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served, are organized appropriate to the scope and complexity of services offered and are in accordance with accepted standards of practice. Services may include but are not limited to the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic - Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital. **PE.02.01.01, EP 4:** The critical access hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials The policies and procedures address the following:		

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- Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors - Disposal of hazardous medications - Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding - Periodic inspection of radiology equipment and prompt correction of hazards found during inspection - Precautions to follow and personally protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers, and MRIs). Note 2: Hazardous gases and vapors include, but are not limited to, ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9) **PE.02.01.01, EP 5:** Radiation workers are checked periodically, by the use of exposure meters or badge tests, for the amount of radiation exposure.		
	§485.635(b)(3) Radiology services.	**Interview**

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	Radiology services furnished by the CAH are provided by personnel qualified under State law, and do not expose CAH patients or personnel to radiation hazards. **Radiology Records** *The CAH radiology records are to be treated in the same manner as any other part of a medical record.* • The medical records CoP at §485.638(a)(4)(ii) requires that the CAH maintain reports of physical examinations, diagnostic and laboratory test results, and consultative findings.	• Ask the person responsible for radiologic services what radiologic services the CAH offers at its main campus. • Are studies interpreted only by qualified staff approved to do so by the CAH's governing body or responsible individual? **Document Review** **General** Review radiation safety policies and procedures to determine if they address the following • Radiation shielding for patients, personnel and facilities including: o Built in shielding; o Types of personal protective shielding tob e used, under what circumstances, for patients, including high risk patients and CAH staff; o Types of containers to be used for various radioactive materials, if applicable, when stored, in transport, in use, and when disposed; o Clear signage identifying hazardous radiation areas; • Labeling of all radioactive materials, including waste, with clear identification of all material(s); • Transportation of radioactive materials between locations within the CAH; • Security of radioactive materials, including determining who may have access to radioactive materials and controlling access to radioactive materials;

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		□ Periodic testing of equipment for radiation hazards; □ Periodic checking of staff regularly exposed to radiation for the level of radiation exposure, via exposure meters or badge tests; □ Storage of radio nuclides and radio pharmaceuticals as well as radioactive waste; and □ Disposal of radio nuclides, unused radio pharmaceuticals, and radioactive waste □ Requirements for periodic inspections of radiology equipment and timely correction of identified problems. □ Review records to verify that hazardous materials are tracked, handled, moved, and stored properly in a safe manner with the requisite containers. □ Review records to verify that periodic tests of radiology personnel by exposure meters or test badges are performed. □ Review the equipment inspection records to verify that periodic inspections and maintenance are conducted in accordance with the manufacturer's recommendations. □ Determine whether any equipment problems identified are properly corrected in a timely manner and that the correction is maintained over time. **Personnel/Credential File** □ Review radiology staff personnel folders to determine if they meet the qualifications for tasks they perform, as established in the CAH's policies and consistent with state law.

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		□ Ask how the CAH ensures that radiologic services are provided consistent with acceptable standards of practice. □ At off-site locations ask how the CAH ensures that patient needs for radiologic services are met, if applicable. **Observation** □ Verify that patient shielding (for example, aprons) are properly maintained and routinely inspected by the CAH. □ Observe areas where radiologic testing is done and check for safety problems. □ Determine which staff are using various pieces of radiological equipment and/or administering patient procedures. □ Ask to see the CAH's written protocols and verify that the staff is adhering to them. □ Determine if the radiologic services staff is familiar with the policies and procedures related to safety. □ Ask staff to explain the protocol for the procedures/studies they administer. □ Verify that hazardous materials are clearly labeled.

Critical Access Hospital Nuclear Medicine Services Evaluation Module (485.635 (b)(3))

Joint Commission Standards / EPs	Critical Access Hospital CoP	Critical Access Hospital Survey Process
NPG.12.01.01, EP 1: Leaders provide for an adequate number and mix of qualified individuals to support safe, quality care, treatment, and services. Note 1: The number and mix of individuals is appropriate to the scope and complexity of the services offered. Services may include but are not limited to the following: - Rehabilitation services - Emergency services - Outpatient services - Respiratory services - Pharmaceutical services, including emergency pharmaceutical services - Diagnostic and therapeutic radiology services. Note 2: Emergency services staff are qualified in emergency care. Note 3: For rehabilitation and psychiatric distinct part units in critical access hospitals: As of the first day of the first cost reporting period for which all other exclusion requirements are met, the unit is fully equipped and staffed and is capable of providing hospital inpatient psychiatric or rehabilitation care regardless of whether there are any inpatients in the unit on that date. **LD.13.03.01, EP 1**: The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in	**§485.635(b)(3) Radiology services.** Radiology services furnished by the CAH are provided by personnel qualified under State law, and do not expose CAH patients or personnel to radiation hazards. **485.635(b)(4)** Emergency procedures. In accordance with requirements of § 485.618, the CAH provides medical services as a first response to common life-threatening injuries and acute illness.	**Interview** **Person Responsible for Radiologic Services** ☐ Ask what radiologic services the CAH offers at its main campus. At off-site locations, ask how the CAH ensures that patient needs for radiologic services are met, if applicable. ☐ Ask how the CAH ensures that radiologic services are provided consistent with acceptable standards of practice. ☐ Ask the nuclear medicine technologists how medical emergencies are addressed should a patient experience an acute or life threatening injury. **Radiologic Services Staff** ☐ Determine if the radiologic services staff is familiar with the policies and procedures related to safety. ☐ Ask staff to explain the protocol for the procedures/studies they administer. ☐ Ask to see the CAH's written protocols and verify that the staff is adhering to them. **Document Review** **Patient Health Record** ☐ Review records to verify that they are properly tracked, handled, and stored in a safe manner with the requisite containers. ☐ Review records to verify that periodic tests of radiology personnel by exposure meters or test badges are performed. **General** ☐ Review the inspection records to verify that periodic inspections and maintenance are conducted in accordance with the manufacturer's recommendations.

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accordance with accepted standards of practice. Services may include but are not limited to the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory – Dietetic - Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital. **PE.02.01.01, EP 4**: The critical access hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials The policies and procedures address the following: - Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors - Disposal of hazardous medications - Minimizing risk when selecting and using		- Determine whether any problems identified are properly corrected in a timely manner and the correction is maintained over time. - Are studies interpreted only by qualified staff approved to do so by the CAH's governing body or responsible individual? **Personnel/Credential File** - Determine which staff are using various pieces of radiological equipment and/or administering patient procedures. Review their personnel folders to determine if they meet the qualifications for tasks they perform, as established in the CAH's policies and consistent with state law. **Observation** - Verify that patient shielding (for example, aprons) are properly maintained and routinely inspected by the CAH. - Observe areas where radiologic testing is done and check for safety problems. - Verify that hazardous materials are clearly labeled.

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hazardous energy sources, including the use of proper shielding - Periodic inspection of radiology equipment and prompt correction of hazards found during inspection - Precautions to follow and personally protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers, and MRIs). Note 2: Hazardous gases and vapors include, but are not limited to, ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9) **PE.02.01.01, EP 5**: Radiation workers are checked periodically, by the use of exposure meters or badge tests, for the amount of radiation exposure. **LD.13.03.01, EP 6**: The critical access hospital provides emergency medical services that meet the needs of its inpatients and outpatients as a first response to common life-threatening injuries and acute illnesses. Note: Emergency services are available 24-hours a day, 7 days a week.		

Critical Access Hospital Food and Dietetic Services Evaluation Module (485.635 (c)(1))

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LD.13.03.03, EP 7: The critical access hospital has agreements or arrangements, as appropriate, with one or more providers or suppliers participating under Medicare to furnish services not directly provided by the critical access hospital to its patients, including but not limited to the following: - Services of doctors of medicine or osteopathy - Additional or specialized diagnostic and clinical laboratory services not available at the critical access hospital - Food and other services to meet inpatient nutritional needs to the extent they are not provided directly by the critical access hospital	**485.635(c)(1)** [The CAH has agreements or arrangements (as appropriate) with one or more providers or suppliers participating under Medicare to furnish other services to its patients, including—] (iii) Food and other services to meet inpatients' nutritional needs to the extent these services are not provided directly by the CAH.	**Interview and Document Review** ☐ Verify that the CAH has an agreement or arrangement with a vendor to provide dietary services to inpatients if the CAH does not use its own staff to provide these services. ☐ Periodic evaluation of policies and procedures, services provided, and quality assurance review. **Observation** ☐ Food and dietary services meet the nutritional needs of inpatients ☐ If the CAH is a grandfathered co-located CAH that obtains food services from the co-located facility, the surveyor must assess the food service operations in the co-located facility as part of the CAH survey.

Critical Access Hospital Nursing Services Evaluation Module (485.635(d))

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LD.13.03.01, EP 2: The critical access hospital has an organized nursing service, with a plan of administrative authority and delineation of responsibility for patient care, that provides nursing services to meet the needs of its patients. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: Rural hospitals with a 24-hour nursing waiver granted under 42 CFR 488.54(c) are not required to have 24-hour nursing services. **NPG.12.02.01, EP 4:** A registered nurse provides (or assign to other staff) the nursing care of each patient, including patients at a skilled nursing facility level of care in a swing-bed critical access hospital. The care is provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available. Note 1: For rehabilitation and psychiatric distinct part units in critical access hospitals: A registered nurse directly provides or supervises the nursing services provided by other staff to patients 24 hours a day, 7 days a week. The critical access hospital has a licensed practical nurse or registered nurse on duty at all times. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: Rural hospitals with a 24-hour nursing waiver granted under 42 CFR	**§485.635(d) Standard: Nursing Services** Nursing services must meet the needs of patients. **§485.635(d)(1)** A registered nurse must provide (or assign to other personnel) the nursing care of each patient, including patients at a SNF level of care in a swing-bed CAH. The care must be provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available. **§485.635(d)(2)** A registered nurse or, where permitted by State law, a physician assistant, must supervise and evaluate the nursing care for each patient, including patients at a SNF level of care in a swing-bed CAH.	**Interview** ☐ Ask the RN responsible for nursing services the following: ○ How are the nursing needs of patients determined? ○ Who makes this determination? ○ How are staff assigned to provide nursing care to patients? ○ How does the CAH ensure that the care provided meets the needs of each patient? ☐ Interview one or more RNs (or PAs, if applicable) who supervise and evaluate the nursing care for CAH patients. **Document Review** **General** ☐ Review the CAH's organizational chart to verify that a registered nurse (RN) has been designated responsible for nursing services. ☐ Review the following to determine the adequacy of staffing: ○ Staffing schedules ○ Nursing care plans for inpatients ○ Credentialing and training files (including contracted staff) ○ Quality assurance activities and reports ☐ Review nursing assignments in one or more inpatient units, the emergency department, and one other outpatient department to assess the following: ○ Did an RN make the assignments? ○ Was the complexity of patient care needs and the competence and specialized qualifications of the nursing staff taken into consideration?

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488.54(c) are not required to have 24-hour nursing services. **NR.11.01.01, EP 4:** A registered nurse (or physician assistant, when permitted by state law) supervises and evaluates the nursing care for each patient, including patients at a skilled nursing facility-level of care in a swing-bed critical access hospital.		☐ Review written staffing schedules to determine the following: o Do they adhere to the CAH's policies and procedures for staffing levels and types of nursing personnel? o Is there supervision of personnel performance and nursing care for each nursing unit? o If there are temporary agency nurses providing services, are they are familiar with the nursing policies and procedures of the unit or department where they are working? ☐ Verify that an RN (or physician assistant [PA] where permitted by state law and CAH policy) supervises and evaluates the nursing care for each patient. **Personnel/Credential File** ☐ Review a sample of staff personnel files to determine the following: o How are staff trained and oriented? o If temporary outside agency nurses are used, how are they oriented and supervised? o Do the nursing staff have required licenses and competencies. **Observation** ☐ Observe nursing care in progress to determine the adequacy of staffing and assess the delivery of care
PC.11.03.01, EP 1: The critical access hospital develops, implements, and revises a written individualized plan of care based on the following: - Needs identified by the patient's	**§485.635(d)(4)** A nursing care plan must be developed and kept current for each inpatient.	**Document Review** **General** ☐ Select a representative sample of nursing care plans based on the number of inpatient records reviewed and verify the following:

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assessment, reassessment, and results of diagnostic testing - The patient's goals and the time frames, settings, and services required to meet those goals Note 1: Nursing staff develops and keeps current a nursing plan of care, which may be a part of an interdisciplinary plan of care, for each inpatient. Note 2: The hospital evaluates the patient's progress and revises the plan of care based on the patient's progress. Note 3: For rehabilitation distinct part units in critical access hospitals: The plan is reviewed and revised as needed by a physician in consultation with other professional staff who provide services to the patient.		○ Are the care plans created as soon as possible after admission for each patient? ○ Are the care plans based on the nurse's assessment of the individual patient? ○ Is there evidence that the care plans are reviewed on an ongoing basis? ○ Is there evidence that the nursing care plan is revised as needed and is there documentation of nursing reassessment? ○ Is there evidence that the nursing care plans have been implemented?
MM.11.01.01, EP 1: Drugs and biologicals are procured, stored, controlled, and distributed, in accordance with federal and state laws and accepted standards of practice. **MM.16.01.01, EP 2:** Drugs, biologicals, and intravenous medications are administered by, or under the supervision of, a registered nurse, a doctor of medicine or osteopathy, or, where permitted by state law, a physician assistant. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: Drugs and biologicals are administered by, or under supervision of, nursing or other staff in accordance with federal and state laws and regulations, including applicable licensing	**§485.635(d)(3)** All drugs, biologicals, and intravenous medications must be administered by or under the supervision of a registered nurse, a doctor of medicine or osteopathy, or, where permitted by State law, a physician assistant, in accordance with written and signed orders, accepted standards of practice, and Federal and State laws.	**Interview** ☐ Ask the person responsible for nursing services what type of personnel administer drugs and biologicals, including IVs. ○ Are they practicing within their permitted scope? ○ If anyone other than a doctor of medicine or osteopathy, registered nurse (RN), or physician assistant (PA) administers drugs or biologicals, are they supervised by an RN or, if permitted under state law and CAH policy, a PA? ☐ Ask nursing staff if the CAH permits verbal orders and, if so, what the policy is for a verbal order. If staff are unaware of any policy, or if their description of a policy suggests it is incomplete or inconsistent with accepted standards of practice, ask to see the written policy.

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requirements, and in accordance with the approved medical staff policies and procedures.		☐ Ask nursing staff if they initiate medications in accordance with standing orders. o Are they familiar with the hospital's policies and procedures for using standing orders? o Are they following the policies and procedures? ☐ Ask nursing staff if the CAH permits patient self-administration of medications. o If yes, does the CAH have policies and procedures addressing this? o Is there an order from a practitioner responsible for the care of the patient permitting self-administration of medications, either issued by the CAH or brought from home? ☐ Interview personnel who administer medication to verify their understanding of the CAH's policies regarding timeliness of medication administration. o Can staff identify time-critical and non-time-critical scheduled medications? o Can they identify medications not eligible for scheduled dosing times? o Can they describe requirements for the timing of administration of time-critical and non-time-critical medications in accordance with the CAH's policies? ☐ Interview nursing staff who administer IV medications and blood transfusions. Verify that they are knowledgeable about the following: o Venipuncture techniques o Safe medication administration practices, including general practices applying to all types of medications and practices concerning IV tubing and infusion pumps o Maintaining fluid and electrolyte balance o Patient assessment for risk related to IV medications and appropriate monitoring

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		○ Early detection and intervention for IV opioid-induced respiratory depression in postoperative patients ○ Blood transfusions, including the following: ▪ Process for verification of the right blood product for the right patient ▪ Transfusion reactions, including identification, treatment, and reporting requirements **Document Review** **General** ☐ Verify that nursing staff who administer drugs have completed training consistent with the CAH's training policy. ☐ Review the protocol for a standing order used by nursing staff. Ask nursing staff to explain how their practice conforms to the protocol. ☐ Determine if all standing orders initiated by a nurse were authenticated by an authorized practitioner. **Patient Health Record** ☐ Review a sample of medication orders to determine if they contain the required elements according to §485.635(d)(3). ○ Ensure that orders are legible, timed, dated, and authenticated with a signature by the practitioner or practitioners responsible for the care of the patient. ○ Was the administration of the medication consistent with the order (that is, the correct medication was administered to the right patient at the right dose via the correct route) and if timing of administration complied with the CAH's policies and procedures? ○ Was the practitioner's order still in force at the time the drug was administered?

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		Observation ☐ Verify that procedures for the preparation of drugs and their administration to patients (medication pass) are being followed. ☐ Is the patient's identity confirmed prior to medication administration? ☐ Are procedures to ensure the correct medication, dose, and route followed? ☐ Are drugs administered in accordance with the hospital's established policies and procedures for timely medication administration? o Does the nurse remain with the patient until medication is taken, unless the patient is permitted to self-administer? o Are patients assessed by nursing and/or other staff, per hospital policy, for their risk to their prescribed medications? o Are patients who are at higher risk and/or receiving high-alert medications monitored for adverse effects? o Are staff knowledgeable about intervention protocols when patients experience adverse medication-related events? ☐ If able, observe blood transfusion and IV medication administration to assess staff adherence to accepted standards of practice. o Were safe medication administration practices used? o Was the transfused patient correctly identified and matched to the correct blood product prior to administration? o Was the appropriate access used for IV medications? o Were appropriate steps taken with regard to IV tubing and infusion pumps? o Are patients being monitored post infusion for adverse reactions?

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		☐ If staff appear to not be following accepted standards of practice for patient risk assessment related to IV medications, particularly opioids, and appropriate monitoring of patients receiving IV medications and/or blood transfusions, review policies and procedures for IV medication administration and blood transfusion to determine if the CAH addresses safe practices considerations.

Critical Access Hospital Nursing Services Evaluation Module Continued (Additional Joint Commission Requirement)

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PC.11.02.01, EP 1: The critical access hospital conducts the patient's initial assessment within the written time frames it defines and in accordance with law and regulation.	**Document Review** **Patient Health Record** ☐ Verify that initial assessments are completed in time frames it defines and in accordance with law and regulation ☐ Verify that screening, assessment, and reassessment is conducted according to hospital policy; including specialized, more in-depth assessments when required

Critical Access Hospital Rehabilitation Services Evaluation Module (485.635 (e))

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HR.11.02.01, EP 1: The critical access hospital defines staff qualifications specific to their job responsibilities. Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control). Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists, as defined in 42 CFR 484, provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the critical access hospital. See Glossary for definitions of physical therapist, physical therapist assistant, occupational therapist, occupational therapy assistant, speech-language pathologist, and audiologist. Note 3: For rehabilitation and psychiatric distinct part units in critical access hospitals: If respiratory care services are provided, staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing.	**§485.635(e) Standard: Rehabilitation Therapy Services.** Physical therapy, occupational therapy, and speech-language pathology services furnished at the CAH, if provided, are provided by staff qualified under State law, and consistent with the requirements for therapy services in §409.17 of this subpart.	**Interview** □ The CAH rehabilitation staff what national standards of rehabilitation practice provide the basis for its rehabilitation services. Is there supporting documentation. **Document Review** **General** □ Review clinical records of patients who received rehabilitation services. Determine whether the required care plan was developed and implemented. □ Verify that policies and procedures are developed and implemented in accordance with State law **Patient Health Record** □ Review clinical records of patients who received rehabilitation services. Determine whether the required care plan was developed and implemented. □ Verify that rehabilitation services were initiated only upon the order of a practitioner responsible for the care of the patient. **Personnel/Credential File (HR File Review/Competency Activity)** □ Review employee personnel files to verify that rehabilitation service providers (that is, physical therapists, physical therapy assistants, occupational therapists, occupational therapy assistants, and/or speech-language pathologists) have the necessary education, experience, training, and documented competencies to provide rehabilitation services.

Critical Access Hospital Medical Record Services Evaluation Module (485.638)

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RC.11.01.01, EP 7: The critical access hospital develops and implements policies and procedures for the maintenance of its medical records system(s). A designated member of the professional staff is responsible for maintaining the records.	**§485.638(a)(1) Standard: Records System** The CAH maintains a clinical records system in accordance with written policies and procedures.	**Document Review** **General** □ Verify that the CAH's written policies and procedures include the following: ○ A system of patient records, pertinent medical information, author identification, and record maintenance that ensures the integrity of the authentication and protects the security of all record entries ○ A medical record system that correctly identifies the author of every medical record entry ○ A medical record system that protects the security of all medical record entries ○ A medical record system that ensures medical record entries are not lost, stolen, destroyed, altered, or reproduced in an unauthorized manner ○ All locations where medical records are stored or maintained must ensure the integrity, security and protection of the records. ○ A system in place that ensures that the identity of the author of each entry is correct. The author of every entry must take a specified action to identify himself/herself as the author (or responsible person) of the entry, the time and dating of the entry, that the entry is accurate, and that he/she takes responsibility for accuracy of the entry ○ If the CAH uses computer entries there must be security system in place to ensure the integrity of the record system, to ensure that the author of each entry is correctly identified, to ensure that record entries are not altered or lost, that limits access to medical records to only authorized persons, and ensures that records are not released to unauthorized individuals. For the purposes of this regulation, electronic signatures

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		comply with those medical record entries that include a requirements for a signature. ○ A medical record for each inpatient and outpatient evaluated or treated in any part or location of the CAH. A unit record for both inpatients and outpatients may be used; however, when two different systems are used they must be appropriately cross referenced ○ When a patient reimbursement status changes from acute care services to swing bed services, a single medical record may be used for both stays as long as the record is sectioned separately. Both sections must include admission and discharge orders, progress notes, nursing notes, graphics, laboratory support documents, any other pertinent documents, and discharge summaries.
RC.11.01.01, EP 4: The critical access hospital develops and implements policies and procedures for accurate, legible, complete, signed, dated, timed, medical record entries that are authenticated by the person responsible for providing or evaluating the service provided. Medical records are promptly completed, systematically organized, and readily accessible.	**§485.638(a)(2)** The records are legible, complete, accurately documented, readily accessible, and systematically organized.	**Document Review** **Patient Health Record** □ For CAH surveys that are conducted after the initial certification survey, review a sample of records using an adequate sample size to evaluate the scope of services provided. In a very small CAH, review all inpatient and outpatient records, if appropriate. □ Entries in the medical record are accurate and completely document all orders, test results, evaluations, treatments, interventions, care provided and the patient's response to those treatments, interventions and care.
RC.11.01.01, EP 7: The critical access hospital develops and implements policies and procedures for the maintenance of its medical records system(s). A designated	**§485.638(a)(3)** A designated member of the professional staff is responsible for maintaining the records and for ensuring that they are completely and accurately	**Document Review** **General** □ Review the CAH's organizational structure and policy statements and to ascertain that the service is structured

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member of the professional staff is responsible for maintaining the records.	documented, readily accessible, and systematically organized.	appropriately to meet the needs of the CAH and the patients . **Interview** □ The director of medical records and confirm they are responsible for both inpatient and outpatient records. □ Ask the person responsible for the medical records service if the CAH employs adequate medical records personnel.
RC.12.01.01, EP 1: The medical record contains the following demographic information for the patient: - Name, address, and date of birth, and the name of any legally authorized representative - Sex - Communication needs, including preferred language for discussing health care - Race and ethnicity Note: If the patient is a minor, is incapacitated, or has a designated advocate, the communication needs of the parent or legal guardian, surrogate decision-maker, or legally authorized representative are documented in the clinical record. **RC.12.01.01, EP 2:** The medical record contains the following clinical information: - Admitting diagnosis - Any emergency care, treatment, and services provided to the patient before their arrival - Any allergies to food and medications - Any findings of assessments and reassessments	**§485.638(a)(4)(i)** For each patient receiving health care services, the CAH maintains a record that includes, as applicable-- Identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;	**Document Review** **Patient Health Record** □ Verify that patient health records contain properly executed consent forms for all procedures or treatment required by CAH policy. A properly executed consent form contains at least the following: o Name of patient and, when appropriate, patient's legal guardian o Name of CAH o Name of procedure(s) o Name of practitioner(s) performing the procedures(s) o Signature of patient or legal guardian o Date and time consent was obtained o Statement that procedure was explained to patient or guardian o Signature of professional person witnessing the consent o Name/signature of person who explained procedure to the patient or guardian

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- Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient - Treatment goals, plan of care, and revisions to the plan of care - Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia - All practitioners' orders - Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition - Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the critical access hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. - Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) - Records of radiology and nuclear medicine services, including signed interpretation reports - All care, treatment, and services provided to the patient - Patient's response to care, treatment, and		□ Review records for completeness and accuracy in accordance with federal and state law and regulation and CAH policy. [4] □ Review patient health records to ensure the documentation contained within does the following: [5] ○ Justify admission ○ Support the diagnosis ○ Describe the patient's progress ○ Describe the patient's response to medications ○ Describe the patient's response to services such as interventions, care, and treatments □ Review records to confirm complete information/ documentation regarding medical history, assessment of the health status and health care needs of the patient, and a summary of the episode, disposition, and instructions to the patient. This information and documentation is contained in a discharge summary.

[4] The sample should be at least 10 percent of the average daily census, as appropriate.

[5] Documentation may include progress and nursing notes, documentation, records, reports, recordings, test results, assessments etc.

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services - Medical history and physical examination, including any conclusions or impressions drawn from the information - Discharge plan and discharge planning evaluation - Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge - Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis. **RC.12.01.01, EP 3:** The medical record contains any informed consent, when required by critical access hospital policy or federal or state law or regulation. Note: The properly executed informed consent is placed in the patient's medical record prior to surgery, except in emergencies. A properly executed informed consent contains documentation of a patient's mutual understanding of and agreement for care, treatment, and services through written signature; electronic signature; or, when a patient is unable to provide a signature, documentation of the verbal agreement by the patient or surrogate decision-maker.		
RC.12.01.01, EP 2: See above	**§485.638(a)(4)(ii)** Reports of physical examinations, diagnostic and laboratory test results, including clinical laboratory services, and consultative findings;	**Document Review** **General**

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		□ Determine that the CAH's bylaws require that a physical examination and medical history be done for each patient. **Patient Health Record** □ Review a sample of health records. to determine if the appropriate practitioner performed all or part of the history and physical (H&P) in accordance with state law and CAH policy. The doctor of medicine or osteopathy must sign the H & P and assume full responsibility for the H & P. □ Verify whether the appropriate practitioner signed reports of physical examinations, diagnostic and laboratory test results, and consultative findings
RC.12.01.01, EP 2: See above	**§485.638(a)(4)(iii)** All orders of doctors of medicine or osteopathy or other practitioners, reports of treatments and medications, nursing notes and documentation of complications, and other pertinent information necessary to monitor the patient's progress, such as temperature graphics, progress notes describing the patient's response to treatment; and	**Document Review** **Patient Health Record** □ Verify that patient health records contain the information necessary to monitor the patient's condition, including the following: ○ All practitioner's orders (properly authenticated); ○ All nursing notes ○ All reports of treatment (including complications and health care–associated infections) ○ All medication records (including unfavorable reactions to drugs) ○ All radiology reports ○ All laboratory reports ○ All vital signs ○ Any other information necessary to monitor the patient's condition □ Verify that necessary information is included in health records in a prompt manner so that health care staff involved in the care of the patient have access to the

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		information necessary to monitor the patient's condition. Such information includes the following; ○ Diagnosis ○ Evaluations ○ Consents ○ Interventions ○ Discharge summary ○ Care provided along with the patient's response to those treatments, interventions, and care □ Every medical record must be promptly completed with all documentation of: ○ orders, ○ diagnosis, ○ evaluations, ○ treatments, ○ test results, ○ consents, ○ interventions, ○ discharge summary, and ○ care provided along with ○ the patient's response to those treatments, interventions, and care.
RC.11.02.01, EP 1: All orders, including verbal orders, are dated, timed, and authenticated by the ordering physician or other licensed practitioner who is responsible for the care of the patient, and who is authorized to write orders, in accordance with critical access hospital policy, law and regulation, and medical staff bylaws, rules, and regulations.	**§485.638(a)(4)(iv)** Dated signatures of the doctor of medicine or osteopathy or other health care professional.	**Document Review** **General** □ Verify that the medical records/health information management department maintains a current list of authenticated signatures, written initials, codes, and stamps when such are used for authorship identification. □ Verify that computer or other code signatures are authorized by the CAH'S governing body and that a list of these codes is maintained under adequate safeguards by the CAH administration.

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		□ Verify that the CAH'S policies and procedures provide for appropriate sanctions for unauthorized or improper use of computer codes. □ Verify that the CAH'S policies and procedures require documents in the electronic medical record system are authenticated after, not before, transcription. **Patient Health Record** □ Verify that health record entries are authenticated by the appropriate doctor of medicine or osteopathy and/or mid-level practitioner, as needed. □ Authentication includes, at a minimum, the following: ○ Method for identifying the author of each entry ○ Action taken by the author to verify that the entry is their entry or that they are responsible for the entry and that the entry is accurate ○ Timing of the entry noted and correct ○ Timing documents the time and date of each entry (for example, orders, reports, notes)
IM.12.01.01, EP 1: The critical access hospital develops and implements policies and procedures addressing the privacy and confidentiality of health information. Note: For swing beds in critical access hospitals: Policies and procedures also address the resident's personal records.	**§485.638(b)(1) Standard: Protection of Record Information** The CAH maintains the confidentially of record information and provides safeguards against loss, destruction, or unauthorized use.	**Interview** Medical Records/Health Information Management staff □ Verify that only authorized persons are permitted access to records maintained by the medical records department and that precautions are taken to prevent unauthorized persons from gaining access to or altering patient records. □ Verify that health records are released only for patient care evaluation, utilization review, treatment, quality assurance programs, and in-house educational purposes or in accordance with federal or state law, court orders, or subpoenas.

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		□ Verify that copies of health records are released outside the CAH only upon written authorization of the patient, legal guardian, or person with an appropriate power of attorney to act on the patient's behalf or only if there is a properly executed subpoena or court order or as mandated by statutes. □ Verify that adequate precautions are taken to prevent physical or electronic altering, damage, or deletion/destruction of patient records or information in patient records. **Document Review** **General** □ Verify that the CAH has a policy to grant patients direct access to their health record if the responsible individual (for example, practitioner responsible for patient's care) determines that direct access is not likely to have an adverse effect on the patient.
IM.12.01.01, EP 3: The critical access hospital develops and implements policies and procedures for the release of medical records. The policies and procedures are in accordance with law and regulation, court orders, or subpoenas. Note: Information from or copies of records may be released only to authorized individuals, and the critical access hospital makes certain that unauthorized individuals cannot gain access to or alter patient records. **IM.12.01.03, EP 1:** The critical access hospital develops and implements a written policy that addresses the security of health information, including the following: - Access and use	**§485.638(b)(2)** Written policies and procedures govern the use and removal of records from the CAH and the conditions for the release of information.	**Document Review** **General** □ Verify that the CAH has policies and procedures for the use and release of records. and that these policies and procedures are enforced. Is access to patient health records controlled? **Observation** □ Observe the CAH'S security practices for patient records. Are patient records left unsecured or unattended? Are records unsecured or unattended in hallways, patient rooms, nurses stations, or on counters where an unauthorized person could gain access?

Joint Commission Standards / EPs	Critical Access Hospital CoP	Critical Access Hospital Survey Process
- Integrity of health information against loss, damage, unauthorized alteration or use, unintentional change, and accidental destruction - Intentional destruction of health information - When and by whom the removal of health information is permitted Note: Removal refers to those actions that place health information outside the critical access hospital's control.		□ If the CAH uses electronic patient records, verify that there are appropriate security safeguards in place.
IM.12.01.01, EP 2: The critical access hospital discloses health information only as authorized by the patient with the patient's written consent or as otherwise required by law and regulation. Note: For swing beds in critical access hospitals: The critical access hospital allows representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with state law.	**§485.638(b)(3)** The patient's written consent is required for release of information not required by law.	**Document Review** **General** □ Verify that the CAH has a policy or procedure that require patients to provide informed consent to release information not required by law.
RC.11.03.01, EP 2: The medical record is retained for at least six years from the date of its last entry and longer if required by state statute or if the record is needed in any pending proceeding.	**§485.638(c) Standard: Retention of Records** The records are retained for at least 6 years from date of last entry, and longer if required by State statute, or if the records may be needed in any pending proceeding.	**Document Review** **Patient Health Record** □ Verify that patient health records are retained for at least 6 years from the date of last entry, or more if required by state or local law or needed in an pending proceeding. Can the CAH promptly retrieve health records of patients evaluated or treated within the past 6 years? **Interview** □ Ask staff responsible for records retention how long records are retained.

Critical Access Hospital Medical Record Services Evaluation Module Continued (Additional Joint Commission Requirements)

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
IM.13.01,01, EP 1: The critical access hospital uses standardized terminology, definitions, abbreviations, acronyms, symbols, and dose designations.	**Interview** □ Verify staff has awareness of hospital standardized terminology, definitions, abbreviations, acronyms, symbols, and dose designations.
PC.12.02.01, EP 1: The critical access hospital performs a learning needs assessment for each patient, which includes the following: - Cultural and religious beliefs - Emotional barriers - Desire and motivation to learn - Physical or cognitive limitations Barriers to communication **PC.12.02.01, EP 3:** Based on the patient's condition and assessed needs, the education and training provided to the patient by the critical access hospital include the following: - An explanation of the plan for care, treatment, and services - Basic health practices and safety - Information on the safe and effective use of medications - Nutrition interventions (for example, supplements) and modified diets - Discussion of pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management - Information on oral health - Information on the safe and effective use of medical equipment or supplies provided by the critical access hospital - Habilitation or rehabilitation techniques to help the patient reach maximum independence - Fall reduction strategies **PC.12.02.01, EP 5:** The critical access hospital provides the patient education on how to communicate concerns about patient safety issues that occur before, during, and after care is received.	**Document Review:** **Patient Medical Record:** □ Verify the patient received a learning needs assessment prior to providing education. □ Review education provided to the patient and determine if the patient's condition and assessed needs are addressed during their stay □ Verify the hospital evaluated the patient's understanding the education provided □ Verify the organization provided education about how to communicate concerns about the care

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RC.11.01.01, EP 3: The medical record of a patient who receives urgent or immediate care, treatment, and services contains the following: - Time and means of arrival - Indication that the patient left against medical advice, when applicable - Conclusions reached at the termination of care, treatment, and services, including the patient's final disposition, condition, and instructions given for follow-up care, treatment, and services - A copy of any information made available to the provider furnishing follow-up care, treatment, or services	**Documentation Review** **Patient Medical Record** □ Verify that if a patient received urgent or immediate care, treatment or services their medical record contains all elements identified in EP 3

Critical Access Hospital Surgical Services Evaluation Module (485.639(a)(d))

Joint Commission Standards / EPs	Critical Access Hospital CoP	Critical Access Hospital Survey Process
LD.13.03.01, EP 1: The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered and are in accordance with accepted standards of practice. Services may include but are not limited to the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic - Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital. **LD.13.03.01, EP 10:** If the critical access hospital provides outpatient surgical services,	**§485.639 Condition of Participation: Surgical Services.**	**Interview** ☐ Verify that an experienced staff member is responsible for supervising the operating room(s) as authorized by State law. **Document Review** **General** ☐ Review the CAH's organizational chart displaying the relationship of operating room services to other services and confirm that the chart indicates lines of authority and delegation of responsibility within the department or service. ☐ Review the staffing schedule to make certain that the appropriate number of qualified staff are present to support surgical services offered in accordance with acceptable standards of practice, including the availability of a registered nurse who is immediately available to supervise and physically intervene and provide care, as required in State law. ☐ Verify that RNs, LPNs, and surgical technologists are working in accordance with applicable state law and approved policies and procedures. ☐ Validate the availability of a registered nurse by requesting and reviewing a staffing schedule for the operating room ☐ Review policies and procedures that pertain to surgical services to make certain they are in accordance with acceptable standards of medical practice and surgical patient care. **Patient Health Record** ☐ Verify that a complete history and physical must was conducted in accordance with acceptable

Joint Commission Standards / EPs	Critical Access Hospital CoP	Critical Access Hospital Survey Process
the services are consistent with the quality of inpatient surgical care. **MS.17.02.01, EP 6:** The critical access hospital designates the practitioners who are allowed to perform surgery, in accordance with appropriate policies and procedures, and with scope of practice laws and regulations. Surgery is performed only by the following: - A doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Social Security Act - A doctor of dental surgery or dental medicine - A doctor of podiatric medicine		standards of practice, and the written document placed on the medical record, prior to surgery. Note: All or part of the H & P may be delegated to other practitioners in accordance with State law and CAH policy, but the surgeon must sign the H & P and assume full responsibility for the H & P ☐ Review the CAH's policies and procedures pertaining to informed consent, including the responsibility of the practitioner to discuss risk, benefits, and alternatives to the proposed intervention **Observation** ☐ Inspect all operating rooms/suites. Request the use of proper PPE for the inspection. ☐ Determine if surgical services are provided in accordance with acceptable standards of practice, including but not limited to: ☐ Access to surgical and recovery area, including traffic flow pattern(s) ☐ Adherence to aseptic and sterile techniques, including cleaning between cases and appropriate terminal cleaning ☐ Appropriate utilization of PPE for type of surgical case(s) performed ☐ Equipment maintenance by the hospital's biomedical equipment program and in accordance with federal and state law, regulations, guidelines, and manufacturer's recommendations ☐ Equipment availability for rapid and routine sterilization of OR equipment and materials ☐ Packaging, handling, labeling, and storage of sterilized materials ☐ Monitoring of temperature and humidity

Joint Commission Standards / EPs	Critical Access Hospital CoP	Critical Access Hospital Survey Process
		☐ Integration of surgical services into the hospital-wide quality assurance/performance improvement program ☐ Verify that the CAH has provisions for postoperative care that are provided in accordance with acceptable standards of practice
MS.17.02.01, EP 6: See above	**§485.639(a) Standard: Designation of Qualified Practitioners** The CAH designates the practitioners who are allowed to perform surgery for CAH patients, in accordance with its approved policies and procedures, and with State scope of practice laws. Surgery is performed only by— (1) A doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Act; (2) A doctor of dental surgery or dental medicine; or (3) A doctor of podiatric medicine	**Interview** ☐ Ask to see where the surgical roster(s) are kept including: ☐ A current roster with each practitioner's specific privileges ☐ A current list of surgeons with suspended or restricted surgical privileges **Document Review** **General** ☐ Review the roster of practitioners to ensure it specifies the surgical privileges of each practitioner ☐ Review the medical staff bylaws for criteria that determine the privileges to be granted to an individual practitioner **Personnel/Credential File** ☐ Verify surgical privileges in accordance with the competencies of each practitioner. ☐ Verify practitioner competency appraisal as established by the hospital's QAPI program and credentialing process in accordance with scope of practice and other State laws and regulations.
PC.13.01.03, EP 7: The critical access hospital discharges patients following the surgical procedure, in the company of a responsible adult, except in situations where the practitioner, who performed the surgical	**§485.639(d) Standard: Discharge** All patients are discharged in the company of a responsible adult, except those exempted by the practitioner who performed the surgical procedure.	**Document Review** **General** ☐ Verify that the CAH has policies and procedures in place to govern discharge procedures and instructions.

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procedure, determines the patient may leave unaccompanied.		

Critical Access Hospital Anesthesia Risk and Evaluation – Evaluation Module (485.639(b)-(c))

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PC.13.01.03, EP 3: A qualified physician or other licensed practitioner, in accordance with 42 CFR 485.639(a), reevaluates the patient immediately before surgery, to evaluate the risk of the procedure to be performed. **PC.13.01.03, EP 1:** A qualified physician or other licensed practitioner, in accordance with 42 CFR 485.639(c), conducts a preanesthesia patient assessment to evaluate the risk of anesthesia. **PC.13.01.03, EP 6:** A qualified physician or other licensed practitioner evaluates the patient for proper anesthesia recovery, as specified in 42 CFR 485.639(c), before discharging the patient from the recovery area or from the critical access hospital.	**§485.639(b) Standard: Anesthetic Risk and Evaluation** (1) A qualified practitioner, as specified in paragraph (a) of this section, must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed. (2) A qualified practitioner, as specified in paragraph (c) of this section, must examine each patient before surgery to evaluate the risk of anesthesia. (3) Before discharge from the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner, as specified in paragraph (c) of this section	**Document Review** **Patient Health Record** □ Review a sample of health records for patients who had surgery or a procedure requiring anesthesia to determine that each patient had: o A pre-anesthesia evaluation performed prior to inpatient or outpatient surgery and performed by an individual qualified to administer anesthesia. o Pre-operative anesthetic evaluation should include: o Notation of anesthesia risk o Anesthesia, drug and allergy history o Any potential anesthesia problems identified o Patient's condition prior to induction of anesthesia o A post-anesthesia follow-up report, written by the individual who administered anesthesia, prior to discharge from anesthesia services, that includes the following: o Cardiopulmonary status o Level of consciousness o Any follow-up care and/or observations o Any complications occurring during post-anesthesia recovery.
MS.17.02.01, EP 1: The critical access hospital, based on recommendations by the organized medical staff and approval by the governing body, establishes criteria that determine if a physician or other licensed practitioner is allowed to provide patient care, treatment, and services within the scope of	**§485.639(c) Standard: Administration of Anesthesia** The CAH designates the person who is allowed to administer anesthesia to CAH patients in accordance with its approved	**Document Review** **Personnel/Credential File** □ Review the qualifications of individuals authorized to deliver anesthesia.

the privilege(s) requested. Evaluation of all of the following are included in the criteria: - Current licensure and/or certification, as appropriate, verified with the primary source - Specific relevant training, verified with the primary source - Evidence of physical ability to perform the requested privilege - Data from professional practice review by an organization(s) that currently privileges the applicant (if available) - Peer and/or faculty recommendation - When renewing privileges, review of the physician's or other licensed practitioner's performance within the critical access hospital **PC.13.01.01, EP 1:** Anesthesia is administered only by the following individuals: - A qualified anesthesiologist - A doctor of medicine or osteopathy other than an anesthesiologist, including an osteopathic practitioner recognized under section 1101(a)(7) of the Social Security Act - A doctor of dental surgery or dental medicine, who is qualified to administer anesthesia under state law - A doctor of podiatric medicine, who is qualified to administer anesthesia under state law - A certified registered nurse anesthetist (CRNA), as defined in 42 CFR 410.69(b) of this chapter, supervised by the operating practitioner except as provided in 42 CFR 485.639(e) regarding the state exemption for this supervision - An anesthesiologist's assistant, as defined in 42 CFR 410.69(b) of this chapter,	policies and procedures and with State scope-of-practice laws. (1) Anesthesia must be administered by only— (i)A qualified anesthesiologist; (ii) A doctor of medicine or osteopathy other than an anesthesiologist; including an osteopathic practitioner recognized under section 1101(a)(7) of the Act; (iii) A doctor of dental surgery or dental medicine; (iv) A doctor of podiatric medicine; (v) A certified registered nurse anesthetist (CRNA), as defined in Sec. 410.69(b) of this chapter; (vi) An anesthesiologist's assistant, as defined in Sec. 410.69(b) of this chapter; or (vii) A supervised trainee in an approved educational program, as described in §§ 413.85 or 413.86 of this chapter	☐ Is there documentation of current licensure or current certification status for all persons administering anesthesia.

supervised by an anesthesiologist - A supervised trainee in an approved educational program Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law, or if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission. Note 2: See Glossary for the definition of certified registered nurse anesthetist (CRNA) and anesthesiologist assistant. Note 3: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's Boards of Medicine and Nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement, and that the opt-out is consistent with state law. The request for		

exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission. Note 4: Only the above individuals can administer deep sedation/analgesia.		
PC.13.01.01, EP 1: See above	§485.639(c)(2) In those cases in which a CRNA administers the anesthesia, the anesthetist must be under the supervision of the operating practitioner except as provided in paragraph (e) of this section. An anesthesiologist's assistant who administers anesthesia must be under the supervision of an anesthesiologist.	**Interview** Surgical services staff: o Ask how they know if someone delivering anesthesia has privileges and if they require supervision, and who can provide that supervision. *Note: §485.639(e) Standard: State Exemption* *(1) A CAH may be exempted from the requirement for MD/DO supervision of CRNAs as described in paragraph (c)(2) of this section, if the State in which the CAH is located submits a letter to CMS signed by the Governor, following consultation with the State's Boards of Medicine and Nursing, requesting exemption from MD/DO supervision for CRNAs. The letter from the Governor must attest that he or she has consulted with the State Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the State and has concluded that it is in the best interests of the State's citizens to opt-out of the current MD/DO supervision requirement, and that the opt-out is consistent with State law.*

Critical Access Hospital Infection Prevention and Control & Antibiotic Stewardship Programs Evaluation Module (485.640)

Note: The interview with the infection preventionist(s)/infection control professional(s) and document review for the infection prevention and control program occur during targeted session on Survey Day 1 (the timing of the session can be negotiated with the organization based on key staff availability). Observations of infection control–related systems and activities are evaluated throughout the survey of all organization settings by all surveyors.

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IC.04.01.01, EP 2: The infection preventionist(s) or infection control professional(s) is responsible for the following: - Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines - Documentation of the infection prevention and control program and its surveillance, prevention, and control activities - Competency-based training and education of critical access hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the critical access hospital, on infection prevention and control guidelines, policies, and procedures and their application - Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures - Communication and collaboration with all components of the critical access hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program - Communication and collaboration with the	**§485.640 Condition of participation: Infection prevention and control and antibiotic stewardship programs.** The CAH must have active facility-wide programs, for the surveillance, prevention, and control of HAIs and other infectious diseases and for the optimization of antibiotic use through stewardship. The programs must demonstrate adherence to nationally recognized infection prevention and control guidelines, as well as to best practices for improving antibiotic use where applicable, and for reducing the development and transmission of HAIs and antibiotic-resistant organisms. Infection prevention and control problems and antibiotic use issues identified in the programs must be addressed in coordination with the facility-wide quality assessment and performance improvement (QAPI) program.	**Document Review** **General** ☐ Review the infection prevention and control and antibiotic stewardship program documents for evidence of the following: ○ The hospital has an active, hospitalwide program for surveillance, prevention, and control of health care–associated infections and other infectious diseases based on national standards of practice and best practices. ○ The infection prevention and control program is working collaboratively with the hospital QAPI program to address issues identified in the infection control program. ○ The hospital has an active hospital-wide program for the optimization of antibiotic use through stewardship based on national standards of practice and best practices. ○ The hospital is working collaboratively between antibiotic stewardship and hospital QAPI when antibiotic use issues are identified.

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critical access hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.11.04.01, EP 1). **IC.04.01.01, EP 3:** The critical access hospital's infection prevention and control program has written policies and procedures to guide its activities and methods for preventing and controlling the transmission of infections within the critical access hospital and between the critical access hospital and other institutions and settings. The policies and procedures are in accordance with the following hierarchy of references: a. Applicable law and regulation. b. Manufacturers' instructions for use. c. Nationally recognized evidence-based guidelines and standards of practice, including the Centers for Disease Control and Prevention's (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings or, in the absence of such guidelines, expert consensus or best practices. The guidelines are documented within the policies and procedures. Note 1: Relevant federal, state, and local law and regulations include but are not limited to the Centers for Medicare & Medicaid Services' Conditions of Participation, Food and Drug		

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Administration's regulations for reprocessing single-use medical devices; Occupational Safety and Health Administration's Bloodborne Pathogens Standard 29 CFR 1910.1030, Personal Protective Equipment Standard 29 CFR 1910.132, and Respiratory Protection Standard 29 CFR 1910.134; health care worker vaccination laws; state and local public health authorities' requirements for reporting of communicable diseases and outbreaks; and state and local regulatory requirements for biohazardous or regulated medical waste generators. Note 2: For full details on the CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, refer to https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html. Note 3: The critical access hospital determines which evidence-based guidelines, expert recommendations, best practices, or a combination thereof it adopts in its policies and procedures. **IC.04.01.01, EP 5:** The infection prevention and control program reflects the scope and complexity of the critical access hospital services provided by addressing all locations, patient populations, and staff. **IC.05.01.01, EP 1:** The critical access hospital's governing body, or responsible individual, is responsible for the implementation, performance, and sustainability of the infection prevention and control program and provides resources to support and track the implementation, success, and sustainability of the program's activities.		

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Note: To make certain that systems are in place and operational to support the program, the governing body, or responsible individual, provides access to information technology; laboratory services; equipment and supplies; local, state, and federal public health authorities' advisories and alerts, such as the CDC's Health Alert Network (HAN); FDA alerts; manufacturers' instructions for use; and guidelines used to inform policies. **IC.05.01.01, EP 2:** The critical access hospital's governing body, or responsible individual, ensures that the problems identified by the infection prevention and control program are addressed in collaboration with critical access hospital quality assessment and performance improvement leaders and other leaders (for example, the medical director, nurse executive, and administrative leaders). **IC.06.01.01, EP 3:** The critical access hospital implements activities for the surveillance, prevention, and control of health care–associated infections and other infectious diseases, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and addresses any infection control issues identified by public health authorities that could impact the critical access hospital. **MM.18.01.01, EP 1:** The antibiotic stewardship program reflects the scope and complexity of the critical access hospital services provided. **MM.18.01.01, EP 3:** The leader(s) of the antibiotic stewardship program is responsible		

Joint Commission Standards / EPs	Critical Access Hospital CoP	Critical Access Hospital Survey Process
for the following: - Development and implementation of a critical access hospitalwide antibiotic stewardship program, based on nationally recognized guidelines, to monitor and improve the use of antibiotics - All documentation, written or electronic, of antibiotic stewardship program activities - Communication and collaboration with the medical staff, nursing, and pharmacy leaders, as well as with the critical access hospital's infection prevention and control and quality assessment and performance improvement programs on antibiotic use issues - Competency-based training and education of critical access hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the critical access hospital, on the practical applications of antibiotic stewardship guidelines, policies, and procedures **PE.04.01.01, EP 1:** The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients.		

Joint Commission Standards / EPs	Critical Access Hospital CoP	Critical Access Hospital Survey Process
Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.		
HR.11.02.01, EP 1: The critical access hospital defines staff qualifications specific to their job responsibilities. Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control). Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists, as defined in 42 CFR 484, provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the critical access hospital. See Glossary for definitions of physical therapist, physical therapist assistant, occupational therapist, occupational therapy assistant, speech-language pathologist, and audiologist. Note 3: For rehabilitation and psychiatric distinct part units in critical access hospitals: If respiratory care services are provided, staff qualified to perform specific respiratory care procedures, and the amount of supervision required to carry out the specific procedures is designated in writing.	**§485.640(a) Standard:** Infection prevention and control program organization and policies. The CAH must demonstrate that: (1) An individual (or individuals), who is qualified through education, training, experience, or certification in infection prevention and control, is appointed by the governing body, or responsible individual, as the infection preventionist(s)/infection control professional(s) responsible for the infection prevention and control program and that the appointment is based on the recommendations of medical staff leadership and nursing leadership;	**Interview** ☐ Interview the infection preventionist(s)/infection professional(s) to determine whether resources are adequate to accomplish the tasks required for the infection prevention and control program. ☐ Interview the hospital leaders about the criteria the hospital uses to determine whether the resource allocation to the IPC program matches the determined needs. **Document Review** **Personnel/Credential File** ☐ Review the personnel file of the infection preventionist(s)/infection control professional(s) to determine whether they are qualified through professional education, training, experience, or certification to oversee IPC program. ☐ Verify that the individual(s) was appointed by the hospital's governing body based on recommendations by medical and nursing staff leaders.

Joint Commission Standards / EPs	Critical Access Hospital CoP	Critical Access Hospital Survey Process
NPG.12.02.01, EP 12: The critical access hospital's governing body, or responsible individual, based on the recommendation of the medical staff and nursing leaders, appoints an infection preventionist(s) or infection control professional(s) qualified through education, training, experience, or certification in infection prevention to be responsible for the infection prevention and control program.		
IC.04.01.01, EP 3: The critical access hospital's infection prevention and control program has written policies and procedures to guide its activities and methods for preventing and controlling the transmission of infections within the critical access hospital and between the critical access hospital and other institutions and settings. The policies and procedures are in accordance with the following hierarchy of references: a. Applicable law and regulation. b. Manufacturers' instructions for use. c. Nationally recognized evidence-based guidelines and standards of practice, including the Centers for Disease Control and Prevention's (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings or, in the absence of such guidelines, expert consensus or best practices. The guidelines are documented within the policies and procedures. Note 1: Relevant federal, state, and local law and regulations include but are not limited to the Centers for Medicare & Medicaid Services' Conditions of Participation, Food and Drug Administration's regulations for reprocessing single-use medical devices; Occupational Safety and Health Administration's Bloodborne	**§485.640(a)(2)** The infection prevention and control program, as documented in its policies and procedures, employs methods for preventing and controlling the transmission of infections within the CAH and between the CAH and other healthcare settings;	**Document Review** **General** - Review policies and procedures for infection prevention and control to ensure that the hospital is employing methods for preventing and controlling the transmission of infections within the hospital and between the hospital and other health care settings. **Observation** - Determine if the IPC program is being applied throughout the hospital to both inpatient and outpatient settings.

Joint Commission Standards / EPs	Critical Access Hospital CoP	Critical Access Hospital Survey Process
Pathogens Standard 29 CFR 1910.1030, Personal Protective Equipment Standard 29 CFR 1910.132, and Respiratory Protection Standard 29 CFR 1910.134; health care worker vaccination laws; state and local public health authorities' requirements for reporting of communicable diseases and outbreaks; and state and local regulatory requirements for biohazardous or regulated medical waste generators. Note 2: For full details on the CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, refer to https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html. Note 3: The critical access hospital determines which evidence-based guidelines, expert recommendations, best practices, or a combination thereof it adopts in its policies and procedures. **IC.04.01.01, EP 4:** The critical access hospital's policies and procedures for cleaning, disinfection, and sterilization of reusable medical and surgical devices and equipment address the following: - Cleaning, disinfection, and sterilization of reusable medical and surgical devices in accordance with the Spaulding classification system and manufacturers' instructions - Use of disinfectants registered by the Environmental Protection Agency for noncritical devices and equipment according to the directions on the product labeling, including but not limited to indication, specified use dilution, contact time, and method of application - Use of FDA–approved liquid chemical sterilants for the processing of critical devices		

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and high-level disinfectants for the processing of semicritical devices in accordance with FDA–cleared label and device manufacturers' instructions - Required documentation for device reprocessing cycles, including but not limited to sterilizer cycle logs, the frequency of chemical and biological testing, and the results of testing for appropriate concentration for chemicals used in high-level disinfection - Resolution of conflicts or discrepancies between a medical device manufacturer's instructions and manufacturers' instructions for automated high-level disinfection or sterilization equipment - Criteria and process for the use of immediate-use steam sterilization - Actions to take in the event of a reprocessing error or failure identified either prior to the release of the reprocessed item(s) or after the reprocessed item(s) was used or stored for later use Note 1: The Spaulding classification system classifies medical and surgical devices as critical, semicritical, or noncritical based on risk to the patient from contamination on a device and establishes the levels of germicidal activity (sterilization, high-level disinfection, intermediate-level disinfection, and low-level disinfection) to be used for the three classes of devices. Note 2: Depending on the nature of the incident, examples of actions may include quarantine of the sterilizer, recall of item(s), stakeholder notification, patient notification, surveillance, and follow-up.		
IC.06.01.01, EP 3: The critical access hospital implements activities for the surveillance,	**§485.640(a)(3)**	**Document Review** **General**

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prevention, and control of health care–associated infections and other infectious diseases, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and addresses any infection control issues identified by public health authorities that could impact the critical access hospital. **IC.06.01.01, EP 4:** The critical access hospital implements its policies and procedures for infectious disease outbreaks, including the following: - Implementing infection prevention and control activities when an outbreak is first recognized by internal surveillance or public health authorities - Reporting an outbreak in accordance with state and local public health authorities' requirements - Investigating an outbreak - Communicating information necessary to prevent further transmission of the infection among patients, visitors, and staff, as appropriate **IC.06.01.01, EP 5:** The critical access hospital implements policies and procedures to minimize the risk of communicable disease exposure and acquisition among its staff, in accordance with law and regulation. The policies and procedures address the following: - Screening and medical evaluations for infectious diseases - Immunizations - Staff education and training - Management of staff with potentially infectious exposures or communicable illnesses	The infection prevention and control program includes surveillance, prevention, and control of HAIs, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and addresses any infection control issues identified by public health authorities; and	☐ Review documentation of surveillance activities, including the measures selected for monitoring, collection, and analysis. Based on the review, determine whether the surveillance program employes methods to permit identifying and monitoring infections and communicable diseases throughout various locations or departments. ☐ Review the water management program documentation related to the hospital risk assessment and water quality monitoring. ☐ Verify that the hospital has policies and procedures for the detection, investigation, and control of outbreaks that are consistent with state and local public health authority requirements for identification, reporting, and containing communicable diseases and outbreaks. **Observation** ☐ Observe the hospital for the sanitary condition of its environments of care, noting the cleanliness of patient rooms, floors, horizontal surfaces, patient equipment, air inlets, mechanical rooms, food service activities, treatment and procedure areas, surgical areas, central supply, storage areas, and medication preparation areas.

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PE.01.01.01, EP 1: The critical access hospital's building is constructed, arranged, and maintained to allow safe access and to protect the safety and well-being of patients. Note 1: Diagnostic and therapeutic facilities are located in areas appropriate for the services provided. Note 2: When planning for new, altered, or renovated space, the critical access hospital uses state rules and regulations or the current Guidelines for Design and Construction of Hospitals published by the Facility Guidelines Institute. If the state rules and regulations or the Guidelines do not address the design needs of the critical access hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria. **PE.04.01.05, EP 1:** The water management program has an individual or a team responsible for the oversight and implementation of the program, including but not limited to development, management, and maintenance activities. **PE.05.04.01, EP 2:** The individual or team responsible for the water management program develops the following: - A basic diagram that maps all water supply sources, treatment systems, processing steps, control measures, and end-use points Note: An example would be a flow chart with symbols showing sinks, showers, water fountains, ice machines, and so forth. - A water risk management plan based on the diagram that includes an evaluation of the physical and chemical conditions of each step		

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of the water flow diagram to identify any areas where potentially hazardous conditions may occur (these conditions are most likely to occur in areas with slow or stagnant water) Note: Refer to the Centers for Disease Control and Prevention's "Water Infection Control Risk Assessment (WICRA) for Healthcare Settings" tool as an example for conducting a water-related risk assessment. - A plan for addressing the use of water in areas of buildings where water may have been stagnant for a period of time (for example, unoccupied or temporarily closed areas) - An evaluation of the patient populations served to identify patients who are immunocompromised - Monitoring protocols and acceptable ranges for control measures Note: Critical access hospitals should consider incorporating basic practices for water monitoring within their water management programs that include monitoring of water temperature, residual disinfectant, and pH. In addition, protocols should include specificity around the parameters measured, locations where measurements are made, and appropriate corrective actions taken when parameters are out of range.		
IC.04.01.01, EP 5: The infection prevention and control program reflects the scope and complexity of the critical access hospital services provided by addressing all locations, patient populations, and staff.	**§485.640(a)(4)** The infection prevention and control program reflects the scope and complexity of the CAH services provided.	**Interview** □ Interview hospital staff in various locations or areas on collection of infection and communicable disease data and actions to reduce the risks of infections. **Document review** **General** □ Determine whether the infection control and prevention program is hospital-wide and program-specific in gathering and assessing infection and

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		communicable disease data and in taking steps to reduce the risks of infections. ☐ Review documentation of surveillance activities to determine whether active surveillance is suitable to the scope and complexity of the hospital's services and the population served.
MM.18.01.01, EP 2: The critical access hospital demonstrates that an individual (or individuals), who is qualified through education, training, or experience in infectious diseases and/or antibiotic stewardship, is appointed by the governing body, or responsible individual, as the leader(s) of the antibiotic stewardship program and that the appointment is based on the recommendations of medical staff leadership and pharmacy leadership.	**§485.640(b)(1) Standard:** **Antibiotic stewardship program organization and policies.** The CAH must demonstrate that: (1) An individual (or individuals), who is qualified through education, training, or experience in infectious diseases and/or antibiotic stewardship, is appointed by the governing body, or responsible individual, as the leader(s) of the antibiotic stewardship program and that the appointment is based on the recommendations of medical staff leadership and pharmacy leadership;	**Interview** ☐ Determine whether the antibiotic stewardship leader(s): o Was appointed by the governing body, or responsible individual, based on recommendations from medical staff and pharmacy leaders and has the responsibility for the antibiotic stewardship program. o Is a physician and/or pharmacist. ☐ Ask the leader(s) about their qualifications to oversee the antibiotic stewardship program. **Note:** *Training and/or certification may be obtained through organizations such as the specialty boards in adult or pediatric infectious diseases offered for physicians by the American Board of Internal Medicine (for internists), the American Board of Pediatrics (for pediatricians), and the Society for Infectious Disease Pharmacists (for pharmacists).* If board members are present, ask how they are involved in decisions about antibiotic stewardship leader(s). **Document Review** **General** ☐ Determine whether the leader(s) of antibiotic stewardship: o Was appointed by the governing body, or responsible individual, based on recommendations by medical staff and pharmacy leaders and has the responsibility for the antibiotic stewardship program. o Has developed and implemented the hospital's antibiotic stewardship policies. **Note:** *Antibiotic stewardship policies should address the roles and responsibilities for antibiotic*

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		stewardship and use within the hospital, how the various hospital committees and departments interface with the antibiotic stewardship program, and how to optimize antibiotic use. ☐ Review the criteria the hospital used to determine the resources necessary to operate effectively and ensure the resource allocation matches the determined needs. **Personnel/Credential File** ☐ Review the personnel file of the antibiotic stewardship leader(s) to determine whether they are qualified through ongoing education, training, experience, or certification to oversee the antibiotic stewardship program. **Note:** *Training and/or certification may be obtained through organizations such as the specialty boards in adult or pediatric infectious diseases offered for physicians by the American Board of Internal Medicine (for internists), the American Board of Pediatrics (for pediatricians), and the Society for Infectious Disease Pharmacists (for pharmacists).*
MM.18.01.01, EP 5: The critical access hospitalwide antibiotic stewardship program: - Demonstrates coordination among all components of the critical access hospital responsible for antibiotic use and resistance, including, but not limited to, the infection prevention and control program, the quality assessment and performance improvement program, the medical staff, nursing services, and pharmacy services. - Documents the evidence-based use of antibiotics in all departments and services of the critical access hospital. - Documents any improvements, including sustained improvements, in proper antibiotic use.	**§485.640(b)(2)** The facility-wide antibiotic stewardship program: **(i)** Demonstrates coordination among all components of the CAH responsible for antibiotic use and resistance, including, but not limited to, the infection prevention and control program, the QAPI program, the medical staff, nursing services, and pharmacy services; **(ii)** Documents the evidence-based use of antibiotics in all departments and services of the CAH; and **(iii)** Documents any improvements, including sustained improvements, in proper antibiotic use;	**Interview** ☐ Verify with staff who prescribe antibiotics that the hospital implements and maintains an active and hospitalwide antibiotic stewardship program as an effective means to improve the hospital's antibiotic-prescribing practices. ☐ Ask staff who prescribe antibiotics how the hospital promotes the evidence-based use of antibiotics to reduce the incidence of adverse consequences of inappropriate antibiotic use, including but not limited to adverse drug events, CDIs, and the growth of antibiotic resistance in the hospital overall. **Document Review** **General**

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		☐ Review antibiotic stewardship policies and procedures for evidence of a process for the coordination of all components of the hospital related to antibiotic use and resistance, including but not limited to the antibiotic stewardship program, the infection prevention and control program, the quality assurance/performance improvement program, the medical staff, nursing services, and pharmacy services. ☐ Confirm that the hospital develops and implements antibiotic stewardship interventions to address issues identified through its assessment activities and then monitors the effectiveness of interventions through further data collection and analysis. ☐ Verify that the hospital promotes evidence-based use of antibiotics to reduce the incidence of adverse consequences of inappropriate antibiotic use, including but not limited to treatment failures, *C. difficile* infections (CDIs), and growth of antibiotic resistance in the hospital overall. ☐ Verify that the hospital's antibiotic use is consistent with their documented evidence-based, hospitalwide antibiotic stewardship program recommendations. ☐ Review documentation of improvements and/or sustainment of improvements through the use of the evidence-based, hospitalwide antibiotic stewardship program recommendations. ☐ Note: It is expected that the hospital will reduce patient risk for adverse drug events and potentially life-threatening, antibiotic-resistant infections, including CDIs. ☐ Confirm that the antibiotic stewardship program is updated with any advancing evidence-based improvements in antibiotic-prescribing practices.
MM.18.01.01, EP 6: The antibiotic stewardship program adheres to nationally recognized guidelines, as well as best practices, for improving antibiotic use.	**§485.640(b)(3)** The antibiotic stewardship program adheres to nationally recognized guidelines, as well as best practices, for improving antibiotic use; and	**Interview** ☐ Ask staff who prescribe antibiotics about the nationally recognized guidelines that have been implemented as part of the hospitalwide antibiotic stewardship program.

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		Document Review **General** ☐ Verify that nationally recognized guidelines have been implemented for the evidence-based, hospitalwide antibiotic stewardship program. ☐ Verify that core elements of best practices have been included within the hospitalwide antibiotic stewardship program, including hospital leadership commitment, accountability, pharmacy expertise, tracking, reporting, education, and appropriate interventions or actions being taken to improve antibiotic use to reduce adverse events, prevent emergence of resistance, and ensure better outcomes for patients in this setting. **Note:** *See the Centers for Disease Control and Prevention's Core Elements of Antibiotic Stewardship at https://www.cdc.gov/antibiotic-use/coreelements/index.html for more information. Examples of other organizations with nationally recognized antibiotic stewardship guidelines and/or recommendations include but are not limited to the Society for Healthcare Epidemiology of America, the Infectious Diseases Society of America, the American Society for Health System Pharmacists, and the Society for Infectious Disease Pharmacists.*
MM.18.01.01, EP 1: The antibiotic stewardship program reflects the scope and complexity of the critical access hospital services provided.	**§485.640(b)(4)** The antibiotic stewardship program reflects the scope and complexity of the CAH services provided.	**Document Review** **General** ☐ Review the parameters of the antibiotic stewardship program to determine whether it is suitable to the scope and complexity of the hospital's services.
IC.05.01.01, EP 1: The critical access hospital's governing body, or responsible individual, is responsible for the implementation, performance, and sustainability of the infection prevention and control program and provides resources to support and track the implementation, success, and sustainability of the program's activities.	**§485.640(c)(1) Standard: Leadership responsibilities** (1) The governing body, or responsible individual, must ensure all of the following: **(i)** Systems are in place and operational for the tracking of all infection surveillance, prevention, and control, and antibiotic use activities, in order to demonstrate the	**Document Review** **General** ☐ Review the hospital policies and governing body meeting minutes for record of support for the infection control and antibiotic stewardship programs. ☐ Verify that the hospital policies are being followed for the tracking of all infection surveillance, prevention and

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Note: To make certain that systems are in place and operational to support the program, the governing body, or responsible individual, provides access to information technology; laboratory services; equipment and supplies; local, state, and federal public health authorities' advisories and alerts, such as the CDC's Health Alert Network (HAN); FDA alerts; manufacturers' instructions for use; and guidelines used to inform policies. **MM.18.01.01, EP 7**: The governing body, or responsible individual, ensures that systems are in place and operational for the tracking of all antibiotic use activities in order to demonstrate the implementation, success, and sustainability of such activities.	implementation, success, and sustainability of such activities.	control, and the monitoring of hospital antibiotic use activities.
IC.05.01.01, EP 2: The critical access hospital's governing body, or responsible individual, ensures that the problems identified by the infection prevention and control program are addressed in collaboration with critical access hospital quality assessment and performance improvement leaders and other leaders (for example, the medical director, nurse executive, and administrative leaders). **MM.18.01.01, EP 4:** The governing body, or responsible individual, ensures all antibiotic use issues identified by the antibiotic stewardship program are addressed in collaboration with the critical access hospital's QAPI leadership.	[**§485.640(c)(1)** The governing body, or responsible individual, must ensure all of the following:] **(ii)** All HAIs and other infectious diseases identified by the infection prevention and control program as well as antibiotic use issues identified by the antibiotic stewardship program are addressed in collaboration with the CAH's QAPI leadership.	**Interview** ☐ Interview program leaders to confirm that the hospital's infection control program and antibiotic stewardship program are being coordinated with their QAPI leadership, medical staff, nursing services, and pharmacy services. **Document Review** **General** ☐ Determine whether infection control and antibiotic use problems identified are reported to the hospital's leadership. ☐ Verify that hospital leadership takes steps to assure that corrective actions are implemented and successful. ☐ Determine whether the hospital's QAPI program and staff in-service training programs address problems identified by the hospital's infection control program and antibiotic stewardship programs.
IC.04.01.01, EP 2: The infection preventionist(s) or infection control professional(s) is responsible for the following:	**§485.640(c)(2) Standard: Leadership responsibilities** (2) The infection preventionist(s)/infection control	**Document Review** **General**

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- Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines - Documentation of the infection prevention and control program and its surveillance, prevention, and control activities - Competency-based training and education of critical access hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the critical access hospital, on infection prevention and control guidelines, policies, and procedures and their application - Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures - Communication and collaboration with all components of the critical access hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program - Communication and collaboration with the critical access hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For	professional(s) is responsible for: **(i)** The development and implementation of facility-wide infection surveillance, prevention, and control policies and procedures that adhere to nationally recognized guidelines.	☐ Verify that the hospital's infection prevention and control program, including its hospital-wide infection surveillance, prevention, and control policies and procedures, is consistent with nationally recognized standards.

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more information on competency requirements, refer to HR.11.04.01, EP 1).		
IC.04.01.01, EP 2: See above	**[§485.640(c)(2)** The infection preventionist(s)/infection control professional(s) is responsible for:] **(ii)** All documentation, written or electronic, of the infection prevention and control program and its surveillance, prevention, and control activities.	**Document Review** **General** ☐ Verify that the hospital's infection preventionist(s) and/or infection prevention and control professional(s) is documenting, in written or electronic form, the IPC program and its surveillance, prevention, and control activities.
IC.04.01.01, EP 2: See above	**[§485.640(c)(2)** The infection preventionist(s)/infection control professional(s) is responsible for:] **(iii)** Communication and collaboration with the CAH's QAPI program on infection prevention and control issues.	**Document Review** **General** ☐ Verify that the hospital's infection preventionist(s) and/or infection control professional(s) is communicating and collaborating with the hospital's QAPI program on all infection prevention and control issues.
HR.11.03.01, EP 1: Staff participate in ongoing education and training to maintain or increase their competency and, as needed, when staff responsibilities change. Staff participation is documented. **HR.11.04.01, EP 1:** Staff competence is assessed and documented once every three years, or more frequently as required by critical access hospital policy or in accordance with law and regulation. **IC.04.01.01, EP 2:** The infection preventionist(s) or infection control professional(s) is responsible for the following: - Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines	**[§485.640(c)(2)** The infection preventionist(s)/infection control professional(s) is responsible for:] **(iv)** Competency-based training and education of CAH personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the CAH, on the practical applications of infection prevention and control guidelines, policies, and procedures.	**Document Review** **General** ☐ Review the hospital's policies and procedures on training and educating staff to confirm that the hospital's infection preventionist(s) and/or infection control professional(s) training and education of hospital personnel and staff is competency based **Personnel/Credential File** ☐ Review a sample of personnel files to verify that training on the practical applications of infection prevention and control guidelines was completed and required competencies were met.

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- Documentation of the infection prevention and control program and its surveillance, prevention, and control activities - Competency-based training and education of critical access hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the critical access hospital, on infection prevention and control guidelines, policies, and procedures and their application - Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures - Communication and collaboration with all components of the critical access hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program - Communication and collaboration with the critical access hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.11.04.01, EP 1).		
- IC.04.01.01, EP 2: The infection preventionist(s) or infection control professional(s) is responsible for the following:	**[§485.640(c)(2)** The infection preventionist(s)/infection control professional(s) is responsible for:] **(v)** The	**Document Review** ☐ Verify that the hospital's infection preventionist(s) and/or infection prevention and control professional(s)

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- Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines - Documentation of the infection prevention and control program and its surveillance, prevention, and control activities - Competency-based training and education of critical access hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the critical access hospital, on infection prevention and control guidelines, policies, and procedures and their application - Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures - Communication and collaboration with all components of the critical access hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program - Communication and collaboration with the critical access hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For	prevention and control of HAIs, including auditing of adherence to infection prevention and control policies and procedures by CAH personnel.	has an active role in auditing the adherence to infection prevention and control policies and procedures by hospital personnel.

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more information on competency requirements, refer to HR.11.04.01, EP 1).		
IC.04.01.01, EP 2: See above	[**§485.640(c)(2)** The infection preventionist(s)/infection control professional(s) is responsible for:] **(vi)** Communication and collaboration with the antibiotic stewardship program.	**Document Review** ☐ Verify that the hospital's infection preventionist(s) and/or infection prevention and control professional(s) is communicating and collaborating with the antibiotic stewardship program.
MM.18.01.01, EP 3: The leader(s) of the antibiotic stewardship program is responsible for the following: -Development and implementation of a critical access hospitalwide antibiotic stewardship program, based on nationally recognized guidelines to monitor and improve the use of antibiotics. - All documentation, written or electronic, of antibiotic stewardship program activities. -Communication and collaboration with medical staff, nursing, and pharmacy leadership, as well as with the critical access hospital's infection prevention and control and QAPI programs, on antibiotic use issues. -Competency-based training and education of critical access hospital personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the critical access hospital, on the practical applications of antibiotic stewardship guidelines, policies, and procedures.	**§485.640(c)(3) Standard: Leadership responsibilities** (3) The leader(s) of the antibiotic stewardship program is responsible for: **(i)** The development and implementation of a facility-wide antibiotic stewardship program, based on nationally recognized guidelines, to monitor and improve the use of antibiotics. **(ii)** All documentation, written or electronic, of antibiotic stewardship program activities. **(iii)** Communication and collaboration with medical staff, nursing, and pharmacy leadership, as well as with the CAH's infection prevention and control and QAPI programs, on antibiotic use issues. **(iv)** Competency-based training and education of CAH personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the CAH, on the practical applications of antibiotic stewardship guidelines, policies, and procedures.	**Document Review** **General** ☐ Verify that the antibiotic stewardship program leader(s) is responsible for the following: ○ Developing and implementing the hospital-wide antibiotic stewardship program, based on nationally recognized guidelines, to monitor and improve the use of antibiotics. ○ Documenting the hospital's antibiotic stewardship program activities and antibiotic use issues. **Note:** *Documentation may be written or electronic.* ○ Communicating and collaborating with medical staff, nursing staff, and pharmacy leaders, as well as the hospital's infection prevention and control and QAPI programs. ○ Providing competency-based training and education for hospital personnel, including medical staff and, as applicable, contracted staff providing services in the hospital, on the practical applications of antibiotic stewardship guidelines, policies, and procedures.
LD.11.01.01, EP 10: If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a	**§485.640(g) Standard: Unified and integrated infection prevention and control and antibiotic stewardship programs for CAH in a multi-facility system.** If a CAH is	**General guidance** ☐ Assess the manner and degree of noncompliance with the standards within this condition to determine whether there is condition-level noncompliance.

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system governing body that is legally responsible for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency hospitals, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member facilities after determining that such a decision is in accordance with applicable law and regulation. Each separately certified critical access hospital subject to the system governing body demonstrates that the unified and integrated infection prevention and control program and the antibiotic stewardship program do the following: - Account for each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered at each critical access hospital - Establish and implement policies and procedures to make certain that the needs and concerns of each separately certified critical access hospital, regardless of practice or location, are given due consideration - Have mechanisms in place to ensure that issues localized to particular critical access hospitals are duly considered and addressed - Designate a qualified individual(s) at the critical access hospital with expertise in infection prevention and control and in antibiotic stewardship as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and	part of a system consisting of multiple separately certified hospitals, CAHs, and/or REHs using a system governing body that is legally responsible for the conduct of two or more hospitals, CAHs, and/or REHs, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member facilities after determining that such a decision is in accordance with all applicable state and local laws. The system governing body is responsible and accountable for ensuring that each of its separately certified CAHs meets all of the requirements of this section. Each separately certified CAH subject to the system governing body must demonstrate that:	

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antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to critical access hospital staff Note: The system governing body is responsible and accountable for making certain that each of its separately certified critical access hospitals meet all of the requirements at 42 CFR 485.640(g).(See also IC.04.01.01, EP 5)		
LD.11.01.01, EP 10: See above	**§485.640(g)(1)** The unified and integrated infection prevention and control and antibiotic stewardship programs are established in a manner that takes into account each member CAH's unique circumstances and any significant differences in patient populations and services offered in each CAH;	***If the hospital is part of a hospital system that has a unified and integrated infection prevention and control and antibiotic stewardship programs:*** **Document Review** ☐ Review the infection prevention and control antibiotic stewardship program and identify unified infection prevention and control and antibiotic stewardship policies and activities and how these take into account the hospitals population and services offered.
LD.11.01.01, EP 10: See above	**§485.640(g)(2)** The unified and integrated infection prevention and control and antibiotic stewardship programs establish and implement policies and procedures to ensure that the needs and concerns of each of its separately certified CAHs, regardless of practice or location, are given due consideration;	***If the hospital is part of a hospital system that has a unified and integrated infection prevention and control and antibiotic stewardship programs:*** **Document Review** ☐ Review the infection prevention and control and antibiotic stewardship programs and identify unified infection prevention and control and antibiotic stewardship policies and procedures and identify how each separately certified hospital's unique needs and areas of concern have been considered in the development of those policies and procedures.
LD.11.01.01, EP 10: See above	**§485.640(g)(3)** The unified and integrated infection prevention and control and antibiotic stewardship programs have mechanisms in place to ensure that issues	***If the hospital is part of a hospital system that has a unified and integrated infection prevention and control and antibiotic stewardship programs:***

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	localized to particular CAHs are duly considered and addressed; and	**Document Review** ☐ Review the QAPI program and identify unified QAPI elements that are unique to a particular hospital. ☐ Identify the process for which these unique elements are integrated into the QAPI program.
LD.11.01.01, EP 10: See above	**§485.640(g)(4)** A qualified individual (or individuals) with expertise in infection prevention and control and in antibiotic stewardship has been designated at the CAH as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, for implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship as directed by the unified infection prevention and control and antibiotic stewardship programs, and for providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to CAH staff.	***If the hospital is part of a hospital system that has a unified and integrated infection prevention and control and antibiotic stewardship programs:*** **Document Review** ☐ Review governing body policies for evidence that a qualified individual(s) has/have been designated as responsible for communicating with the unified infection prevention program and antibiotic stewardship program, for implementing and maintaining policies and procedures governing the infection prevention and control and antibiotic stewardship programs, and training of hospital staff. ☐ Review documentation that the designated individual(s) communicate(s) with the unified program leadership related to issues with infection prevention and antibiotic stewardship. ☐ Review hospital training documents related to education in infection prevention and antibiotic stewardship as evidence of training of hospital staff.

Critical Access Hospital Quality Assessment and Performance Improvement Evaluation Module (485.641)

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LD.12.01.01, EP 1: The critical access hospital develops, implements, maintains, and documents an effective, ongoing, data-driven, hospitalwide quality assessment and performance improvement program. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital maintains and demonstrates evidence of its QAPI program for review by CMS.	**485.641 Condition of participation: Quality assessment and performance improvement program.** The CAH must develop, implement, and maintain an effective, ongoing, CAH-wide, data-driven quality assessment and performance improvement (QAPI) program. The CAH must maintain and demonstrate evidence of the effectiveness of its QAPI program. (a) ***Definitions.*** For the purposes of this section— *Adverse event* means an untoward, undesirable, and usually unanticipated event that causes death or serious injury or the risk thereof. *Error* means the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors can include problems in practice, products, procedures, and systems; and *Medical error* means an error that occurs in the delivery of healthcare services.	**Interview** □ Ask staff to describe their quality assessment/performance improvement (QAPI) program. Is there evidence that the program encompasses the entire organization and is data driven, ongoing, and effective?
LD.11.01.01, EP 8: The governing body or designated individual is responsible and accountable for the quality assessment and performance improvement program. The governing body makes sure that performance improvement activities reflect the complexity of the critical access hospital's organization and services; are ongoing and	(b) **Standard: QAPI Program Design and scope.** The CAH's QAPI program must: (1) Be appropriate for the complexity of the CAH's organization and services provided.	**Interview** □ Ask leaders and staff to provide examples of ongoing monitoring that is underway throughout the CAH. □ Ask staff about their QAPI efforts in all CAH services and locations.

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comprehensive; involve all departments and services, including those services provided under contract or arrangement; and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors and objective measures to evaluate its organizational processes, functions, and services. (For more information on contracted services, see Standard LD.14.03.03) Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: If the hospital does not have a governing body, it identifies the leadership structure that is responsible for these activities. **PI.11.01.01, EP 1:** The performance improvement program addresses outcome indicators related to the following: - Improved health outcomes and the prevention and reduction of medical errors - Adverse events - Sentinel events - Health care–acquired conditions - Transitions of care, including unplanned readmissions	(2) Be ongoing and comprehensive. (3) Involve all departments of the CAH and services (including those services furnished under contract or arrangement). (4) Use objective measures to evaluate its organizational processes, functions and services. (5) Address outcome indicators related to improved health outcomes and the prevention and reduction of medical errors, adverse events, CAH-acquired conditions, and transitions of care, including readmissions.	**Document Review** **General** □ Review QAPI program documents to verify the program meets the following requirements: ○ Is appropriate for the complexity of the CAH's organization and services provided. ○ Is ongoing and comprehensive. ○ Involves all departments of the CAH and services, including services furnished under contract or arrangement. ○ Uses objective measures to evaluate its organization processes, functions, and services. ○ Uses outcome indicators related to improved patient health outcomes and the prevention and reduction of medical errors, adverse events, CAH-acquired conditions, and transitions of care, including readmissions. **Observation** □ Look for evidence of QAPI activity when visiting different areas of the CAH (for example, posted progress reports, comparisons, performance graphs, quality recognition awards, notes).
LD.11.01.01, EP 8: The governing body or designated individual is responsible and accountable for the quality assessment and performance improvement program. The governing body makes sure that performance improvement activities reflect the complexity of the critical access hospital's organization and services; are ongoing and comprehensive; involve all departments and	**485.641 (c)** **Standard: Governance and leadership.** The CAH's governing body or responsible individual is ultimately responsible for the CAH's QAPI program and is responsible and accountable for ensuring that the QAPI	**Interview** □ Ask QAPI program leader and staff how the governing body or designated individual monitors the program to determine it is ○ Appropriate for the complexity of the CAH's organization and services provided? ○ Ongoing and comprehensive?

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services, including those services provided under contract or arrangement; and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors and objective measures to evaluate its organizational processes, functions, and services. (For more information on contracted services, see Standard LD.14.03.03) Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: If the hospital does not have a governing body, it identifies the leadership structure that is responsible for these activities.	program meets the requirements of paragraph (b) of this section.	○ Involving all departments of the CAH and services (including those services furnished under contract or arrangement)? ○ Using objective measures to evaluate its organizational processes, functions, and services? ○ Addressing outcome indicators related to improved health outcomes and the prevention and reduction of medical errors, adverse events, CAH–acquired conditions, and transitions of care, including readmissions. **Document Review** **General** □ Ask to see **evidence** that the governing body or a designated individual is responsible and accountable for the QAPI program.
LD.12.01.01, EP 2: As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities related to improved health outcomes that are shown to be predictive of desired patient outcomes, patient safety, and quality of care - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities and consider the incidence, prevalence, and severity of problems in those areas - Identify the frequency and detail of data collection for performance improvement activities - Use measures to analyze and track performance	(d) ***Standard: Program activities.*** For each of the areas listed in paragraph (b) of this section, the CAH must: (1) Focus on measures related to improved health outcomes that are shown to be predictive of desired patient outcomes. (2) Use the measures to analyze and track its performance. (3) Set priorities for performance improvement, considering either high-volume, high-risk services, or problem-prone areas. (e) Standard: Program data collection and analysis. The program must	**Interview** □ Ask QAPI program leaders and staff how the CAH analyzes and tracks the measures to monitor performance. □ Ask the governing body or the leaders who oversee the QAPI program to provide evidence that its improvement activities are focused on high-risk, high-volume, or problem-prone areas. ○ Does the CAH have any data (either derived from its own QAPI data collection or public data) on incidence, prevalence, or severity to support its choices? Does the CAH have evidence that the activities affect health outcomes through improving quality of care or patient safety? **Document Review** **General**

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PI.11.01.01, EP 2: The critical access hospital has an ongoing quality assessment and performance improvement program that shows measurable improvement for indicators that are selected based on evidence that they will improve health outcomes and aid in the identification and reduction of medical errors. The program incorporates quality indicator data, including patient care data and other relevant data to achieve the goals of the program. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: Relevant data includes data submitted to or received from Medicare quality reporting and quality performance programs including but not limited to data related to hospital readmissions and hospital-acquired conditions. **PI.14.01.01, EP 1:** The critical access hospital acts on improvement priorities.	incorporate quality indicator data including patient care data, and other relevant data, in order to achieve the goals of the QAPI program.	□ Ask to see a list of current or recent performance improvement activities. o Is the CAH focusing on measures related to improved health outcomes? o Are the selected measures predictive of desired patient outcomes?
LD.11.01.01, EP 9: If a critical access hospital is part of a system consisting of multiple separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a system governing body that is legally responsible	**485.641** (f) ***Standard: Unified and integrated QAPI program for a CAH in a multi-facility system.*** If a CAH is part of a system consisting of multiple separately certified hospitals,	**Interview** *If the hospital is part of a multihospital system:* □ Ask staff if their system governing body has elected to have a unified and integrated QAPI program.

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for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency hospitals, the system governing body can elect to have a unified and integrated quality assessment and performance improvement program for all of its member facilities after determining that such decision is in accordance with all applicable state and local laws. Each separately certified critical access hospital subject to the system governing body demonstrates that the unified and integrated quality assessment and performance improvement program does the following: - Accounts for each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered in each critical access hospital - Establishes and implements policies and procedures to make certain that the needs and concerns of each of its separately certified hospitals, regardless of practice or location, are given due consideration, and that the unified and integrated program has mechanisms in place to ensure that issues localized to particular critical access hospitals are duly considered and addressed Note: The system governing body is responsible and accountable for making certain that each of its separately certified critical access hospitals meets the requirements for quality assessment and performance improvement at 42 CFR 485.641.	CAHs, and/or REHs using a system governing body that is legally responsible for the conduct of two or more hospitals, CAHs, and/or REHs, the system governing body can elect to have a unified and integrated QAPI program for all of its member facilities after determining that such a decision is in accordance with all applicable state and local laws. The system governing body is responsible and accountable for ensuring that each of its separately certified CAHs meets all of the requirements of this section. Each separately certified CAH subject to the system governing body must demonstrate that: (1) The unified and integrated QAPI program is established in a manner that takes into account each member CAH's unique circumstances and any significant differences in patient populations and services offered in each CAH; and (2) The unified and integrated QAPI program establishes and implements policies and procedures to ensure that the needs and concerns of each of its separately certified CAHs, regardless of practice or location, are given due consideration, and that the unified and integrated QAPI program has mechanisms in place to ensure that	○ Did the system check state and local laws to determine if a unified program was acceptable? Ask leaders and QAPI staff at each individual hospital how they participate in the unified and integrated program and if it addresses their unique circumstances. **Document Review** **General** *If the hospital is part of a multihospital system:* □ Ask if there are any descriptions of the unified and integrated QAPI program. ○ Does the program include governing body expectations for each certified hospital? ○ Does it take into account each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital? □ Ask to see policies and procedures that guide the unified and integrated QAPI program to ensure that the following requirements are met: ○ The needs and concerns of each separately certified hospital, regardless of practice or location, are given due consideration. ○ The unified and integrated QAPI program has procedures in place to ensure that issues localized to particular hospitals are duly considered and addressed. □ Ask to see reports provided to the governing body about QAPI performance. ○ Do such reports reveal the performance of each certified hospital?

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	issues localized to particular CAHs are duly considered and addressed.	

Critical Access Hospital Organ, Tissue, and Eye Procurement Evaluation Module (485.643)

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	§485.643 Condition of Participation: Organ, Tissue, and Eye Procurement The CAH must have and implement written protocols that:	**Document Review** ☐ Organ procurement policies and procedures that address the CAH's responsibilities, including: o Timely notification of OPO or third party designated by the OPO of individuals whose death is imminent or who have died in the CAH.
TS.11.01.01, EP 1: The critical access hospital develops and implements written policies and procedures for organ procurement responsibilities that include the following: - A written agreement with an organ procurement organization (OPO) that includes the critical access hospital notifying, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the critical access hospital and that includes the OPO's responsibility to determine medical suitability for organ donation - A written agreement with at least one tissue bank and at least one eye bank to cooperate in retrieving, processing, preserving, storing, and distributing tissues and eyes to make certain that all usable tissues and eyes are obtained from potential donors, such that the agreement does not interfere with organ procurement - Designation of an individual, who is an organ procurement representative, an organizational representative of a tissue or eye bank, or a designated requestor, to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes	**§485.643(a)** Incorporate an agreement with an OPO designated under part 486 of this chapter, under which it must notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the CAH. The OPO determines medical suitability for organ donation and, in the absence of alternative arrangements by the CAH, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the CAH for this purpose;	**Interview** ☐ Interview the staff to verify that they are aware of the CAH'S policies and procedures for organ, tissue, and eye procurement. ☐ Verify that the organ, tissue, and eye donation program is integrated into the CAH's QA program. **Document Review** ☐ Review the CAH'S written agreement with the OPO to verify that it addresses all required information. See below. o Written agreement with an Organ Procurement Organization (OPO), designated under 42 CFR Part 486 that at a minimum addresses the following: ☐ The criteria for referral, including the referral of all individuals whose death is imminent or who have died in the CAH. ☐ Includes a definition of "imminent death;" ☐ Includes a definition of "timely notification;"

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- Procedures for informing the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes, in collaboration with the designated OPO - Education and training of staff in the use of discretion and sensitivity to the circumstances, views, and beliefs of the family when discussing potential organ, tissue, or eye donations Note 1: The critical access hospital has an agreement with an OPO designated under 42 CFR part 486. Note 2: The requirements for a written agreement with at least one tissue bank and at least one eye bank may be satisfied through a single agreement with an OPO that provides services for organ, tissue, and eye, or by a separate agreement with another tissue and/or eye bank outside the OPO, chosen by the critical access hospital. Note 3: A designated requestor is an individual who has completed a course offered or approved by the OPO. This course is designed in conjunction with the tissue and eye bank community to provide a methodology for approaching potential donor families and requesting organ and tissue donation. Note 4: The term “organ” means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs). Note 5: For additional information about criteria for the determination of brain death, see the American Academy of Neurology guidelines available at https: //n.neurology.org/content/early/2023/09/13/WNL.0000000000207740, the American Academy of Pediatrics guidelines available at		□ Addresses the OPO’s responsibility to determine medical suitability for organ donation. □ Specifies how the tissue and/or eye bank will be notified about potential donors using notification protocols developed by the OPO in consultation with the CAH-designated tissue and eye bank(s). □ Provides for notification of each individual death in a timely manner to the OPO (or designated third party) in accordance with the terms of the agreement. □ Ensures that the designated requestor training program offered by the OPO has been developed in cooperation with the tissue bank and eye bank designated by the CAH. □ Permits the OPO, tissue bank, and eye bank access to the CAH’s death record information according to a designated schedule, e.g., monthly, or quarterly. □ Includes that the CAH is not required to perform credentialing reviews for, or grant privileges to, members of organ recovery teams as long as the OPO sends only “qualified, trained individuals” to perform organ recovery; and □ The interventions the CAH will utilize to maintain potential organ donor patients so that the patient organs remain viable. □ Verify that the CAH’S governing body has approved the CAH’S organ procurement policies. **Patient Health Record**

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https://www.aan.com/Guidelines /Home/GuidelineDetail/1085, and the interactive tool that can be used alongside the new guidance to help walk clinicians through the BD/DNC evaluation process at https://www.aan.com/Guidelines/BDDNC.		☐ Review a sample of death records to verify that the CAH has implemented its organ procurement policies.
TS.11.01.01, EP 1: See above	**§485.643(b)** Incorporate an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage and distribution of tissues and eyes, as may be appropriate to assure that all usable tissues and eyes are obtained from potential donors, as far as such an agreement does not interfere with organ procurement;	**Document Review** ☐ Verify that the CAH has an agreement with at least one tissue bank and one eye bank that specifies criteria for referral of all individuals who have died in the CAH. The agreement must also acknowledge that it is the OPO's responsibility to determine medical suitability for tissue and eye donation unless the CAH has an alternative agreement with a different tissue and/or eye bank.
TS.11.01.01, EP 1: See above **TS.11.01.01, EP 3:** The individual designated by the critical access hospital documents that the patient or family accepts or declines the opportunity for the patient to become an organ, tissue, or eye donor.	**§485.643(c)** Ensure, in collaboration with the designated OPO, that the family of each potential donor is informed of its option to either donate or not donate organs, tissues, or eyes. The individual designated by the CAH to initiate the request to the family must be a designated requestor. A designated requestor is an individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ or tissue donation;	**Interview** ☐ How does the CAH ensure that only designated requestors are approaching families to ask them to donate? ☐ Verify that the CAH ensures that the family of each potential donor is informed of its options to donate organs, tissues, or eyes, including the option to decline to donate. **Document Review** **Credential/Personnel File** ☐ Review training schedules and personnel files to verify that all designated requestors have completed the required training.
TS.11.01.01, EP 1: See above	**§485.643(d)**	**Interview**

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	Encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of the family of potential donors;	☐ Interview a CAH-designated requestor regarding approaches to donation requests. **Document Review** **General** ☐ Review the designated requestor training program to verify that it addresses the use of discretion. ☐ Review the facility complaint file for any relevant complaints.
TS.11.01.01, EP 2: The critical access hospital develops and implements policies and procedures for working with the organ procurement organization (OPO) and tissue and eye banks to do the following: - Review death records in order to improve identification of potential donors. - Maintain potential donors while the necessary testing and placement of potential donated organs, tissues, and eyes takes place in order to maximize the viability of donor organs for transplant. - Educate staff about issues surrounding donation.	**§485.643(e)** Ensure that the CAH works cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes takes place.	**Interview** ☐ How does the CAH ensure that all appropriate staff have attended an educational program regarding donation issues and how to work with the OPO, tissue bank, and eye bank? ☐ How is patient confidentiality is ensured during the review process? **Document Review** **General** ☐ Verify by review of policies and records that the CAH works with the OPO, tissue bank, and eye bank in reviewing death records. The policies must address how patient confidentiality will be maintained during the review process. ☐ Verify that the effectiveness of any protocols and policies is monitored as part of the CAH'S quality improvement program. ☐ Validate how often the reviews are to occur. Review the protocols in place to guide record reviews and analysis.

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		☐ Verify that there are policies and procedures in place to ensure coordination between the facility staff and the OPO staff in maintaining the potential donor. ☐ Determine by review what policies and procedures are in place to ensure that potential donors are identified and declared dead by an appropriate practitioner within an acceptable timeframe. **Credential/Personnel File** ☐ Review in-service training schedules and attendance sheets. ○ The training program must be developed in cooperation with the OPO, tissue bank and eye bank, and should include, at a minimum: 1. Consent process; 2. Importance of using discretion and sensitivity when approaching families; 3. Role of the designated requestor; 4. Transplantation and donation, including pediatrics, if appropriate; 5. Quality improvement activities; and 6. Role of the organ procurement organization. 7. Training should be conducted with new employees annually, whenever there are policy/procedure changes, or when problems are determined through the CAH'S QA program.

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TS.10.01.01, EP 1: See above	**§485.643(f)** For purpose of these standards, the term "organ" means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs).	See identified survey processes above.

Critical Access Hospital Swing Beds Evaluation Module (485.645)

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This CoP is determined by CMS at the time the CAH seeks approval to provide post-hospital skilled nursing care.	**§485.645 Special Requirements for CAH Providers of Long-Term Care Services ("Swing-Beds").** **A CAH must meet the following requirements in order to be granted an approval from CMS to provide post-CAH SNF care, as specified in §409.30 of this chapter, and to be paid for SNF-level services, in accordance with paragraph (c) of this section.**	**CMS RO makes the determination whether the CAH has satisfied the eligibility criteria and awards approval of swing-bed status.** **CMS grants approval for CAH to provide post-CAH SNF care.** The eligibility criteria at 42 CFR 485.645(a) requires: • The CAH has a Medicare provider agreement. • An initial CAH applicant may seek swing-bed approval. If the CAH applicant meets all Federal Requirements for participation, including those for swing bed approval, the CAH applicant's approval for swing-bed services will be effective with the CAH's effective date of Medicare participation
LD.13.01.01, EP 3 Except as permitted for critical access hospitals having distinct part units under 42 CFR 485.647, the critical access hospital maintains no more than 25 inpatient beds that can be used for either inpatient or swing bed services. Note: Any bed in a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility applies to the state for designation as a critical access hospital is not counted in this 25-bed count.	**§485.645(a) Eligibility** A CAH **must** meet the following eligibility requirements: (1) The facility has been certified as a CAH by CMS under §485.606(b) of this subpart; and **(2) The facility provides not more than 25 inpatient beds. Any bed of a unit of the facility that is licensed as a distinct-part SNF at** the time the facility applies to the State for designation as a CAH is not counted under paragraph (a) of this section. Interpretive Guidelines §485.645(a) Eligibility CAHs seeking swing-bed approval are screened prior to survey for their eligibility for swing-beds. However, the CMS RO makes the determination whether the CAH has satisfied the eligibility criteria, regardless of whether the SA or AO, as applicable, recommends approval of swing-bed status (this responsibility may not be delegated	This CoP is determined by CMS at the time the CAH seeks approval to provide post-hospital skilled nursing care. 485.645 (a)(1), (b) through(c) **Observation** • The CAH provides not more than 25 inpatient beds. Any bed of a unit of the facility that is licensed as a distinct-part SNF

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	to the SA). The eligibility criteria at 42 CFR 485.645(a) requires: • The CAH has a Medicare provider agreement; • An initial CAH applicant may seek swing-bed approval. If the CAH applicant meets all Federal Requirements for participation, including those for swingbed approval, the CAH applicant's approval for swing-bed services will be effective with the CAH's effective date of Medicare participation;	
	§485.645(b) Facilities Participating as Rural Primary Care Hospitals (RPCHs) on September 30, 1997 These facilities must meet the following requirements: (1) Notwithstanding paragraph (a) of this section, a hospital that participated in Medicare as a RPCH on September 30, 1997, and on that date had in effect an approval from CMS to use its inpatient facilities to provide post-hospital SNF care may continue in that status under the same terms, conditions, and limitations that were applicable at the time these approvals were granted.. (2) A CAH that was granted swing-bed approval under paragraph (b)(1) of this section may request that its application to be a CAH and swing-bed provider be reevaluated under paragraph (a) of this section. If this request is approved, the approval is effective not earlier than October 1, 1997. As of the date of approval, the CAH no longer has any status under paragraph (b)(1) of this section and may not request reinstatement under paragraph (b)(1) of this section.	This CoP is determined by CMS at the time the CAH seeks approval to provide post-hospital skilled nursing care.
N/A	§485.645(c) Payment Payment for inpatient RPCH services to a CAH that has qualified as a CAH under the provisions in paragraph (a) of this section is made in accordance with §413.70 of this chapter. Payment for post-hospital SNF-level of care	This CoP is determined by CMS at the time the CAH seeks approval to provide post-hospital skilled nursing care.

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	services is made in accordance with the payment provisions in §413.114 of this chapter.	
IM.12.01.01, **EP 1** The critical access hospital develops and implements policies and procedures addressing the privacy and confidentiality of health information. Note: For swing beds in critical access hospitals: Policies and procedures also address the resident's personal records. **EP 2** The critical access hospital discloses health information only as authorized by the patient with the patient's written consent or as otherwise required by law and regulation. Note: For swing beds in critical access hospitals: The critical access hospital allows representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with state law. **LD.13.02.01, EP 2;** For swing beds in critical access hospitals: Each Medicaid-eligible resident is informed in writing, either at the time of admission or when the resident becomes eligible for Medicaid, of the following: - Items and services included in the state plan for which the resident may not be charged - Items and services that the critical access hospital offers, those for which the resident may be	**§485.645(d) SNF Services.** The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter: §485.645(d)(1) Resident Rights **(§483.10(b)(7), (c)(1), (c)(2)(iii), (c)(6), (d), (e)(2) and (4), (f)(4)(ii) and (iii), (g)(8) and (17), (g)(18) introductory text, (h) of this chapter).** • **§483.10(b)(7)** In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. • **§483.10(c)** Planning and implementing care. The resident has the right to be informed of, and participate in, his or her treatment, including: (1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. • **§483.10(c)(2)(iii)** The right to be informed, in advance, of changes to the plan of care. • **§483.10(c)(6)** The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. • **§483.10(d)** Choice of attending physician. The resident has the right to choose his or her attending physician. (1) The physician **must** be licensed to practice, and (2)	**Survey Process Guidance** Evaluate the CAH's compliance with the swing-bed requirements at **42 CFR 485.645** found in appendix W of the SOM and for those requirements referenced from **42 CFR 483 use Appendix PP**. Swing-bed requirements apply to any patient discharged from a hospital or CAH and admitted to a swing-bed for skilled nursing services. The requirements for acute-care CAHs also apply to swing-bed patients. - There must be discharge orders from acute inpatient care services and subsequent admission orders for swing-bed services, the same as if the patient had been transferred to a separately certified skilled nursing facility. - The same clinical record may be used for a swing-bed patient, but it must include discharge orders from acute care and admission orders to swing-bed services, and the swing-bed services (which may be SNF or NF level services) must be clearly delineated within the clinical record. The survey process framework for the evaluation of **485.645 (d) through (d)(8),** the requirements for acute-care CAHs, the **identified 483** requirements, and Joint Commission standards include interview of personnel and patients, document review (policies and procedures, personnel file review, patient health record review, etc.), and observation. **Interview**

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charged, and the amount of charges for those services Note: The critical access hospital informs the resident when changes are made to the items and services. **EP 3** For swing beds in critical access hospitals: The critical access hospital informs residents before or at the time of admission, and periodically during the resident's stay, of services available in the critical access hospital and of charges for those services not covered under Medicare, Medicaid, or by the critical access hospital's per diem rate. **PC.11.03.01, EP 2** The critical access hospital involves the patient in the development and implementation of their plan of care. Note: For swing beds in critical access hospitals: The resident has the right to be informed, in advance, of changes to their plan of care. **RI.11.01.01, EP 5** The critical access hospital respects the patient's right to personal privacy. Note 1: This element of performance (EP) addresses a patient's personal privacy. For EPs addressing the privacy of a patient's health information, refer to Standard IM.12.01.01. Note 2: For swing beds in critical access hospitals: Personal privacy includes accommodations, medical	If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment. (3) The facility **must** ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. (4) The facility **must** inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility **must** discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options. (5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility **must** honor that choice. • **§483.10(e)(2)** The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. • **§483.10(e)(4)** The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. • §483.10(f)(4)(ii) The facility **must** provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; •	☐ Ask CAH leadership and staff if swing-bed patients are present during the on-site survey. If yes, conduct an open record review and an environmental assessment. ☐ Swing bed care staff about required processes to achieve positive outcomes for the patient. ☐ Assess the care and services provided, including the appropriateness of the care and services provided within the context of the CoPs (485.645, the requirements for acute-care CAHs, and the identified 483 requirements), and Joint Commission standards. ☐ Interview 2 swing bed patients to assess compliance with the identified 485.645, the requirements for acute-care CAHs, and the identified 483.10 requirements. **Document Review** **General** Review policies, procedures, and contracted services to assure that the CAH has the capability to provide the services needed. **Patient Health Records** ☐ Review records of swing bed patients for compliance with 485.655, the requirements for acute-care CAHs, and the identified 483 requirements. **See the identified 483 CoPs.** ☐ If there no swing-bed patients are present during the on-site survey, review at a minimum two closed records for compliance with swing-bed requirements

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treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. **EP 8** For swing beds in critical access hospitals: The critical access hospital provides immediate family and other relatives immediate access to the resident, except when the resident denies or withdraws consent. The critical access hospital provides others who are visiting immediate access to the resident, except when reasonable clinical or safety restrictions apply or when the resident denies or withdraws consent. **RI.11.02.01, EP 1** The critical access hospital provides information, including but not limited to the patient's total health status, in a manner tailored to the patient's age, language, and ability to understand. Note: The critical access hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs. **RI.12.01.01, EP 1** The patient or their representative (as allowed, in accordance with state law) has the right to make informed decisions regarding their care. The patient's rights include	§483.10(f)(4)(iii) The facility **must** provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; • §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. • §483.10(g)(17) The facility **must**— (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of— (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. • §483.10(g)(18)[introductory text only] The facility **must** inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per diem rate. • §483.10(h) Privacy and confidentiality. The resident has a right to	**Observation** ☐ Observe the actual provision of care and services to swing bed patients and the effects and outcomes of the care and treatments provided. Assess whether the care provided meets the needs of the individual patient. *Note: Use Appendix PP as additional resource for identified 483.10 requirements.*

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being informed of their health status, being involved in care planning and treatment, and being able to request or refuse treatment. This does not mean the patient has the right to demand the provision of treatment or services deemed medically unnecessary or inappropriate. **EP 3** For swing beds in critical access hospitals: If a resident is adjudged incompetent under state law by a court of proper jurisdiction, the rights of the resident automatically transfer to and are exercised by a resident representative appointed by the court under state law to act on the resident's behalf. The resident representative exercises the resident's rights to the extent allowed by the court in accordance with state law. Note 1: If a resident representative's decision-making authority is limited by state law or court appointment, the resident retains the right to make those decision outside the representative's authority. Note 2: The resident's wishes and preferences are considered by the representative when exercising the patient's rights. Note 3: To the extent practicable, the resident is provided with opportunities to participate in the care planning process. **EP 4** For swing beds in critical access hospitals: The resident has the right to request, refuse, and/ or	personal privacy and confidentiality of his or her personal and medical records. (1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (2) The facility **must** respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. (3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility **must** allow representatives of the Office of the State Long Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. **Interpretive Guidelines §485.645(d)(1) Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.**	

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discontinue treatment; to participate in or refuse to participate in experimental research; and to formulate an advance directive. **EP 6** For swing beds in critical access hospitals: The critical access hospital supports the residents right to choose a licensed attending physician. Note: If the physician chosen by the resident refuses to or does not meet requirements for attending physicians at 42 CFR 483, the critical access hospital may seek alternative physician participation to assure provision of appropriate and adequate care and treatment. The critical access hospital informs the resident if it determines that the physician chosen by the resident is unlicensed or unable to serve as the attending physician. The critical access hospital also discusses alternative physician participation with the resident and honors the resident's preferences, if any, among the options. **RI.13.01.03, EP 1** For swing beds in critical access hospitals: The critical access hospital allows the resident to keep and use personal clothing and possessions, unless this infringes on others' rights or is medically or therapeutically contraindicated, based on the setting or service. **EP 2** For swing beds in critical access hospitals: The critical access hospital allows the resident to share a room with their spouse when married residents are living in the same critical access hospital		

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and when both individuals consent to the arrangement. **EP 3** For swing beds in critical access hospitals: The critical access hospital supports the resident's right to send and promptly receive unopened mail and to receive letters, packages, and other materials delivered to the critical access hospital for the resident through a means other than a postal service. The critical access hospital respects the resident's right to privacy of such communications and allows access to stationery, postage, and writing implements at the resident's own expense.		
PC.14.01.01, EP 4 The patient, the patient's caregiver(s) or support person(s), physicians, other licensed practitioners, clinical psychologists, and staff who are involved in the patient's care, treatment, and services participate in planning the patient's discharge or transfer. The patient and their caregiver(s) or support person(s) are included as active partners when planning for post-discharge care. Note 1: For rehabilitation and psychiatric distinct part units in critical access hospitals: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (refer to the Glossary).	§**485.645(d)(2) Admission, Transfer and Discharge Rights** (§483.5 definition of transfer & discharge, §483.15(c)(1), (c)(2), (c)(3), (c)(4), (c)(5), (c)(7), (c)(8), and (c)(9) of this chapter). • §483.5 definition of transfer & discharge: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility. • §483.15(c)(1) Transfer and discharge—(1) Facility requirements— (i) The facility **must** permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless— (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the	

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Note 2: For psychiatric distinct part units in critical access hospitals: Social service staff responsibilities include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the critical access hospital. Note 3: For swing beds in critical access hospitals: The critical access hospital notifies the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and reasons for the move. The notice is in writing, in a language and manner they understand, and includes the items described in 42 CFR 483.15(c)(5). The critical access hospital also provides sufficient preparation and orientation to residents to make sure that transfer or discharge from the critical access hospital is safe and orderly. The critical access hospital sends a copy of the notice to a representative of the office of the state's long-term care ombudsman. **EP 12** For swing beds in critical access hospitals: The critical access hospital provides the written notice of transfer or discharge at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered; the health	facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to §431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to §431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility **must** document the danger that failure to transfer or discharge would pose. • §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility **must** ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's	

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of the individuals in the facility would be endangered; the resident's health improves sufficiently to allow a more immediate transfer or discharge, and immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the facility for 30 days. **EP 13** For swing beds in critical access hospitals: The written notice before transfer or discharge specified in 42 CFR 483.15(c)(3) includes the following: - Reason for transfer or discharge - Effective date of transfer or discharge - Location to which the resident is transferred or discharged - Statement of the resident's appeal rights, including the name, address (mailing and e-mail), and telephone number of the entity which receives appeal requests; information on how to obtain an appeal form; where to find assistance in completing the form; and how to submit the appeal hearing request - Name, address (mailing and e-mail), and telephone number of the office of the state's long-term care ombudsman - For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals,	medical record **must** include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section **must** be made by— (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider **must** include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident (B) Resident representative information including contact information. (C) Advance Directive information. (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals, (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2), as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. • §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility **must**— (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility **must** send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record	

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established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 - For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act. **PC.14.01.03, EP 1** For swing beds in critical access hospitals: The critical access hospital transfers or discharges residents only under at least one of the following conditions: - The resident's health has improved to the point where they no longer need the critical access hospital's services. - The transfer or discharge is necessary for the resident's welfare and the critical access hospital cannot meet the resident's needs. - The safety of the individuals in the critical access hospital is endangered due to the resident's clinical or behavioral status. - The health of individuals in the critical access hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under	the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii)Include in the notice the items described in paragraph (c)(5) of this section. • §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (8) of this section, the notice of transfer or discharge required under this section **must** be made by the facility at least 30 days before the resident is transferred or discharged. (ii)Notice **must** be made as soon as practicable before transfer or discharge when—(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. • §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section **must** include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The	

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Medicare or Medicaid) a stay at the critical access hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a critical access hospital, the critical access hospital may charge a resident only the allowable charges under Medicaid. - The critical access hospital ceases operation. Note: The critical access hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the critical access hospital. The critical access hospital documents the danger that failure to transfer or discharge would pose. **EP 2** For critical access hospitals with swing beds: In the case of critical access hospital closure, the individual who is the administrator of the critical access hospital provides written notification prior to the impending closure to the state survey agency, the office of the state's long-term care ombudsman, residents of the critical access hospital, and the resident's representatives, as	name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. • **§483.15(c)(7)** Orientation for transfer or discharge. A facility **must** provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation **must** be provided in a form and manner that the resident can understand. • **§483.15(c)(8)** Notice in advance of facility closure. In the case of facility closure, the individual who is the administrator of the facility **must** provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.70(l). • §483.15(c)(9) Room changes in a composite	

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well as the plan for the transfer and adequate relocation of the residents. **PC.14.02.03, EP 1:** The critical access hospital provides or transmits necessary medical information when discharging, transferring, or referring the patient to post–acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners who are responsible for the patient's follow-up or ancillary care. Necessary medical information includes, at a minimum, the following: - Current course of illness and treatment - Postdischarge goals of care - Treatment preferences at the time of discharge Note: For swing beds in critical access hospitals: The information sent to the receiving provider also includes the following: - Contact information of the physician or other licensed practitioner responsible for the care of the resident - Resident representative information, including contact information - Advance directive information - All special instructions or precautions for ongoing care, when appropriate - Comprehensive care plan goals - All other necessary information, including a copy of the residents discharge summary, consistent with 42 CFR 483.21(c)(2), and any other documentation, as applicable, to support a safe and effective transition of care. **RC.11.01.01, EP 2** The medical record includes the following:	distinct part. Room changes in a facility that is a composite distinct part (as defined in §483.5) are subject to the requirements of §483.10(e)(7) and **must** be limited to moves within the particular building in which the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part's locations. **Interpretive Guidelines §485.645(d)(2) Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.**	

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- Information needed to justify the patient's admission and continued care, treatment, and services - Information needed to support the patient's diagnosis and condition - Information about the patient's care, treatment, and services that promotes continuity of care among staff and providers Note: For critical access hospitals that elect Joint Commission's Primary Care Medical Home option: This requirement refers to care provided by both internal and external providers. **RC.12.03.01, EP 1** For swing beds in critical access hospitals: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. A physician document in the resident's medical record when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered. The resident's physician documents in the medical record when the transfer is due to the resident improving and no longer needing long term care services or when the transfer is due to the resident's welfare and resident's needs cannot be met in the critical access hospital's swing bed. **RC.12.03.01, EP 2:** For swing beds in critical access hospitals: The resident's		

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discharge information includes the following: - Reason for transfer, discharge, or referral - Treatment provided, diet, medication orders, and orders for the resident's immediate care - Referrals provided to the resident, the referring physician's or other licensed practitioner's name, and the name of the physician or other licensed practitioner who has agreed to be responsible for the resident's medical care and treatment, if this person is someone other than the referring physician or other licensed practitioner - Medical findings and diagnoses; a summary of the care, treatment, and services provided; and progress reached toward goals - Information about the resident's behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation - Nursing information that is useful in the resident's care - Any advance directives - Instructions given to the resident before discharge - Attempts to meet the resident's needs **EP 3** For swing beds in critical access hospitals: When the resident is transferred or discharged because the critical access hospital cannot meet their needs, the critical access hospital documents which needs could		

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not be met, the critical access hospital's attempts to meet the resident's needs, and the services available at the receiving organization that will meet the resident's needs. **EP 4** For swing beds in critical access hospitals: The critical access hospital records the reasons for the transfer or discharge in the resident's medical record in accordance with 42 CFR 483.15(c)(2). **RI.11.02.01, EP 1** The critical access hospital provides information, including but not limited to the patient's total health status, in a manner tailored to the patient's age, language, and ability to understand. Note: The critical access hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs. **RI.13.01.03, EP 4** For swing beds in critical access hospitals: Room changes in an organization that is a composite distinct part (a distinct part consisting of two or more noncontiguous components that are not located within the same campus, as defined in 42 CFR 413.65(a)(2)) are limited to moves within the particular building in which the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part's locations.		

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HR.11.02.01, EP 4 For swing beds in critical access hospitals: The critical access hospital does not employ individuals who have been found guilty by a court of law of abusing, neglecting, exploiting, misappropriating property, or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of residents' property. **PC.13.02.01, EP 1** The critical access hospital does not use restraint or seclusion of any form as a means of coercion, discipline, convenience, or staff retaliation. Restraint or seclusion is only used to protect the immediate physical safety of the patient, staff, or others when less restrictive interventions have been ineffective and is discontinued at the earliest possible time, regardless of the length of time specified in the order. **EP 2** The critical access hospital uses the least restrictive form of restraint or seclusion that will be effective to protect the patient, a staff member, or others from harm. **RI.13.01.01, EP 1** The critical access hospital protects the patient from harassment, neglect, exploitation, corporal punishment, involuntary seclusion, and verbal, mental, sexual, or physical abuse that could occur while the	**§485.645(d)(3) Freedom from abuse, neglect and exploitation** (§483.12(a)(1), (a)(2), (a)(3)(i), (a)(3)(ii), (a)(4), (b)(1), (b)(2), (c)(1), (c)(2), (c)(3), and (c)(4) of this chapter). • §483.12(a)(1) Freedom from abuse, neglect, and exploitation. The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.(a) The facility **must**—(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; • §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility **must** use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. • §483.12(a)(3) Not employ or otherwise engage individuals who— (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property. • §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. • §483.12(b) The facility **must**	

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patient is receiving care, treatment, and services. For swing beds in critical access hospitals: The critical access hospital also protects the resident from misappropriation of property. **EP 2** For swing beds in critical access hospitals: The critical access hospital reports to the state nurse aide registry or licensing authorities any knowledge it has of any actions taken by a court of law against an employee that would indicate unfitness for service as a nurse aide or other facility staff. **EP 3** For critical access hospitals with swing beds: The critical access hospital develops and implements written policies and procedures that prohibit and prevent mistreatment, neglect, and abuse of residents and misappropriation of resident property. The policies and procedures also address investigation of allegations related to these issues. **EP 4** The critical access hospital reports allegations, observations, and suspected cases of neglect, exploitation, and abuse to appropriate authorities based on its evaluation of the suspected events, or as required by law. Note: For swing beds in critical access hospitals: Alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are	develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, • §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility **must**: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action **must** be taken. **Interpretive Guidelines §485.645(d)(3) Refer to Appendix PP of the**	

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reported to the administrator of the facility and to other officials (including the state survey agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law and established procedures. The alleged violations are reported in the following time frames: - No later than 2 hours after the allegation is made if the allegation involves abuse or serious bodily injury - No later than 24 hours after the allegation is made if the allegation does not involve abuse or serious bodily injury **EP 5** For critical access hospitals with swing beds: The critical access hospital has evidence that all alleged violations of abuse, neglect, exploitation, or mistreatment are thoroughly investigated and that it prevents further abuse, neglect, exploitation, or mistreatment while the investigation is in progress. The results of all investigations are reported to the administrator or their designated representative and to other officials in accordance with state law, including the state survey agency, within five working days of the incident. If the alleged violation is verified, appropriate corrective actions is taken.	**State Operations Manual (SOM) for interpretive guidelines.**	
PC.14.02.01, EP 2 For swing beds in critical access hospitals: The critical access hospital provides medically-related social	§**485.645(d)(4) Social Services** (§483.40(d) of this chapter). • §483.40(d) The facility **must** provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of	

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services to attain or maintain the optimal physical, mental, and psychosocial well-being of each resident.	each resident. **Interpretive Guidelines §485.645(d)(4) Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.**	
PC.11.02.01, EP 6 For swing beds in critical access hospitals: The critical access hospital completes the resident's comprehensive assessment within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. Note: For this element of performance, the term ''readmission'' means a return to the facility following a temporary absence for hospitalization or for therapeutic leave. **EP 7** For swing beds in critical access hospitals: The critical access hospital conducts a comprehensive assessment within 14 calendar days after it determines that there has been a significant change in the resident's physical or mental condition. Note: For this element of performance, the term ''significant change'' means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and that requires interdisciplinary review or revision of the care plan, or both.	§**485.645(d)(5) Comprehensive assessment, comprehensive care plan, and discharge planning** (§483.20(b), and §483.21(b) and (c)(2) of this chapter), except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b) of this chapter). • §483.20(b) Comprehensive assessments— (1) Resident assessment instrument. A facility **must** make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment **must** include at least the following: (i) Identification and demographic information. (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychosocial well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnoses and health conditions. (xi) Dental and nutritional status. (xii) Skin condition. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment	**Survey Procedures §485.645(d)(5) Refer to Identified Appendix PP of the State Operations Manual (SOM) for survey procedures.** *NOTE: The CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b) of this chapter). Also, note that CAHs are not required to complete the PASARR. However, if a patient had a PASARR completed by a facility that was required to do so prior to admission into a CAH swing bed, the recommendations from the PASARR should be included in the CAHs comprehensive treatment plan for the patient.

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EP 8 For swing beds in critical access hospitals: Each resident receives a comprehensive assessment no less often than every 12 months. **EP 11** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental status - Nutritional status (such as usual body weight or desirable body weight range, electrolyte balance) - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning Note: The critical access hospital maintains the resident's acceptable nutritional status parameters unless the resident's clinical condition demonstrates that this is not possible or	process **must** include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. (2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility **must** conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2) (i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) (ii) Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purposes of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) (iii) Not less often than once every 12 months. • §483.21(b) Comprehensive care plans. (1) The facility **must** develop and implement a comprehensive personcentered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes	

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the resident's preferences indicate otherwise. **EP 12** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes documentation of summary information about the additional assessment(s) performed through the resident assessment protocols. **EP 13** For swing beds in critical access hospitals: The comprehensive assessment includes direct observation and communication with the resident and communication with staff members on all shifts. **PC.11.03.01, EP 1:** The critical access hospital develops, implements, and revises a written individualized plan of care based on the following: -Needs identified by the patient's assessment, reassessment, and results of diagnostic testing -The patient's goals and the time frames, settings, and services required to meet those goals Note 1: Nursing staff develops and keeps current a nursing plan of care, which may be a part of an interdisciplinary plan of care, for each inpatient. Note 2: The hospital evaluates the patient's progress and revises the plan of care based on the patient's progress. Note 3: For rehabilitation distinct part units in critical access hospitals: The plan is reviewed and revised as needed by a physician in consultation with other	measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan **must** describe the following: (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25, or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25, or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (1) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it **must** indicate its rationale in the resident's medical record. (2) In consultation with the resident and the resident's representative(s)— (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities **must** document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. (2) A comprehensive care plan **must** be— (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to- (A) The attending	

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professional staff who provide services to the patient. **PC.11.03.01, EP 6:** For swing beds in critical access hospitals: The interdisciplinary team involves the resident and the resident's representative in developing the person-centered, comprehensive treatment plan. Note 1: The treatment plan includes documentation of the following: - Any specialized or rehabilitation services the critical access hospital will provide as a result of preadmission screening and resident review (PASARR) recommendations and disagreement with PASARR recommendations - Resident's goals for admission and desired outcomes - Resident's preferences and potential for future discharge, including whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities for this purpose - Discharge plans - Measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs Note 2: If not feasible for the resident and the resident's representative to participate in the development of the treatment plan, an explanation is	physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation **must** be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. (3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, **must**— (i) Meet professional standards of quality. (ii) Be provided by qualified persons in accordance with each resident's written plan of care. (iii) Be culturally-competent and trauma-informed. • §483.21(c)(2) Discharge summary. When the facility anticipates discharge a resident **must** have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's	

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included in the resident's medical record. **PC.11.03.01, EP 8:** For swing beds in critical access hospitals: The critical access hospital develops the resident's written comprehensive plan of care as soon as possible after admission, but no later than seven calendar days after the resident's comprehensive assessments are completed. **PC.11.03.01, EP 9:** For swing beds in critical access hospitals: The resident's written plan of care is developed by an interdisciplinary team comprised of health care professionals involved in the resident's care, treatment, and services. At a minimum, the team includes the attending physician, registered nurse with responsibility for the resident, nurse aide with responsibility for the resident, a member of the food and nutrition services staff, and other appropriate staff as determined by the resident's needs or as requested by the resident. Note: The plan of care is reviewed and revised by the interdisciplinary team after each assessment. **RC.12.03.01, EP 5** For swing beds in critical access hospitals: When the critical access hospital anticipates the discharge of a resident, the discharge summary includes but is not limited to the following:	representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care **must** indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. **Interpretive Guidelines §485.645(d)(5) Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines**.	

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- A summary of the resident's stay that includes at a minimum the resident's diagnosis, course of illness/treatment or therapy, and pertinent laboratory, radiology, and consultation results - A final summary of the resident's status to include items in 42 CFR 483.20 (b)(1) at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. - Reconciliation of all predischarge medications with the resident's postdischarge medications (both prescribed and over-the-counter). - A postdischarge plan of care, which will assist the resident to adjust to his or her new living environment, that is developed with the participation of the resident and, with the resident's consent, the resident representative(s). The postdischarge plan of care indicates where the individual plans to reside, any arrangements that have been made for the resident's follow up care, and any postdischarge medical and nonmedical services.		
PC.11.03.01, EP 1 The critical access hospital develops, and revises a written individualized plan of care based on the following: - Needs identified by the patients assessment, reassesment, and results of diagnostic testing	**§485.645(d)(6) Specialized Rehabilitative Services** (§483.65 of this chapter). • §483.65 (a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for a mental disorder and intellectual disability or services of a lesser	

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- The patients goals and the time frames, settings, and services required to meet those goals Note 1: Nursing staff develops and keeps current a nursing plan of care, which may be a part of an interdisciplinary plan of care, for each inpatient. Note 2: The hospital evaluates the patient's progress and revises the plan of care based on the patient's progress. Note 3: For rehabilitation distinct part units in critical access hospitals: The plan is reviewed and revised as needed by a physician in consultation with other professional staff who provide services to the patient. **PC.12.01.01, EP 1** Prior to providing care, treatment, and services, the critical access hospital obtains or renews orders (verbal or written) from a physician or other licensed practitioner in accordance with professional standards of practice; law and regulation; critical access hospital policies; and medical staff bylaws, rules, and regulations. Note 1: This includes but is not limited to respiratory services, radiology services, rehabilitation services, nuclear medicine services, and dietary services, if provided. Note 2: Patient diets, including therapeutic diets, are ordered by the physician or other licensed practitioner responsible for the patient's care, or by a qualified dietitian or qualified nutrition professional who is	intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility **must**— (1) Provide the required services; or (2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. (b) Qualifications. Specialized rehabilitative services **must** be provided under the written order of a physician by qualified personnel. **Interpretive Guidelines §485.645(d)(6) Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.**	

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authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals. The requirement of 42 CFR 483.25(i) is met for inpatients receiving care at a skilled nursing facility subsequent to critical access hospital care. **PC.14.02.01, EP 8** For swing beds in critical access hospitals: If a residents comprehensive plan of care requires specialized rehabilitative services, including but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for a mental disorder and intellectual disability or services of a lesser intensity, the critical access hospital provides or obtains the required services from a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Social Security Act.		
PC.14.02.01, EP 3 For swing beds in critical access hospitals: The critical access hospital assists residents who are eligible and wish to apply for reimbursement of dental services as an incurred medical expense under the state plan. The critical access hospital may charge a Medicare resident an additional amount for routine and emergency dental services.	**§485.645(d)(7) Dental Services (§483.55(a)(2), (3), (4), and (5) and (b) of this chapter). • §483.55 Dental services.** The facility **must** assist residents in obtaining routine and 24-hour emergency dental care. (a) Skilled nursing facilities. A facility- (2) May charge a Medicare resident an additional amount for routine and emergency dental services; (3) **Must** have a policy identifying those circumstances when the loss or damage	

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EP 4 For swing beds in critical access hospitals: The critical access hospital develops and implements a policy identifying circumstances when loss of or damage to a resident's dentures is the critical access hospital's responsibility and it may not charge a resident for the loss or damage of dentures. **EP 5** For swing beds in critical access hospitals: If necessary or requested, the critical access hospital assists residents in making dental appointments and arranging for transportation to and from the dental services location. **EP 6** For critical access hospitals with swing beds: The critical access hospital refers residents with lost or damaged dentures for dental services within three days. If referral does not occur within three days, the critical access hospital documents what was done to make sure that the resident could adequately eat and drink and any extenuating circumstances that led to the delay. **EP 7** For swing beds in critical access hospitals: The critical access hospital provides or obtains from an outside resource routine (to the extent covered under the state plan) and emergency dental services.	of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; (4) **Must** if necessary or if requested, assist the resident— (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and (5) **Must** promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility **must** provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. (b) Nursing facilities. The facility- (1) **Must** provide or obtain from an outside resource, in accordance with §483.70(g), the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; (2) **Must**, if necessary or if requested, assist the resident— (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; (3) **Must** promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility **must** provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; (4) **Must** have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may	

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	not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and (5) **Must** assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. **Interpretive Guidelines §485.645(d)(7) Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.**	
PC.11.02.01, EP 11 For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental status - Nutritional status (such as usual body weight or desirable body weight range, electrolyte balance) - Skin - Pursuit of activity - Medications	**§485.645(d)(8) Nutrition (§483.25(g)(1) and (g)(2) of this chapter).** • §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility **must** ensure that a resident— (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (2) Is offered sufficient fluid intake to maintain proper hydration and health. **Interpretive Guidelines §485.645(d)(8) Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.**	

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- Need for special treatment(s) and procedure(s) - Discharge planning Note: The critical access hospital maintains the resident's acceptable nutritional status parameters unless the resident's clinical condition demonstrates that this is not possible or the resident's preferences indicate otherwise. **PC.12.01.09, EP 3:** For swing beds in critical access hospitals: The critical access hospital offers the resident sufficient fluid intake to maintain proper hydration and health.		

Critical Access Hospital Obstetrical Services Evaluation Module (485.649)

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LD.13.03.01, EP 1 The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic - Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital.	**§ 485.649 Condition of participation: Obstetrical services.** If the CAH offers obstetrical services, the services must be well organized and provided in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, postpartum patients. If outpatient obstetrical services are offered, the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.	**CMS Guidance Pending**
LD.13.03.01, EP 1 The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate	a) ***Standard: Organization and staffing.*** Effective January 1, 2026, the organization of the obstetrical services must be appropriate to the scope of the services offered. As applicable, the	**CMS Guidance Pending**

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to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic - Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital.	services must be integrated with other departments of the CAH.	
LD.13.01.07, EP 4 If obstetrical services are provided, the critical access hospital labor and delivery rooms/suites (including labor rooms; delivery rooms, including rooms for operative delivery; and post-partum/recovery rooms whether combined or separate) are supervised by an experienced registered nurse, certified nurse midwife, nurse practitioner, physician assistant, or a doctor of medicine or a doctor of osteopathy (MD/DO).	**(1)** Labor and delivery rooms/suites (including labor rooms, delivery rooms (including rooms for operative delivery), and post-partum/recovery rooms whether combined or separate) must be supervised by an experienced registered nurse, certified nurse midwife, nurse practitioner, physician assistant, or a Doctor of Medicine or a Doctor of Osteopathy (MD/DO).	**CMS Guidance Pending**
MS.17.02.01, EP 10 If obstetrical services are provided, obstetrical privileges are delineated for all practitioners providing obstetrical care in	**(2)** Obstetrical privileges must be delineated for all practitioners providing obstetrical care in accordance with the competencies of each	**CMS Guidance Pending**

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accordance with the competencies of each practitioner, and consistent with credentialing agreements established under 42 CFR 485.616(b). For 485.616(b), refer to https://www.ecfr.gov/current/title-42/part-485/section-485.616#p-485.616(b).	practitioner, and consistent with credentialing agreements established under § 485.616(b).	
LD.13.03.01, EP 23 If obstetrical services are provided, obstetrical services are consistent with the needs and resources of the critical access hospital. Policies governing obstetrical care are designed to assure the achievement and maintenance of high standards of medical practice and patient care and safety.	(b) ***Standard: Delivery of service.*** Effective January 1, 2026, obstetrical services must be consistent with needs and resources of the CAH. Policies governing obstetrical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care and safety.	**CMS Guidance Pending**
PC.12.01.05, EP 2 If obstetrical services are provided, the following equipment is kept at the critical access hospital and is readily available for treating obstetrical cases to meet the needs of patients in accordance with the scope, volume, and complexity of services offered: call-in-system, cardiac monitor, and fetal doppler or monitor.	(1) The following equipment must be kept at the CAH and be readily available for treating obstetrical cases to meet the needs of patients in accordance with the scope, volume, and complexity of services offered: call-in-system, cardiac monitor, and fetal doppler or monitor.	**CMS Guidance Pending**
LD.13.03.01, EP 24 If obstetrical services are provided, the critical access hospital has adequate provisions and protocols, consistent with nationally recognized and evidence-based guidelines, for obstetrical emergencies, complications, immediate post-delivery care, and other patient health and safety events as identified as part of the quality assessment and performance improvement (QAPI) program (42 CFR 485.641). Provisions include equipment (in addition to the equipment required under 42 CFR 485.649 (b)(1)), supplies, and medication used in treating emergency cases. Such provisions are kept in the critical access hospital and are readily available for treating emergency cases.	(2) There must be adequate provisions and protocols, consistent with nationally recognized and evidence-based guidelines, for obstetrical emergencies, complications, immediate post-delivery care, and other patient health and safety events as identified as part of the QAPI program (§ 485.641). Provisions include equipment (in addition to the equipment required under paragraph (b)(1) of this section), supplies, and medication used in treating emergency cases. Such provisions must be kept in the CAH and be readily available for treating emergency cases.	**CMS Guidance Pending**

Critical Access Hospital Obstetrical Services Evaluation Module (485.649)

Joint Commission Standards/EPs	Critical Access Hospital CoP	Critical Access Hospital Survey Process
Note 1: For 485.641, refer to https://www.ecfr.gov/current/title-42/section-485.641. Note 2: For 485.649(b)(1), refer to https://www.ecfr.gov/current/title-42/part-485/section-485.649#p-485.649(b) (1).		

The Joint Commission™

CRITICAL ACCESS HOSPITAL

COMPLIANCE EVALUATION TOOLS

CAH Medical Records Documentation Requirements (C Tags)

Medical Records Review The denominator needs to be no fewer than 20 inpatient records (minimum of 5 of the 20 records should be swing bed patient records) for all unshaded items, provided that number is adequate to determine compliance. Additionally, select a sample of outpatients in order to determine compliance in outpatient and emergency services.	
Reference	**Admission and Registration**
485.614(h)(1-4)	➢ Patient informed of **visitation rights**; records contain documentation that the required notice was provided
485.614(b)(3)	➢ **Advanced directives** – record contains documentation that notice of the hospital's advance directives policy was provided at the time of admission or registration; document in a prominent part of the patient's medical record whether or not the patient has executed an advance directive; if yes, a copy of the patient's advance directive is in the medical record.
485.614(b)(4)	➢ **Patient asked (unless incapacitated) about notifying** family and physician about inpatient admission; if the patient was incapacitated at the time of admission record documents what steps were taken to identify a family member or representative and the patient's physician.
485.638(b)(3)	➢ The patient's written consent is required for **release of information** not required by law.
Reference	**Care Documentation**
485.635(b)(1)(i)	➢ The CAH provides those diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at another entry point into the health care delivery system, such as a low intensity hospital outpatient department or emergency department.

	○ These CAH services include **medical history, physical examination, specimen collection**, **assessment of health status**, and **treatment** for a variety **of medical conditions**.
485.638(a)(2)	➢ The records are **legible**, **complete**, **accurately documented**, readily accessible, and systematically organized.
485.638(a)(4)(iv)	➢ **Dated signatures** of the doctor of medicine or osteopathy or other health care professional.
Reference	**Intervention Documentation**
485.638(a)(4)(i)	➢ Identification and social data, **evidence of properly executed informed consent forms**, pertinent **medical history**, **assessment of the health status** and **health care needs** of the patient, and a brief **summary of the episode**, **disposition**, and **instructions to the patient**;
485.638(a)(4)(ii)	➢ **Reports** of physical exams, diagnostic and laboratory test results, and consultative findings
485.638(a)(4)(iii)	➢ **All orders** of doctors of medicine or osteopathy or other practitioners, **reports of treatments** and **medications**, **nursing notes** and documentation of **complications**, and other pertinent information necessary to **monitor the patient's progress**, such as temperature graphics, **progress notes describing the patient's response to treatment**; and
485.639(b)(1)	➢ A **qualified practitioner . . .must examine the patient immediately before surgery** to evaluate the **risk of the procedure to be performed**.
485.639(b)(2)	➢ A **qualified practitioner . . .must examine** each **patient before surgery** to **evaluate the risk of anesthesia**.
485.639(b)(3)	➢ **Before discharge** from the CAH, each **patient must be evaluated for proper anesthesia recovery** by a qualified practitioner . . .

485.635(a)(3)(vi)	➢ Procedures that ensure that the **nutritional needs** of inpatients are met in accordance with recognized dietary practices. All patient diets, including therapeutic diets, **must be ordered** by the practitioner responsible for the care of the patients or by a qualified dietitian or qualified nutrition professional as authorized by the medical staff in accordance with State law governing dietitians and nutrition professionals and that the requirement of § 483.25(i) of this chapter is met with respect to inpatients receiving post CAH SNF care.
485.614(e)(4)	➢ **Restraint and seclusion:** The CAH must have **written policies and procedures** regarding the use of restraint and seclusion that are **consistent with current standards of practice**.
485.614(g)(3)(i) and (ii)	➢ Medical record includes the **date and time death associated with use of restraint or seclusion** was reported to CMS or recorded in the internal log or other system
Reference	**Discharge Planning, Evaluation, Post Hospital Needs**
485.635(d)(4)	A **nursing care plan** must be developed and kept current for each inpatient.
485.635(e)	Physical therapy, occupational therapy, and speech-language therapy pathology services furnished at the CAH, if provided, are provided by staff qualified under State law, and consistent with the requirements for therapy services in §409.17 . . . which specifies the following **rehabilitation services plan of care requirements**: • – **Establishment of the plan**: "The plan must be established before treatment begins by one of the following: (1) A physician; (2) A nurse practitioner, a clinical nurse specialist or a physician assistant; (3) The physical therapist furnishing the physical therapy services; (4) A speech-language pathologist furnishing the speech-language pathology services; (5) An occupational therapist furnishing the occupational therapy services." – **Content of the plan**: "The plan: (1) Prescribes the type, amount, frequency, and duration of the physical therapy, occupational therapy, or speech-language pathology services to be furnished to the individual; and (2) Indicates the diagnosis and anticipated goals."

	– **Changes in the plan**: "Any changes in the plan are implemented in accordance with the provider's policies and procedures."
485.639(d)	➢ All patients are discharged **in the company of a responsible adult**, except those exempted by the practitioner who performed the **surgical procedure**.
485.642(a)	(a) ***Standard: Discharge planning process.*** The CAH's discharge planning process must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning and must provide a discharge planning evaluation for those patients so identified as well as for other patients upon the request of the patient, patient's representative, or patient's physician.
485.642(a)(1)	Any **discharge planning evaluation** must be made on a timely basis to ensure that appropriate arrangements for post-CAH care will be made before discharge and to avoid unnecessary delays in discharge.
485.642(a)(2)	A discharge planning evaluation **must include** an evaluation of a patient's likely need for appropriate post-CAH services, including, but not limited to, hospice care services, post-CAH extended care services, home health services, and non-health care services and community based care providers, and must also include a determination of the availability of the appropriate services as well as of the patient's access to those services.
485.642(a)(3)	The discharge planning evaluation **must be included in the patient's medical record** for use in establishing an appropriate discharge plan and the results of the evaluation **must be discussed** with the patient (or the patient's representative).
485.642(a)(4)	Upon the request of a patient's physician, the CAH must arrange for the development and initial implementation of a discharge plan for the patient.
485.642(a)(5)	Any **discharge planning evaluation or discharge plan required** under this paragraph must be developed by, or under the supervision of, a registered **nurse, social worker, or other** appropriately qualified personnel.
485.642(a)(6)	The CAH's **discharge planning process must require regular re-evaluation** of the patient's condition to identify changes that require modification of the discharge plan. The discharge plan must be **updated, as needed, to reflect these changes**.
485.642(a)(7)	The CAH must assess its discharge planning process on a regular basis. The assessment must include ongoing, periodic review of a representative sample of discharge plans, including those

	patients who were readmitted within 30 days of a previous admission, to ensure that the plans are responsive to patient post-discharge needs. (**This is NOT in the medical record, see OQPI**)
485.642(a)(8)	The CAH must assist patients, their families, or the patient's representative in **selecting a post-acute care provider by using and sharing data** that includes, but is not limited to, HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The CAH must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.
485.642(b)	The CAH must discharge the patient, **and also transfer or refer the patient where applicable, along with all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, at the time of discharge, to the appropriate post-acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners responsible for the patient's follow-up or ancillary care.**

CAH Psychiatric and Rehabilitation Distinct Part Units (DPUs) Medical Records Documentation Requirements (A Tags and 412.27, 412.29)

<table>
<tr><td colspan="2"><u>Introduction to Medical Record Reviews</u>

▪ <u>Review a sample of active and closed medical records for completeness and accuracy in accordance with Federal and State laws and regulations and hospital policy.</u>
▪ <u>The sample should be 10 percent of the average daily census and be no less than 30 records.</u>
▪ <u>Within the sample, select at least one patient from each nursing unit (e.g., med/surg, ICU, OB, pediatrics, specialty units, etc.). In addition to the inpatient sample, select a sample of outpatients in order to determine compliance in outpatient departments, services, and locations. The sample size may be expanded as needed to assess the hospital's compliance with the CoPs.</u>
▪ <u>Request patient care policies and other supporting documents prior to reviewing medical records.</u>
▪ <u>This worksheet will assist surveyors in determining an organization's compliance with medical record documentation requirements and provide the opportunity to see trends in performance as well as track progress on performing the required quantity of review.</u></td></tr>
<tr><td><u>485.647 Condition of participation: psychiatric and rehabilitation distinct part units.</u></td><td><u>(a) Conditions.</u>

<u>(1) If a CAH provides inpatient psychiatric services in a distinct part unit, the services furnished by the distinct part unit must comply with the hospital requirements specified in subparts A, B, C, and D of part 482 of this subchapter, the common requirements of § 412.25(a)(2) through (f) of part 412 of this chapter for hospital units excluded from the prospective payment systems, and the additional requirements of § 412.27 of part 412 of this chapter for excluded psychiatric units.</u>

<u>(2) If a CAH provides inpatient rehabilitation services in a distinct part unit, the services furnished by the distinct part unit must comply with the hospital requirements specified in subparts A, B, C, and D of part 482 of this subchapter, the common requirements of § 412.25(a)(2) through (f) of part 412 of this chapter for hospital units excluded from the prospective payments systems, and the additional requirements of §§ 412.29 and § 412.30 of part 412 of this chapter related specifically to rehabilitation units.</u></td></tr>
<tr><td><u>Reference</u></td><td><u>Admission and Registration</u></td></tr>
</table>

482.13(a)(1)	➢ **Records of Medicare beneficiaries** contain a signed and dated standardized notice, "An Important Message from Medicare" (IM) provided to inpatients within 2 days of the admission. For patients whose discharge occurred more than 2 days after the initial IM notice was issued, determine whether the hospital provided another copy of the IM to the patient prior to discharge in a timely manner.
482.13(b)(3)	➢ **Advanced directives** – record contains documentation that notice of the hospital's advance directives policy was provided at the time of admission or registration; document in a prominent part of the patient's medical record whether or not the patient has executed an advance directive; if yes, a copy of the patient's advance directive is in the medical record.
482.13(b)(4)	➢ **Patient asked (unless incapacitated) about notifying** family and physician about inpatient admission; if the patient was incapacitated at the time of admission record documents what steps were taken to identify a family member or representative and the patient's physician.
482.13(h)(1)	➢ Patient informed of **visitation rights**; records contain documentation that the required notice was provided
Reference	**Care Documentation**
	Justification for Admission:
482.24(c)(4)(ii)	➢ **Admitting diagnosis**
482.24(c)	➢ Medical record information **justifies admission and continued hospitalization**, supports the diagnosis, and describes patient's progress and response to medications, services (interventions, care, treatments).
482.24(c)(1)	➢ Medical record entries are **legible, complete, dated, timed & authenticated** -consistent with policy/procedure

482.24(c)(3)(iv)	➢ **Pre-printed or electronic standing orders,** order sets, and protocols are dated, timed, and authenticated promptly in the medical record
482.24(c)(4)(iv)	➢ Documentation of **complications, healthcare associated infections (HAI's) and unfavorable** reactions to drugs **and anesthesia**
	Admission Note or H&P:
482.24(c)(4)(i)(A)	➢ A **medical history and physical examination** completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, and except as provided under paragraph (c)(4)(i)(C) of this section. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.
482.24(c)(4)(i)(B)	➢ An **updated examination** of the patient, including any changes in the patient's condition, when the medical history and physical examination are completed within 30 days before admission or registration, and except as provided under paragraph (c)(4)(i)(C) of this section. Documentation of the updated examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.
482.24(c)(4)(i)(C)	➢ An **assessment of the patient (in lieu of** the requirements of paragraphs (c)(4)(i)(A) and (B) of this section) completed and documented after registration, but prior to surgery or a procedure requiring anesthesia services, when the patient is receiving specific outpatient surgical or procedural services and when the medical staff has chosen to develop and maintain a policy that identifies, in accordance with the requirements at §482.22(c)(5)(v), specific patients as not requiring a comprehensive medical history and physical examination, or any update to it, prior to specific outpatient surgical or procedural services.

482.51(b)(1)(i)	**Surgical or procedure requiring anesthesia services H&P** ➢ **Prior to surgery or a procedure requiring anesthesia** services and except in the case of emergencies: A **medical history and physical examination** must be completed and documented no more than 30 days before or 24 hours after admission or registration, and except as provided under paragraph (b)(1)(iii) of this section.
482.51(b)(1)(ii)	➢ **Prior to surgery or a procedure requiring anesthesia** services and except in the case of emergencies: An **updated examination** of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration when the medical history and physical examination are completed within 30 days before admission or registration, and except as provided under paragraph (b)(1)(iii) of this section.
482.51(b)(1)(iii)	➢ **Prior to surgery or a procedure requiring anesthesia** services and except in the case of emergencies: An **assessment of the patient must** be completed and documented after registration (in lieu of the requirements of paragraphs (b)(1)(i) and (ii) of this section) when the patient is receiving specific outpatient surgical or procedural services and when the medical staff has chosen to develop and maintain a policy that identifies, in accordance with the requirements at § 482.22(c)(5)(v), specific patients as not requiring a comprehensive medical history and physical examination, or any update to it, prior to specific outpatient surgical or procedural services.
482.24(c)(4)(v)	**Informed Consent**: ➢ **Properly executed informed consent forms** for **procedures and treatments** specified by the medical staff, or by Federal or State law if applicable, to require written patient consent. (The medical record must contain a document recording the patient's informed consent for those procedures and treatments that have been specified as requiring informed consent). A properly executed informed consent form contains the following minimum elements: Name of the hospital…, Name of the specific procedure…, Name of the responsible practitioner…, Statement that the procedure or treatment, including the anticipated benefits, material risks, and alternative therapies, was explained to the patient…, Signature of the patient…, Date and time the informed consent form is signed by the patient… o If there is applicable State law governing the content of the informed consent form, then the hospital's form must comply with those requirements.
482.51(b)(2)	➢ A properly executed informed consent **form for the operation must be in the patient's chart before surgery**, except in emergencies.

482.24(c)(4)(vi) 482.26(b)(4) 482.26(d)(1) 482.28(b)(2) 482.53(d)(2) 482.57(b)(4) 482.24(c)(2) 482.28(b)(1), (b)(2)	**Monitoring of Care:** ➢ The medical record **must contain**: all practitioners' orders, nursing notes, reports of treatment, medication records, radiology, and laboratory reports, and vital signs and other information necessary to monitor the patient's condition ○ **Orders radiologic services** ○ **Radiologist signs reports of interpretation** ○ **Orders for patient diets** ○ **Nuclear med interpretation** of tests signed and dated ○ **Respiratory care orders** ➢ **All orders, including verbal orders, are dated, timed, and authenticated.** The receiver of a verbal order must date, time, and sign the verbal order in accordance with hospital policy ➢ **Nutritional needs** – monitoring the dietary intake and nutritional status of patients identified as having special nutritional needs; diet orders prescribed by the practitioner, a qualified dietician, or qualified nutrition professional.
Reference	**Intervention Documentation**
482.52(b)(1) 482.52(b)(2) 482.52(b)(3)	**Anesthesia:** ➢ **Pre-anesthesia eval** within 48 hours prior to surgery or anesthesia ➢ **Intraoperative anesthesia** record or report ➢ **Post anesthesia eval** no later than 48 hours after surgery or anesthesia

482.51(b)(6)	**Procedure**: ➢ An **operative report** describing techniques, findings, and tissues removed or altered must be written or dictated immediately following surgery and signed by the surgeon
482.24(c)(4)(iii)	**Consults:** ➢ **Results of all consultative evaluations** of the patient and appropriate findings **by clinical and other staff** involved in the care of the patient.
482.23(c)(1)(i) &(ii) 482.23(c)(2) 482.23(c)(3)	**Medication:** ➢ Review a sample of patient health records to determine: o if medication administration conformed to an authorized practitioner's order (that is, there is an order from an authorized practitioner, or an applicable standing order, and that the correct medication was **administered to the right patient at the right dose via the correct route**) and if the **timing of administration complied with the hospital's policies and procedures**. o All drugs and biologicals must be **administered by, or under supervision of, nursing or** other personnel….. o Orders for drugs and biologicals are documented and signed by any practitioner who is authorized…. Influenza and pneumococcal vaccines may be administered per physician-approved hospital policy after an assessment of contraindications…
482.23(c)(4)	➢ Review a sample of medical records of patients who received **blood transfusions or IV medications**. o Are blood transfusions and IV medications administered in accordance with state law and approved medical staff policies and procedures? o Are blood transfusions and IV medications administered by personnel who are working within their scope of practice in accordance with state law and approved medical staff policies?

482.23(c)(6)(i)(E)	**Medication Self Administration** ➢ Documentation of **self-administration** of hospital issued medication as reported by patient
482.23(c)(6)(ii)(E)	➢ Documentation of **self-administration** of medication brought in by patient as reported by patient
	Blood Products:
482.27 (b)(6)(iii)	➢ Documentation of **notification** of or attempts **to notify patient** of potentially infectious blood.
482.27(b)(7)(ii)	➢ If hospital unable to locate patient, it documents in the medical record the extenuating circumstances that caused notification to exceed 12 weeks.
	Restraints:
482.13(e)(8)(i)	➢ **Orders for restraint or seclusion** used for the management of violent or self-destructive behavior may only be renewed in accordance with the following limits for up to a total of 24 hours: (A) 4 hours for adults 18 years of age or older; (B) 2 hours for children and adolescents 9 to 17 years of age; or (C) 1 hour for children under 9 years of age;
482.13(e)(16)(i-v)	➢ **Documentation** of the following when restraints or seclusion is used: (i)The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior; (ii) A description of the patient's behavior and the intervention used; (iii) Alternatives or other less restrictive interventions attempted (as applicable); (iv) The patient's condition or symptom(s) that warranted the use of the restraint or seclusion; (v) The patient's response to the intervention(s) used, including the rationale for continued use of the intervention
482.13(e)(12)	➢ **Face-to-face** evaluation **within 1 hour** after the initiation of restraint or seclusion is used for the management of violent or self-destructive behavior by a— (A) Physician or other licensed practitioner

482.13 (e)(12)(i)	(B) Registered nurse who has been trained in accordance with the requirements in 482.13(f)
482.12(e)(12)(ii)	➢ **Documentation of the face-to-face** evaluation includes the following: (A) The patient's immediate situation; (B) The patient's reaction to the intervention; (C) The patient's medical and behavioral condition; and (D) The need to continue or terminate the restraint or seclusion.
482.13(e)(14)	➢ **Documentation of consultation** with the attending physician or other LP when the 1-hour face-to-face evaluation was conducted by a trained RN (as soon as possible in accordance with hospital policy)
482.13(g)(3)(i) and (ii)	➢ Medical record includes the **date and time death associated with use of restraint or seclusion** was reported to CMS or recorded in the internal log or other system
Reference	**Discharge Planning, Evaluation, Post Hospital Needs**
	Care Plans (nursing or interdisciplinary)
482.13(b)(1)	➢ Confirm that there is evidence that the patient or their representative was included or proactively involved in the development and implementation of their plan of care. ➢ For each plan reviewed, verify the following with respect to the nursing care component:
482.23(b)(4)	• Was the plan initiated as soon as possible after admission for each patient? • Does the plan describe and reflect patient goals as part of the patient's nursing care assessment and, as appropriate, physiological and psychosocial factors and patient discharge planning? • Is the plan consistent with the medical care plan of the practitioner responsible for the care of the patient? • Is there evidence of reassessment of the patient's nursing care needs and response to nursing interventions and, as applicable, revisions to the plan? • Was the plan implemented in a timely manner?
	Case Manager and/or Social Work Notes

482.43(a)(1)	➢ Discharge planning in **early stage of hospitalization** to ensure appropriate arrangements for post-hospital care will be made before discharge
482.43(a)(2)	➢ Discharge planning **evaluation** – eval of pt needing post-hospital services and determination of the availability of services
482.43(a)(3) & (a)(5)	➢ Discharge planning **evaluation and plan** – by, or under the supervision of a RN, social worker, or other qualified personnel; the discharge planning evaluation results are included **in the medical record**
482.43(a)(3)	➢ Discharge planning **evaluation results discussion**– with the patient or representative and communication documented in the medical record
482.43(a)(6)	➢ **Reassess** discharge plan
482.43(d)(1)(i) &(iii)	➢ Document in the record that the **list of HHAs, SNFs, IRFs, or LTCHs** was presented to the patient or to the patient's representative. (Note: disclosable financial interests if they exist must be stated on the list provided to the patient)
482.43(d)(1)(ii)	➢ Patients enrolled in **managed care organizations** made aware of the need to verify which providers or suppliers are in network
482.43(b)	➢ Necessary medical information is forwarded to next provider(s) of care
482.24(c)(4)(vii)	➢ **Discharge summary** with outcome of hospitalization, disposition of case, and provisions for follow-up care. (including final diagnosis)
482.24(c)(4)(viii)	➢ Final diagnosis with **completion of medical records within 30 days** following discharge.
485.647 Condition of participation: psychiatric and	(a) ***Conditions.***

rehabilitation distinct part units.	(1) If a CAH provides **inpatient psychiatric services in a distinct part unit**, the services furnished by the distinct part unit **must comply with the hospital requirements specified in subparts A, B, C, and D of part 482 of this subchapter,** the common requirements of § 412.25(a)(2) through (f) of part 412 of this chapter for hospital units excluded from the prospective payment systems, and the additional requirements of § 412.27 of part 412 of this chapter for excluded psychiatric units.
412.25 Excluded hospital units: Common requirements.	(a)(2) Have written admission criteria that are applied uniformly to both Medicare and non-Medicare patients.
412.27(a)	Admit only patients whose admission to the unit is required for active treatment, of an intensity that can be provided appropriately only in an inpatient hospital setting, of a psychiatric principal diagnosis that is listed in the International Classification of Diseases, Tenth Revision, Clinical Modification.
412.27(c)(1)	***Development of assessment/diagnostic data.*** Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the inpatient is treated in the unit.
412.27(c)(1)(i)	The identification data must include the inpatient's legal status.
412.27(c)(1)(ii)	A provisional or admitting diagnosis must be made on every inpatient at the time of admission, and must include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.
412.27(c)(1)(iii)	The reasons for admission must be clearly documented as stated by the inpatient or others significantly involved, or both.
412.27(c)(1)(iv)	The social service records, including reports of interviews with inpatients, family members, and others must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.
412.27(c)(1)(v)	When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.
412.27(c)(2)	***Psychiatric evaluation.*** Each inpatient must receive a psychiatric evaluation that must—
412.27(c)(2)(i)	Be completed within 60 hours of admission;

412.27(c)(2)(ii)	Include a medical history;
412.27(c)(2)(iii)	Contain a record of mental status;
412.27(c)(2)(iv)	Note the onset of illness and the circumstances leading to admission;
412.27(c)(2)(v)	Describe attitudes and behavior;
412.27(c)(2)(vi)	Estimate intellectual functioning, memory functioning, and orientation; and
412.27(c)(2)(vii)	Include an inventory of the inpatient's assets in descriptive, not interpretative fashion
412.27(c)(3)(i)	Each inpatient must have an individual comprehensive treatment plan that must be based on an inventory of the inpatient's strengths and disabilities. The written plan must include a substantiated diagnosis; short-term and long-term goals; the specific treatment modalities utilized; the responsibilities of each member of the treatment team; and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out; and
412.27(c)(3)(ii)	The treatment received by the inpatient must be documented in such a way as to assure that all active therapeutic efforts are included.
412.27(c)(4)	***Recording progress.*** Progress notes must be recorded by the doctor of medicine or osteopathy responsible for the care of the inpatient, a nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the inpatient but must be recorded at least weekly for the first two months and at least once a month thereafter and must contain recommendations for revisions in the treatment plan as indicated as well as precise assessment of the inpatient's progress in accordance with the original or revised treatment plan.
412.27(c)(5)	**Discharge planning and discharge summary.** *The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the inpatient's hospitalization in the unit and recommendations from appropriate services concerning follow-up or aftercare as well as a brief summary of the patient's condition on discharge.*
412.27(d)(5)	**Social services**. There must be a director of social services who monitors and evaluates the quality and appropriateness of social services furnished. The services must be furnished in accordance with accepted standards of practice and established policies and procedures. Social service staff responsibilities must include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of appropriate information with sources outside the hospital.

485.647 Condition of participation: psychiatric and rehabilitation distinct part units.	(a) ***Conditions.*** (2) If a CAH provides **inpatient rehabilitation services in a distinct part unit**, the services furnished by the distinct part unit **must comply with the hospital requirements specified in subparts A, B, C, and D of part 482 of this subchapter**, the common requirements of § 412.25(a)(2) through (f) of part 412 of this chapter for hospital units excluded from the prospective payments systems, and the additional requirements of §§ 412.29 and § 412.30 of part 412 of this chapter related specifically to rehabilitation units.
412.29(d)	Except for care furnished to patients in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge, as defined in § 412.622 of this chapter, during the Public Health Emergency, as defined in § 400.200 of this chapter, have in effect a **preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital program.** This procedure must ensure that the preadmission screening for each Medicare Part A fee-for-Service patient is reviewed and approved by a rehabilitation physician prior to the patient's admission to the IRF.
412.29(e)	Except for care furnished to patients in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge, as defined in § 412.622, during the Public Health Emergency, as defined in § 400.200 of this chapter, **have in effect a procedure to ensure that patients receive close medical supervision, as evidenced by at least 3 face-to-face visits per week by a licensed physician with specialized training and experience in inpatient rehabilitation to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process** except that during the Public Health Emergency, as defined in § 400.200 of this chapter, for the COVID-19 pandemic such visits may be conducted using telehealth services (as defined in section 1834(m)(4)(F) of the Act). Beginning with the second week, as defined in § 412.622, of admission to the IRF, a non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation may conduct 1 of the 3 required face-to-face visits with the patient per week, provided that such duties are within the non-physician practitioner's scope of practice under applicable state law.

412.29(h)	Except for care furnished to patients in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge, as defined in § 412.622 of this chapter, during the Public Health Emergency, as defined in § 400.200 of this chapter, have a plan of **treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient**.

Ambulatory Health Care Occupancy LSC and HCFC Evaluation Tool

The Ambulatory Health Care Occupancy LSC and HCFC Evaluation Tool reflects the Centers for Medicare & Medicaid Services (CMS) K-tags which represent the detailed NFPA 101 Life Safety Code and NFPA 99 Health Care Facilities Code requirements that are evaluated for compliance to determine if hospitals and critical access hospitals meet the Conditions of Participation. Hospitals and critical access hospitals and surveyors must refer to the tool for the content of Code requirements as these details no longer appear in individual elements of performance under the new, streamlined Joint Commission Physical Environment (PE) standards.

The tool will assist both organizations and surveyors in identifying the hospital and critical access hospital Conditions of Participation (CoPs) and the Physical Environment requirements that relate to the K-tags. Refer to the hospital and critical access hospital crosswalks for more detailed information related to the Physical Environment CoP requirements and Joint Commission Physical Environment standards relationships.

K-tag	Code Requirement	CoP	TJC EP	Comments
SECTION 1 – GENERAL REQUIREMENTS				
K100	**General Requirements – Other** Any LSC Section 20.1 and 21.1 General Requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01** The hospital/CAH addresses life safety from fire. **EP 3** The hospital/CAH meets the applicable provisions of the Life Safety Code (NFPA 101: 2012 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4).	
K111	**Building Rehabilitation** ***Repair, Renovation, Modification, or Reconstruction*** Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: Requirements of Chapter 21 Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6. 20.1.1.4.3, 21.1.1.4.3, 43.1.2.1 ***Change of Use or Change of Occupancy*** Any building undergoing change of use or change of occupancy classification complies with the	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01** The hospital/CAH addresses building safety and facility management. **EP 1** The hospital/CAH meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2,	

K-tag	Code Requirement	CoP	TJC EP	Comments
	requirements of Section 43.7, unless permitted by 20.1.1.4.2 or 21.1.1.4.2. 20.1.1.4.2, 21.1.1.4.2, 43.1.2.2 (43.7) *Additions* Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. 20.1.1.4.1, 21.1.1.4.1.1, 4.6.5, 4.6.7, 43.1.2.3 (43.8)			
K131	**Multiple Occupancies – Sections of Ambulatory Health Care Facilities** Multiple occupancies shall be in accordance with 6.1.14. Sections of ambulatory health care facilities shall be permitted to be classified as other occupancies, provided they meet both of the following: • The occupancy is not intended to serve ambulatory health care occupants for treatment or customary access • They are separated from the ambulatory health care occupancy by a 1 hour fire resistance rating Ambulatory health care facilities shall be separated from other tenants and occupancies and shall meet all of the following: • Walls have not less than 1 hour fire resistance rating and extend from floor slab to roof slab • Doors are constructed of not less than 1-3/4 inches thick, solid-bonded wood core or equivalent and is equipped with positive latches. • Doors are self-closing and are kept in the closed position, except when in use. • Windows in the barriers are of fixed fire window	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

<table>
<tr><th>K-tag</th><th>Code Requirement</th><th>CoP</th><th>TJC EP</th><th>Comments</th></tr>
<tr><td></td><td>assemblies per 8.3.
Per regulation, ASCs are classified as Ambulatory Health Care Occupancies, regardless of the number of patients served.
20.1.3.2, 21.1.3.3, 20.3.7.1, 21.3.7.1,42 CFR 416.44</td><td></td><td></td><td></td></tr>
<tr><td>K161</td><td>Building Construction Type and Height
Building construction type and stories meet Table 20.1.6.1 or Table 21.1.6.1, respectively.
<table>
<tr><td></td><td></td><td>Construction Type</td><td></td></tr>
<tr><td>1</td><td></td><td>I (442), I (332), II (222),
II (111), III (211), IV (2HH),
V (111)</td><td>Any number of stories non-sprinklered or sprinklered</td></tr>
<tr><td>2</td><td></td><td>II (000), III (200), V (000)</td><td>One story non-sprinklered
Any number of stories sprinklered</td></tr>
</table>
Any level below the level of exit discharge shall be separated by Type II (111), Type III (211), or Type V (111) construction unless both of the following are met:
1. Such levels are under the control of the ambulatory health care occupancy.
2. Hazardous spaces are protected per section 8.7.
Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 20.3.5 or 21.3.5, respectively)
Give a brief description, in REMARKS, of the construction, the number of stories, including</td><td>HAP 482.41(b)(1)(i)
CAH 485.623(c)(1)(i)</td><td>PE.03.01.01, EP 3</td><td></td></tr>
</table>

K-tag	Code Requirement	CoP	TJC EP	Comments
	basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. 20.1.6.1, 20.1.6.2, 21.1.6.1, 21.1.6.2			
K163	**Interior Nonbearing Wall Construction** Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls required to have a minimum 2-hour fire resistance rating are permitted to be fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. 20.1.6.3, 20.1.6.4, 21.1.6.3, 21.1.6.4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
SECTION 2 – MEANS OF EGRESS REQUIREMENTS				
K200	**Means of Egress Requirements – Other** Any LSC Section 20.2 and 21.2 Means of Egress requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K211	**Means of Egress – General** Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 20/21.2.2 through 20/21.2.11. 20.2.1, 21.2.1, 7.1.10.1	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K222	**Egress Doors** Special locking arrangements are in accordance with section 7.2.1.6 ☐ DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. ☐ ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. ☐ ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 20.2.2.2, 21.2.2.2, 7.2.1.6.1 through 7.2.1.6.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K223	**Doors with Self-Closing Devices** Doors required to be self-closing are permitted to be held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment, entire facility, and all stair enclosure doors upon activation of: • Required manual fire alarm system; and • Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	• Automatic sprinkler system, if installed; and • Loss of power. 20.2.2.4, 20.2.2.5, 21.2.2.4, 21.2.2.5			
K231	**Means of Egress Capacity** The capacity of required means of egress is in accordance with 7.3. 20.2.3.1, 21.2.3.1, 38.2.3, 39.2.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K232	**Aisle, Corridor or Ramp Width** The clear width of any corridor or passageway required for egress shall be not less than 44 inches wide. Where a corridor is 6 feet wide, projections of not more than 6 inches from the corridor wall above the handrail height are permitted for alcohol-based hand rub dispensers. 20.2.3.2, 20.2.3.3, 21.2.3.2, 21.2.3.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K233	**Clear Width of Exit and Exit Access Doors** **2012 EXISTING** Doors in the means of egress from diagnostic or treatment areas, such as x-ray, surgical, or physical therapy, shall provide a clear width of not less than 32 inches, unless the doors are existing 34 inch wide doors. 21.2.3.4 **2012 NEW** Doors in the means of egress from diagnostic or treatment areas, such as x-ray, surgical, or physical therapy, shall provide a clear width of not less than 32 inches. 20.2.3.4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K241	Number of Exits – Story and Compartment 2012 EXISTING Single means of egress is allowed from a mezzanine or balcony if one of the following exist: 1. Common path of travel is under 100 feet if in a sprinklered building. 2. Common path of travel 75 feet if in a non-sprinklered building. 3. Common path of travel is not limited if occupant load is under 30. Not less than 2 exits, as described in 38.2.2, are remotely located for each fire section or patient care area of the building and are accessible from each smoke compartment. Patient care suites larger than 2500 square feet have 2 exits remotely located from each other. Egress from smoke compartments, if installed, shall be permitted through adjacent compartments provided the egress does not return through the compartment of fire origin. 21.2.3.1 through 21.2.3.5, 7.4.1.1, 7.4.1.3 through 7.4.1.6 2012 NEW Meets the requirements of section 7.4. Not less than 2 exits, as described in 38.2.2, are remotely located for each fire section or patient care area of the building and are accessible from each smoke compartment. Patient care suites larger than 2500 square feet have 2 exits remotely located from each other. Egress from smoke compartments, if installed,	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	TJC EP	Comments
	shall be permitted through adjacent compartments provided the egress does not return through the compartment of fire origin. 20.2.4.1 through 20.2.4.5, 7.4			
K251	**Dead-End Corridors and Common Path of Travel** **2012 EXISTING** Dead end corridors shall not exceed 50 feet. Common path of travel is no more 75 feet, and no more than 100 feet sprinklered story. Common path of travel is not limited in single tenant space with an occupant load not exceeding 30 persons. 21.2.5, 39.2.5.2 **2012 NEW** Dead-end corridors are no more than 50 feet in sprinklered buildings, and no more than 20 feet in non-sprinklered buildings. Common path of travel is no more 75 feet, and no more than 100 feet in sprinklered buildings or single tenant space with an occupant load not exceeding 30 persons. 20.2.5, 38.2.5.2, 38.2.5.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K261	**Travel Distance to Exits** Travel distance between any point in a room and an exit is 150 feet or 200 feet in sprinklered buildings. 20.2.6, 21.2.6	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K271	**Discharge from Exits** Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface in	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	accordance with CMS Survey and Certification Letter 07-38. 20.2.7, 21.2.7, 38.2.7, 39.2.7, 7.7			
K281	**Illumination of Means of Egress** Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 20.2.8, 21.2.8, 7.8	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K291	**Emergency Lighting** Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 20.2.9.1, 21.2.9.1, 7.9	HAP 482.41(a)(1) HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d) **EP 3 applies to CAH but is not linked to a CAH CoP (Above and beyond requirement)**	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1** **PE.04.01.03, EP 1** The hospital/CAH has emergency power and lighting in, at a minimum, the following areas: • Operating rooms • Recovery rooms • Intensive care • Emergency rooms • Stairwells Battery lamps and flashlights are available in all other areas not serviced by the emergency power supply source.	

K-tag	Code Requirement	CoP	TJC EP	Comments
K292	**Life Support Means of Egress** Where general anesthesia or life-support equipment is used, each ambulatory health care facility shall be provided with an essential electric system in accordance with NFPA 99. (N/A if life support equipment is for emergency purposes only.) 20.2.9.2, 21.2.9.2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i) HAP 482.41(c) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K293	**Exit Signage** Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 20.2.10, 21.2.10, 7.10	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i) HAP 482.41(c) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
SECTION 3 - PROTECTION				
K300	**Protection – Other** Any LSC Section 20.3 and 21.3 Protection requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K311	**Vertical Openings – Enclosure** **2012 EXISTING** Vertical openings shall be enclosed or protected per 8.6, unless one of the following conditions exist: 1. Unenclosed vertical openings per 8.6.9.1 are permitted. 2. Unenclosed openings which do not serve as a required means of egress are permitted. 3. Exit access stairs may be unenclosed if they meet the following conditions: **Two stories or less**	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	a. Building is protected throughout by a supervised sprinkler system per 9.7.1.1(1). b. Total travel distance to outside does not exceed 100 feet. **Three stories or less** a. Occupant load per story does not exceed 15 people. b. Building is sprinkler protected throughout per 9.7.1.1(1). c. Building contains an automatic smoke detection system per 9.6. d. Activation of the sprinkler system or smoke detection system notifies all occupants of the building. e. Total travel distance to outside does not exceed 100 feet. Floors that are below the street level and are used for storage or any use other than a business occupancy, shall not have any unprotected openings to the business occupancy floors. 21.3.1, 39.3.1.1, 39.3.1.2 **2012 NEW** Vertical openings shall be enclosed or protected per 8.6, unless one of the following conditions exist: 1. Unenclosed vertical openings per 8.6.9.1 are permitted. 2. Exit access stairs may be unenclosed if they meet the 2 conditions: a. Building is sprinkler protected throughout. b. Total travel distance to outside does not exceed 100 feet. Floors that are below the street level and are used for			

K-tag	Code Requirement	CoP	TJC EP	Comments
	storage or any use other than a business occupancy, shall not have any unprotected openings to the business occupancy floors. 20.3.1, 38.3.1.1, 38.3.1.2			
K321	**Hazardous Areas – Enclosure** Hazardous areas must meet one of the following: ☐ Contain 1-hour rated enclosure when non-sprinklered ☐ Sprinkler-protected with smoke resistive separation ☐ Severe hazard locations contain sprinkler protection and 1 hour separation with 3/4 hour rated self-closing doors 20.3.2, 21.3.2, 38.3.2, 38.3.2.2, 39.3.2.1, 39.3.2.2, 8.7	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K322	**Laboratories** Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard are protected by 1-hour fire resistance-rated separation, automatic sprinkler system, and are in accordance with 8.7 and with NFPA 99. Laboratories not considered a severe hazard are protected as hazardous areas (see K321). Laboratories using chemicals are in accordance with NFPA 45, *Standard on Fire Protection for Laboratories Using Chemicals*. Gas appliances are of appropriate design and installed in accordance with NFPA 54. Shutoff valves are marked to identify material they control. Devices requiring medical grade oxygen from the	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i) HAP 482.41(c) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	piped distribution system meet the requirements under 11.4.2.2 (NFPA 99). 20.3.2.2, 21.3.2.2 9.3.1.2, 11.4.3.2, 15.4 (NFPA 99)			
K323	**Anesthetizing Locations** Areas designated for administration of general anesthesia (i.e., inhalation anesthetics) are in accordance with 8.7 and NFPA 99. Zone valves are: located immediately outside each life-support, critical care, and anesthetizing location of moderate sedation, deep sedation, or general anesthesia for medical gas or vacuum; readily accessible in an emergency; and arranged so shutting off any one anesthetizing location will not affect others. Area alarm panels are provided to monitor all medical gas, medical- surgical vacuum, and piped WAGD systems. Panels are at locations that provide for surveillance, indicate medical gas pressure decreases of 20 percent and vacuum decreases of 12-inch gauge HgV, and provide visual and audible indication. Alarm sensors are installed either on the source side of individual room zone valve box assemblies or on the patient/use side of each of the individual zone box valve assemblies. The EES critical branch supplies power for task illumination, fixed equipment, select receptacles, and select power circuits, and EES equipment system supplies power to ventilation system. Heating, cooling, and ventilation are in accordance with ASHRAE 170. Medical supply and equipment manufacturer's instructions for use are considered before reducing humidity levels to those allowed by	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i) HAP 482.41(c) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	ASHRAE, per S&C 13-58. 20.3.2.3, 21.3.2.3, NFPA 99 5.1.4.8.7, 5.1.4.8.7.2, 5.1.9.3.4, 6.4.2.2.4.2			
K324	**Cooking Facilities** Commercial cooking equipment shall be installed per NFPA 96 unless used for food warming or limited cooking. 20.3.2.4, 20.3.2.5, 21.3.2.4, 21.3.2.5, 9.2.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
	The hospital maintains fire safety equipment and fire safety building features by inspecting the following: - Any automatic fire-extinguishing system in the kitchen every 6 months Note: For automatic kitchen fire-extinguishing systems, see NFPA 96-2011: 11.2.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	
K325	**Alcohol Based Hand Rub Dispenser (ABHR)** ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: • Corridor is at least 6 feet wide. • Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols. • Dispensers shall have a minimum of four foot horizontal spacing. • Not more than an aggregate of 10 gallons of fluid or 1135 ounces of aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room. • Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30.	HAP 482.41(b)(7) CAH 485.623(c)(5)	**PE.03.01.01** The hospital/CAH addresses life safety from fire. **EP 7** When the hospital/CAH installs alcohol-based hand rub dispensers, it installs the dispensers in a manner that protects against inappropriate access.	

K-tag	Code Requirement	CoP	TJC EP	Comments
	• Dispensers are not installed within 1 inch of an ignition source. • If floor is carpeted, the building is fully sprinkler protected.. • ABHR does not exceed 95 percent alcohol. • Operation of the dispenser shall comply with Section 20.3.2.6(11) or 21.3.2.6(11). • ABHR is protected against inappropriate access. 20.3.2.6, 21.3.2.6, 8.7.3.1, CFR 416.44			
K331	**Interior Wall and Ceiling Finish** **2012 EXISTING** Interior wall and ceiling finishes in exits and exit access corridors shall have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. All other areas may be class C rated material. Indicate flame spread rating(s) walls._____ _____ 20.3.3, 21.3.3, 38.3.3, 39.3.3, 10.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K332	**Interior Floor Finish** **2012 NEW (N/A for 2012 EXISTING)** Interior floor finish in exit enclosures must meet 10.2 and be Class I or Class II. All other areas must meet 10.2.7.1 or 10.2.7.2. Indicate rating(s) for floors____ 20.3.3, 21.3.3, 38.3.3, 39.3.3, 10.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K341	**Fire Alarm System – Installation** A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, *National Electric Code,* and NFPA 72, *National Fire Alarm Code* to provide effective warning	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring, or other transmission paths are monitored for integrity. 20.3.4.2.1, 21.3.4.1, 9.6			
K342	**Fire Alarm System – Initiation** Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit and 200 ft travel distance is not exceeded. 20.3.4.2, 21.3.4.2, 9.6.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K343	**Fire Alarm – Notification** **2012 EXISTING** A positive alarm sequence in accordance with 9.6.3.4 is permitted. Occupant notification is provided automatically, without delay, in accordance with 9.6.3. Fire department notification is accomplished automatically per 9.6.4. Smoke detection devices or systems equipped with reconfirmation features shall not be required to automatically notify the fire department, unless the alarm condition is reconfirmed within 120 seconds (2 minutes) 21.3.4.3 through 21.3.4.3.2.2, 9.6.3, 9.6.4 **2012 NEW** A positive alarm sequence in accordance with 9.6.3.4 is permitted. Occupant notification is provided automatically, without delay, in accordance with 9.6.3. Fire department notification is accomplished automatically per	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	9.6.4. 20.3.4.3 through 20.3.4.3.2.1, 9.6.3, 9.6.4			
K344	**Fire Alarm – Control Functions** The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 20.3.4.4, 21.3.4.4	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K345	**Fire Alarm System – Testing and Maintenance** A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, *National Electric Code,* and NFPA 72, *National Fire Alarm and Signaling Code.* Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	
	The hospital maintains fire safety equipment and fire safety building features by testing the following every 12 months: - Duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors on the inventory - Visual and audible fire alarms (including speakers and door-releasing devices on the inventory) - Fire alarm equipment on the inventory for notifying off-site responders - Automatic smoke-detection shutdown devices for air-handling equipment Note: For additional guidance on duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors; visual and audible fire alarms; and fire alarm equipment, see NFPA 72-2010: Table 14.4.5; 17.14.	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	TJC EP	Comments
K346	**Fire Alarm – Out of Service** Fire alarms that are out of service for 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.9.6.1.6	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K351	**Sprinkler System – Installation** Sprinkler systems (if installed) are installed per NFPA 13. Where more than two sprinklers are installed in a single area for protection, waterflow devices shall be provided to sound the building fire alarm system or to notify a constantly attended location such as a PBX, security office, or emergency room. 20.3.5.1, 20.3.5.2, 21.3.5.1, 21.3.5.2, 9.7.1.2, 9.7, NFPA 13	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K353	**Sprinkler System – Maintenance and Testing** Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, *Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.* Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	
	The hospital maintains fire safety equipment and fire safety building features by testing the following based on the identified timeframes: - Supervisory signal devices on the inventory, quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices; semiannually for	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	TJC EP	Comments
	valve supervisory switches; and annually for other supervisory initiating devices Note: For supervisory signal devices, water storage tanks and associated water storage equipment do not require testing. For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5. The hospital maintains fire safety equipment and fire safety building features by testing the following every 12 months: - For automatic sprinkler systems, main drains at system low point or at all system risers - For automatic sprinkler systems, fire pumps under flow(fire pump supervisory signals for "pump running" and "pump power loss") Note: For automatic sprinkler systems, main drains, and system risers, see NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1. Note 3: For automatic sprinkler system fire pumps, see NFPA 25-2011: 8.3.3; 8.3.3.4. The hospital maintains fire safety equipment and fire safety building features by testing the following based on the identified timeframes: - Vane-type and pressure-type water flow devices every 6 months - For automatic sprinkler systems, electric motor-driven fire pumps monthly and diesel engine-driven fire pumps every week under no-flow conditions - Hydrostatic and water flow for standpipe systems every 5 years - Automatic fire extinguishing systems (carbon dioxide systems every 12 months, halon systems every 6 months, other special systems per NFPA standards and manufacturer's recommendations) - Hydrostatic tests on standpipe occupant hoses 5 years			

K-tag	Code Requirement	CoP	TJC EP	Comments
	after installation and every 3 years thereafter Note 1: For vane-type and pressure-type water flow devices, mechanical water flow devices (including but not limited to water motor gongs) should be tested quarterly. (For full text, refer to NFPA 25-2011: Table 5.1.1.2). For additional guidance also see NFPA 72-2010: Table 14.4.5. Note 2: For hydrostatic tests on standpipe occupant hoses, see NFPA 1962-2008: Chapter 7 and NFPA 25-2011: Chapter 6 The hospital maintains fire safety equipment and fire safety building features by inspecting the following: - For automatic sprinkler systems, all fire department water supply connections every quarter Note: For automatic sprinkler systems, see NFPA 25-2011: 13.7; Table 13.1.1.2.			
K354	Sprinkler System – Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 9.7.5, 15.5.2 (NFPA 25)	HAP 482.41(b)(8)(i) HAP 482.41(b)(8)(ii) CAH 485.623(c)(6)(i) CAH 485.623(c)(6)(ii)	**PE.03.01.01** The hospital/CAH addresses life safety from fire. **EP 8** When a sprinkler system is shut down for more than 10 hours, the critical access hospital either evacuates the building or portion of the building affected by the system outage until the system is back in service or establishes a fire watch until the system is back in service.	

K-tag	Code Requirement	CoP	TJC EP	Comments
K355	**Portable Fire Extinguishers** Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, *Standard for Portable Fire Extinguishers.* 20.3.5.3, 21.3.5.3, 9.7.4.1, NFPA 10	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
	The hospital maintains fire safety equipment and fire safety building features by inspecting the following: - Portable fire extinguishers at least monthly (this includes recharging every 12 months) Note 3: For portable fire extinguishers, there are many ways to document the inspections, such as using bar-coding equipment, using check marks on a tag, or using an inventory. Inspections involve a visual check to determine correct type of and clear and unobstructed access to a fire extinguisher, in addition to a check for broken parts and full charge. For additional guidance on inspection of fire extinguishers, see NFPA 10-2010: 7.1.2; 7.2.2; 7.2.4; 7.3.1.	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	
K362	**Corridors – Construction of Walls** 2012 NEW (Indicate N/A for 2012 EXISTING) Where access to exits is provided by corridors, such corridors shall be separated from use areas by a minimum 1-hour fire barrier constructed per section 8.3, unless one of the following exists: 1. Where exits are available from an open floor area 2. Where the entire space is a single tenant 3. Where the building is protected throughout by an approved automatic sprinkler system installed per 9.7.1.1(1) If the walls have a fire resistance rating, give the rating. _____ 20.3.6.1, 38.3.6.1, 38.3.6.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K364	**Corridor - Openings** 2012 NEW (Indicate N/A for 2012 EXISTING) Miscellaneous openings, such as mail slots, pharmacy/laboratory/cashier pass-through windows, shall be permitted to be installed in vision panels or doors without special protection provided that they meet both of the following: 1) The aggregate opening does not exceed 20 square inches. 2) The opening is installed at or below half the distance from the floor to the ceiling. If the room is protected throughout by an automatic sprinkler system. The aggregate opening shall not exceed 80 square inches. 20.3.6.2.1, 20.3.6.2.2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K371	**Subdivision of Building Spaces – Smoke Compartments** Smoke compartments do not exceed 25,000 square feet in size. Every story shall be divided into not less than 2 smoke compartments unless one of the following conditions occur: ☐ Facility is less than 5,000 square feet protected by an approved smoke detection system. ☐ Facility is less than 10,000 square feet protected by an approved, supervised sprinkler system per 9.7. ☐ Adjoining occupancy is used as a smoke compartment if all of the following are met: a. Separating wall is 1 hour fire resistive rated. b. Doors in the 1 hour rated wall at 1-3/4 inches thick. c. Doors in the 1 hour rated wall are self-closing.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	d. Windows in the 1 hour rated wall are fixed fire window assemblies per 8.3. e. The ambulatory health care facility is less than 22,500 square feet. f. Access from the ambulatory health care facility is unrestricted to another occupancy. 20.3.7.2, 21.3.7.2			
K372	**Subdivision of Building Spaces – Smoke Barrier Construction** **2012 EXISTING** Smoke barriers shall be constructed to a ½ hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 21.3.7.5, 21.3.7.6, 8.5 **2012 NEW** Smoke barriers shall be constructed to provide at least a 1-hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 20.3.7.5, 20.3.7.6, 8.5	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
	The hospital maintains fire safety equipment and fire safety building features by testing the following based on the identified timeframes: - Fire and smoke dampers 1 year after installation and at least every 6 years thereafter to verify they fully close Note: For operation of fire and smoke dampers, see NFPA 90A-2012: 5.4.8; NFPA 80-2010: 19.4; NFPA	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	TJC EP	Comments
	105-2010: 6.5.			
K374	**Subdivision of Building Spaces – Smoke Barrier Doors** **2012 EXISTING** Smoke barrier doors shall be a minimum of 1-3/4 inches thick, solid-bonded wood core or equivalent with self-closing or automatic-closing devices in accordance with 21.2.2.4. Latching hardware is not required. Doors are not required to swing in the direction of egress travel. 21.3.7.9, 21.3.7.10 **2012 NEW** Smoke barrier doors shall be a minimum of 1-3/4 inches thick, solid-bonded wood core or equivalent with self-closing or automatic-closing devices in accordance with 21.2.2.4. Latching hardware is not required. Doors are required to swing in the direction of egress travel. Rabbets, bevels, or astragals are at meeting edges, and stops are at the head and sides of door frames. Center mullions are prohibited in smoke barrier door openings. 20.3.7.9, 20.3.7.10, 20.3.7.13, 20.3.7.14	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K379	**Smoke Barrier Door Glazing** 2012 NEW (Indicate N/A for 2012 EXISTING) Cross-corridor swinging doors or cross corridor horizontal-sliding doors, contain a vision panel consisting of fire-rated glazing in approved frames in each door. Vision panels in any other door in the smoke barrier, if provided, shall be fire-rated glazing in approved frames.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	20.3.7.11, 20.3.7.12, 21.3.7.7, 8.3			
SECTION 4 – SPECIAL PROVISIONS				
K400	**Special Provisions – Other** Any LSC Section 20.4 and 21.4 Special Provisions requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K421	**High-Rise Buildings** **2012 EXISTING** High-rise buildings are protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.1.1(1), or an engineered life safety system complying with 39.4.2.1(2). 21.4, 39.4.2 **2012 NEW** High-rise buildings comply with section 11.8. 20.4, 38.4.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
SECTION 5 – BUILDING SERVICES				
K500	**Building Services – Other** Any LSC Section 20.5 and 21.5 Building Services requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K511	**Utilities – Gas and Electric** Equipment using gas or related gas piping complies with NFPA 54, *National Fuel Gas Code*, electrical wiring and equipment complies with NFPA 70, *National Electric Code*. Existing installations can continue in service provided no hazard to life. 20.5.1, 21.5.1, 9.1.1, 9.1.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K521	**HVAC** Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 20.5.2.1, 21.5.2.1, 9.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K522	**HVAC – Any Heating Device** Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: • is chimney or vent connected. • takes air for combustion from outside. • provides for a combustion system separate from occupied area atmosphere. 20.5.2.2, 20.5.2.2.1, 21.5.2.2, 21.5.2.2.1	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K523	**HVAC – Suspended Unit Heaters** Suspended unit heaters are permitted provided the following are met: • Not located in means of egress or in patient rooms. • Located high enough to be out of reach of people in the area. • Has a safety feature to stop fuel and shut down equipment if there is excessive	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	temperature or ignition failure. 20.5.2.2.2, 21.5.2.2.2			
K531	**Elevators** **2012 EXISTING** Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, *Safety Code for Elevators and Escalators.* Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 21.5.3, 9.4.2, 9.4.3 **2012 NEW** Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, *Safety Code for Elevators and Escalators.* Firefighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, *Safety Code for Elevators and Escalators,* including Firefighter's Service Requirements. (Includes firefighter's Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)	HAP 482.41(b)(1)(i) HAP 482.41(d)(2) CAH 485.623(c)(1)(i) CAH 485.623(b)(1)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 2**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	20.5.3, 9.4.2, 9.4.3			
K532	**Escalators, Dumbwaiters, and Moving Walks** Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. (Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters, includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.) 20.5.3, 21.5.3, 9.4	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K541	**Rubbish Chutes, Incinerators, and Laundry Chutes** **2012 EXISTING** Rubbish chutes are installed per section 9.5: ☐ Walls, partitions, and inlet openings meet the requirements of 8.3. ☐ Doors of chutes open to a room designed exclusively for accessing the chute opening. ☐ Room used for accessing the chute opening(s) are separated from other spaces per 8.7. ☐ Chutes shall be permitted to open into rooms not exceeding 400 cubic feet in size if the room is sprinkler protected and the room is not used for storage. **OR**	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	Existing installations having properly enclosed and maintained chute openings shall be permitted to have inlets open to a corridor or normally occupied space. 21.5.4, 9.5, NFPA 82 **2012 NEW** Rubbish chutes are installed per section 9.5: ☐ Walls, partitions, and inlet openings meet the requirements of 8.3. ☐ Doors of chutes open to a room designed exclusively for accessing the chute opening. ☐ Room used for accessing the chute opening(s) are separated from other spaces per 8.7. ☐ Chutes shall be permitted to open into rooms not exceeding 400 cubic feet in size if the room is sprinkler protected and the room is not used for storage. ☐ Maintenance and installation are per NFPA 82. 20.5.4, 9.5, NFPA 82			
SECTION 7 – OPERATING FEATURES				
K700	**Operating Features – Other** Any LSC Section 20.7 and 21.7 Operating Features requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K711	**Evacuation and Relocation Plan** There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 20/21.7.2.1.2 and provides for all of the fire safety plan components per 20/21.7.2.2. 20.7.1.1 through 20.7.1.3, 20.7.1.8 through 20.7.2.3.3 21.7.1.1 through 20.7.1.3, 21.7.1.8 through 20.7.2.3.3			
K712	**Fire Drills** Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 20.7.1.4 through 20.7.1.7, 21.7.1.4 through 21.7.1.7 ***Varying conditions means: Fire drills vary by at least one hour for each shift from quarter to quarter through four consecutive quarters	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K741	**Smoking Regulations** Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 20.7.4, 21.7.4			
K751	**Draperies, Curtains, and Loosely Hanging Fabrics** Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies at showers and baths. 20.7.5.1 through 20.7.5.3, 21.7.5.1 through 21.7.5.3	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K752	**Upholstered Furniture and Mattresses** Newly introduced upholstered furniture meets Class I or char length, and heat release criteria in accordance with 10.3.2.1 and 10.3.3, unless the building is fully sprinklered. Newly introduced mattresses shall meet char length and heat release criteria in accordance with 10.3.2.2 and 10.3.4, unless the building is fully sprinklered. Upholstered furniture and mattresses belonging to nursing home residents do not have to meet these requirements as all nursing homes are required to be fully sprinklered. Newly introduced upholstered furniture and	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	mattresses means purchased on or after the LSC final rule effective date. 20.7.5.2, 20.7.5.3, 21.7.5.2, 21.7.5.3			
K753	**Combustible Decorations** Combustible decorations shall be prohibited unless one of the following is met: • Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. • Decorations meet NFPA 701. • Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. • The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 20.7.5.4, 21.7.5.4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K754	**Soiled Linen and Trash Containers** Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. 20.7.5.5, 21.7.5.5	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K761	**Maintenance, Inspection & Testing - Doors** Fire doors assemblies are inspected and tested annually in accordance with NFPA 80 *Standard for Fire Doors and Other Opening Protectives*. Fire doors that are not located in required fire barriers, including corridor doors to patient rooms and	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01, EP 2**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspection and testing have an understanding of the operating components of the doors. Written records of inspection and testing are maintained and are available for review. 20.7.6, 21.7.6, 8.3.3.1 (LSC), 5.2. 5.2.3 (NFPA 80)			
	The hospital maintains fire safety equipment and fire safety building features by testing the following every 12 months: - Sliding and rolling fire doors, smoke barrier sliding or rolling doors, and sliding and rolling fire doors in corridor walls and partitions for proper operation and full closure - Fire door assemblies (inspection and testing) Note 5: For fire doors and smoke barrier doors, see NFPA 80-2010: 5.2.14.3; NFPA 105-2010: 5.2.1; 5.2.2. Note 6: For fire door assemblies, nonrated doors, including corridor doors to patient care rooms and smoke barrier doors, are not subject to the annual inspection and testing requirements of either NFPA 80 or NFPA 105. For hospitals that use Joint Commission accreditation for deemed status purposes: Nonrated doors should be routinely inspected and maintained in accordance with the facility maintenance program. For additional guidance on testing of door assemblies, see NFPA 101-2012: 7.2.1.5.10.1; 7.2.1.5.11; 7.2.1.15; NFPA 80-2010: 4.8.4; 5.2.1; 5.2.3; 5.2.4; 5.2.6; 5.2.7; 6.3.1.7; NFPA 105-2010: 5.2.1. The critical access hospital maintains fire safety equipment and fire safety building features by inspecting the following: - Fire door assemblies annually by a qualified individual (testing begins with a pre-test visual inspection and	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	TJC EP	Comments
	includes both sides of the opening)			
K771	**Engineer Smoke Control Systems** When installed, engineered smoke control systems are tested in accordance with established engineering principles. Test documentation is maintained on the premises. 20.7.7.1 through 20.7.7.3, 21.7.7.1 through 21.7.7.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K781	**Portable Space Heaters** Portable space heating devices shall be prohibited in all health care occupancies. Unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 20.7.8, 21.7.8	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K791	**Construction, Repair, and Improvement Operations** Construction, repair, and improvement operations shall comply with 4.6.10. Any means of egress in any area undergoing construction, repair, or improvements shall be inspected daily to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241. 20.7.9.1, 20.7.9.2, 21.7.9.1, 21.7.9.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	The hospital does not remove or minimize an existing life safety feature when such feature is a requirement for new construction. Existing life safety features, if not required by the Life Safety Code, can be either maintained or removed. (For full text, refer to NFPA 101-2012: 4.6.12.2; 4.6.12.3; 18/19.7.9)	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
PART II – HEALTH CARE FACILITIES CODE REQUIREMENTS				
K900	**Health Care Facilities Code - Other** Any NFPA 99 requirements (excluding Chapter 7, 8, 12, and 13) that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Health Care Facilities Code or NFPA standard citation, should be included in the finding.	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K901	**Fundamentals – Building System Categories** Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K902	**Gas and Vacuum Piped Systems – Other** Any NFPA 99 Chapter 5 Gas and Vacuum Systems requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding. Chapter 5 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K903	**Gas and Vacuum Piped Systems – Categories** Medical gas, medical air, surgical vacuum, WAGD, and air supply systems are designated: ☐ Category 1. Systems in which failure is likely to cause	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	major injury or death. ☐ Category 2. Systems in which failure is likely to cause minor injury. ☐ Category 3. Systems in which failure is not likely to cause injury but can cause discomfort. Deep sedation and general anesthesia are not to be administered using a Category 3 medical gas system. 5.1.1.1, 5.2.1, 5.3.1.1, 5.3.1.5 (NFPA 99)			
K904	**Gas and Vacuum Piped Systems – Warning Systems** All master, area, and local alarm systems used for medical gas and vacuum systems comply with appropriate Category warning system requirements, as applicable. 5.1.9, 5.2.9, 5.3.6.2.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K905	**Gas and Vacuum Piped Systems – Central Supply System Identification and Labeling** Containers, cylinders and tanks are designed, fabricated, tested, and marked in accordance with 5.1.3.1.1 through 5.1.3.1.7. Locations containing only oxygen or medical air have doors labeled with "Medical Gases, NO Smoking or Open Flame". Locations containing other gases have doors labeled "Positive Pressure Gases, NO Smoking or Open Flame, Room May Have Insufficient Oxygen, Open Door and Allow Room to Ventilate Before Opening." 5.1.3.1, 5.2.3.1, 5.3.10 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K906	**Gas and Vacuum Piped Systems – Central Supply System Operations** Adaptors or conversion fittings are prohibited. Cylinders are handled in accordance with 11.6.2. Only cylinders, reusable shipping containers, and their accessories are stored in rooms containing central	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	supply systems or cylinders. No flammable materials are stored with cylinders. Cryogenic liquid storage units intended to supply the facility are not used to transfill. Cylinders are kept away from sources of heat. Valve protection caps are secured in place, if supplied, unless cylinder is in use. Cylinders are not stored in tightly closed spaces. Cylinders in use and storage are prevented from exceeding 130°F, and nitrous oxide and carbon dioxide cylinders are prevented from reaching temperatures lower than manufacture recommendations or 20°F. Full or empty cylinders, when not connected, are stored in locations complying with 5.1.3.3.2 through 5.1.3.3.3, and are not stored in enclosures containing motor-driven machinery, unless for instrument air reserve headers. 5.1.3.2, 5.1.3.3.17, 5.1.3.3.1.8, 5.1.3.3.4, 5.2.3.2, 5.2.3.3, 5.3.6.20.4, 5.6.20.5, 5.3.6.20.7, 5.3.6.20.8, 5.3.6.20.9 (NFPA 99)			
K907	**Gas and Vacuum Piped Systems – Maintenance Program** Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99)	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses building safety and facility management. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	TJC EP	Comments
K908	**Gas and Vacuum Piped Systems – Inspection and Testing Operations** The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99)	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01, EP 2**	
K909	**Gas and Vacuum Piped Systems – Information and Warning Signs** Piping is labeled by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (Table 5.1.11), and operating pressure if other than standard. Labels are at intervals not more than 20 feet, are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency. 5.1.14.3, 5.1.11.1, 5.1.11.2, 5.2.11, 5.3.13.3, 5.3.11 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K910	**Gas and Vacuum Piped Systems – Modifications** Whenever modifications are made that breach the pipeline, any necessary installer and verification test specified in 5.1.2 is conducted on the downstream portion of the medical gas piping system. Permanent records of all tests required by system verification tests are maintained. 5.1.14.4.1, 5.1.14.4.6, 5.2.13, 5.3.13.4.3 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K911	**Electrical Systems – Other** Any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding. Chapter 6 (NFPA 99)	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K912	**Electrical Systems – Receptacles** Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, playrooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K913	**Electrical Systems – Wet Procedure Locations** Operating rooms are considered wet procedure locations, unless otherwise determined by a risk assessment conducted by the facility governing body. Operating rooms defined as wet locations are protected by either isolated power or ground-fault circuit interrupters. A written record of the risk assessment is maintained and available for inspection. 6.3.2.2.8.4, 6.3.2.2.8.7, 6.4.4.2	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K914	**Electrical Systems – Maintenance and Testing** Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01, EP 2**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of ≤ 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals ≤ 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)			
K915	**Electrical Systems – Essential Electric System Categories** ☐ Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. ☐ General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. ☐ Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1 1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K916	**Electrical Systems – Essential Electric System Alarm Annunciator** A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K917	**Electrical Systems – Essential Electric System Receptacles** Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K918	**Electrical Systems – Essential Electric System Maintenance and Testing** The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20–40-day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads and are conducted by competent personnel. Maintenance and	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01, EP 2**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
K919	**Electrical Equipment – Other** Any NFPA 99 Chapter 10, *Electrical Equipment*, requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.04.01.01, EP 1** **PE.03.01.01, EP 3**	
K920	**Electrical Equipment – Power Cords and Extension Cords** Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non- PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5			
K921	**Electrical Equipment – Testing and Maintenance Requirements** The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient care-related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuing training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01, EP 2**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K922	**Gas Equipment – Other** Any NFPA 99 Chapter 11 Gas Equipment requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding. Chapter 11 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K923	**Gas Equipment – Cylinder and Container Storage** **≥ 3,000 cubic feet** Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. **> 300 but <3,000 cubic feet** Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. **≤ 300 cubic feet** In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of ≤ 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING". Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
K924	**Gas Equipment – Testing and Maintenance Requirements** Anesthesia apparatus are tested at the final path to patient after any adjustment, modification or repair. Before the apparatus is returned to service, each connection is checked to verify proper gas and an oxygen analyzer is used to verify oxygen concentration. Defective equipment is immediately removed from service. Areas designated for servicing of oxygen equipment are clean and free of oil, grease, or other flammables. Manufacturer service manuals are used to maintain equipment and a scheduled maintenance program is followed. 11.4.1.3, 11.5.1.3, 11.6.2.5, 11.6.2.6 (NFPA 99)	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01, EP 2**	
K925	**Gas Equipment – Respiratory Therapy Sources of Ignition** Smoking materials are removed from patients receiving respiratory therapy. When a nasal cannula is delivering oxygen outside of a patient's room, no sources of ignition are within in the site of intentional expulsion (1-foot). When other oxygen deliver equipment is used or oxygen is delivered inside a patient's room, no sources of ignition are within the area are of administration (15-feet). Solid fuel-burning appliances is not in the area of administration. Nonmedical appliances with hot surfaces or sparking mechanisms are not within oxygen-delivery equipment or site of intentional expulsion.	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	11.5.1.1, TIA 12-6 (NFPA 99)			
K926	**Gas Equipment – Qualifications and Training of Personnel** Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K927	**Gas Equipment – Transfilling Cylinders** Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, *Transfilling of High-Pressure Gaseous Oxygen Used for Respiration*. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K928	**Gas Equipment – Labeling Equipment and Cylinders** Equipment listed for use in oxygen-enriched atmospheres are so labeled. Oxygen metering equipment and pressure reducing regulators are labeled "OXYGEN-USE NO OIL". Flowmeters, pressure reducing regulators, and oxygen-dispensing apparatus are clearly and permanently labeled designating the gases for which they are intended. Oxygen-metering equipment, pressure reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	or supplier. Cylinders and containers are labeled in accordance with CGA C-7. Color coding is not utilized as the primary method of determining cylinder or container contents. All labeling is durable and withstands cleaning or disinfecting. 11.5.3.1 (NFPA 99)			
K929	**Gas Equipment – Precautions for Handling Oxygen Cylinders and Manifolds** Handling of oxygen cylinders and manifolds is based on CGA G-4, Oxygen. Oxygen cylinders, containers, and associated equipment are protected from contact with oil and grease, from contamination, protected from damage, and handled with care in accordance with precautions provided under 11.6.2.1 through 11.6.2.4 (NFPA 99). 11.6.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K930	**Gas Equipment – Liquid Oxygen Equipment** The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K931	**Hyperbaric Facilities** All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99. Chapter 14 (NFPA 99)	HAP 482.41(d)(2) HAP 482.41(c) CAH 485.623(b)(1) CAH 485.623(d)	**PE.04.01.01, EP 1** **PE.04.01.01, EP 2**	
K932	**Features of Fire Protection – Other** Any NFPA 99 Chapter 15 Features of Fire Protection requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	citation, should be included in the finding. Chapter 15 (NFPA 99)			
K933	**Features of Fire Protection – Fire Loss Prevention in Operating Rooms** Periodic evaluations are made of hazards that could be encountered during surgical procedures, and fire prevention procedures are established. When flammable germicides or antiseptics are employed during surgeries utilizing electrosurgery, cautery or lasers: • packaging is non-flammable. • applicators are in unit doses. • Preoperative "time-out" is conducted prior the initiation of any surgical procedure to verify: o application site is dry prior to draping and use of surgical equipment. o pooling of solution has not occurred or has been corrected. o solution-soaked materials have been removed from the OR prior to draping and use of surgical devices. o policies and procedures are established outlining safety precautions related to the use of flammable germicide or antiseptic use. Procedures are established for operating room emergencies including alarm activation, evacuation, equipment shutdown, and control operations. Emergency procedures include the control of chemical spills, and extinguishment of drapery, clothing and equipment fires. Training is provided to new OR	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	personnel (including surgeons), continuing education is provided, incidents are reviewed monthly, and procedures are reviewed annually. 15.13 (NFPA 99) ***The preoperative time-out is addressed by the clinical surveyor.			
	The hospital labels utility system controls to facilitate partial or complete emergency shutdowns. Note 1: Examples of utility system controls that should be labeled are utility source valves, utility system main switches and valves, and individual circuits in an electrical distribution panel. Note 2: For example, the fire alarm system's circuit is clearly labeled as Fire Alarm Circuit; the disconnect method (that is, the circuit breaker) is marked in red; and access is restricted to authorized personnel. Information regarding the dedicated branch circuit for the fire alarm panel is located in the control unit. For additional guidance, see NFPA 101-2012: 18/19.3.4.1; 9.6.1.3; NFPA 72-2010: 10.5.5.2.	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

Fire Drill Matrix

Hospital Name:										Score at PE.03.01.01EP 3					
Quarterly Hospital Fire Drills (NFPA 101-2012 18/19 19.7.1)															
Day = M, Tu, W, Th, F, Sa, Su Time: 24 hour formatted			Q1			Q2			Q3			Q4			
			Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.	
1st Shift	Normal	**Location/Buil**	flr/Main												
		Day													
		Date													
		Time													
	ILSM	**Location/Building**													
		Day													
		Date													
		Time													
2nd Shif	Normal	**Location/Building**													
		Day													
		Date													
		Time													
	ILSM	**Location/Building**													
		Day													
		Date													
		Time													
3rd Shift	Normal	**Location/Building**													
		Day													
		Date													
		Time													
	ILSM	**Location/Building**													
		Day													
		Date													
		Time													

Required Annual Fire Drills (NFPA 99-2012 15.13.3.10.3 & 14.3.1.4.5 and 14.2.4.5.4/14.2.4.5.4.1 - if applicable)														
Locatio	**Previous**	**Current**	**Locatio**	**Previous**	**Current**	**Time?**								
OR			**Hyperbaric**											
Day			Day											
Date			Date											
Time			Time											

Quarterly Ambulatory Fire Drills										
		Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4
1st Shift	**Location/Building**					**Location/Buildi**				
	Day					Day				
	Date					Date				
	Time					Time				

Annual Business Occupancy Fire Drills (2 Years of drills)														
	Previous	**Current**		**Previous**	**Current**		**Previous**	**Current**		**Previous**	**Current**		**Previous**	**Current**
Building	**Medical Office Buliding**		**Building**			**Building**			**Building**			**Building**		
Day			Day			Day			Day			Day		
Date			Date			Date			Date			Date		
Time			Time			Time			Time			Time		

Definitions of Shifts: Provide timeframes for shift hours below (e.g. 1st shift: 0700-1600, 2nd shift: 1600-2400, 3rd shift: 2400-0700)

1st	
2nd	
3rd	

NA	Not applicable for no shift, building, location or ILSM.
NC	Not completed or missed

Critical Access Hospital Physical Environment Document List & Review Tool

Revised - Effective: 4/20/2024

The following pages present documentation required by the Critical Access Hospital Accreditation program Physical Environment standards. The Life Safety surveyor will begin review of these documents soon after arrival for the onsite survey. Surveyors may request other documents, as needed, throughout the survey. This list also includes some elements of performance that do not require documentation but appear as reminders to both organizations and surveyors of these expectations.

Please conduct during Facility Orientation.

Legend: C=Compliant; NC=Not compliant; NA=Not applicable; IOU=Surveyor awaiting documentation

STANDARD - EPs	See Legend				Document / Requirement	Yes	No	
	C	NC	NA	IOU				
PE.03.01.01					Buildings serving patients comply w/ NFPA 101 (2012)			
EP 1					Current and accurate drawings w/ fire safety features & related square footage a. Areas of building fully sprinklered (if building only partially sprinklered) b. Locations of all hazardous storage areas c. Locations of all fire-rated barriers d. Locations of all smoke-rated barriers e. Sleeping and non-sleeping suite boundaries, including size of identified suites f. Locations of designated smoke compartments g. Locations of chutes and shafts h. Any approved equivalencies or waivers	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
EP 5					The hospital maintains written evidence of regular inspection and approval by state or local fire control agencies.			
EP 2					The hospital maintains current Basic Building Information (BBI) within the Statement of Conditions (SOC).			
COMMENTS:								

STANDARD - EPs	See Legend				Document / Requirement	Yes	No	
	C	NC	NA	IOU				
PE.03.01.01					Hospital Manages Fire Risk – Fire Response Plan			
EP 4					The hospital has written fire control plans that include provisions for prompt reporting of fires; extinguishing fires; protection of patients, staff, and guests; evacuation; and cooperation with firefighting authorities. Staff periodically instructed on/kept informed of duties under plan Copy of plan readily available with telephone operator or security NFPA 101-2012: 18/19.7.1; 7.2	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	
COMMENTS:								

Please conduct after Facility Orientation, during Document Review activity.

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Q1 Semi	Q2	Q3 Semi	Q4 Annual
	C	NC	NA	IOU						
PE.04.01.01					Fire Protection and Suppression Testing and Inspection					
EP 2 (Specific content addressed on K-tag Tool)					Testing for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices NFPA 72-2010: Table 14.4.5	Quarterly				
					Testing for valve supervisory switches NFPA 72-2010: Table 14.4.5	Semiannual				
					Testing for other supervisory initiating devices	Annually				

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Q1 Semi	Q2	Q3 Semi	Q4 Annual
	C	NC	NA	IOU						
PE.04.01.01					Fire Protection and Suppression Testing and Inspection					
					NFPA 72-2010: Table 14.4.5					
EP 2					Water flow devices NFPA 72-2010: Table 14.4.5 NFPA 25-2011: Table 5.1.1.2	Semiannual				
					Tamper switches NFPA 72-2010: Table 14.4.5	Semiannual				
EP 2					Duct, heat, smoke detectors, and manual fire alarm boxes NFPA 72-2010: Table 14.4.5; 17.14	Annually				
EP 2					Notification devices (audible & visual), and door-releasing devices NFPA 72-2010: Table 14.4.5	Annually				
EP 2					Emergency services notification transmission equipment NFPA 72-2010: Table 14.4.5	Annually				
EP 2					Electric motor-driven fire pumps tested under no-flow conditions NFPA 25-2011: 8.3.1; 8.3.2	Monthly				
					Diesel-engine-driven fire pumps tested under no-flow conditions NFPA 25-2011: 8.3.1; 8.3.2	Weekly				
EP 2					Sprinkler systems main drain tests on all risers NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1	Annually				
EP 2					Fire department connections inspected (Fire hose connections N/A) NFPA 25-2011: 13.7; Table 13.1.1.2	Quarterly				
EP 2					Fire pump(s) tested – under flow	Annually				

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Q1 Semi	Q2	Q3 Semi	Q4 Annual
PE.04.01.01					Fire Protection and Suppression Testing and Inspection					
					Fire pump supervisory signals for pump running and pump power loss tested NFPA 25-2011: 8.3.3; 8.3.3.4					
EP 2					Standpipe flow test every 5 years NFPA 25-2011: 6.3.1; 6.3.2; Table 6.1.1.2	5 years				
EP 2					Kitchen suppression semi-annual testing NFPA 96-2011: 11.2	Semiannual				
EP 2					Carbon dioxide systems tested NFPA 12-2011:4.8.3.2	Annually				
					Halon systems NFPA 12A-2009: 6.1	Semiannual				
					Other special systems per National Fire Protection Association standards and manufacturers' recommendations NFPA 11-2010; NFPA 16-2011; NFPA 17-2009; NFPA 17A-2009					
EP 2					Portable fire extinguishers inspected monthly NFPA 10-2010: 7.2.2; 7.2.4	Monthly				
EP 2					Portable fire extinguishers maintained annually NFPA 10-2010: 7.1.2; 7.2.2; 7.2.4; 7.3.1	Annually				
EP 2					Fire hoses hydro tested 5 years after install; every 3 years thereafter NFPA 1962-2008: Chapter 7 and NFPA 25-2011: Chapter 6	5 years / 3 years				
EP 2					Smoke and fire dampers tested to verify full closure NFPA 90A-2012: 5.4.8; NFPA 80-2010: 19.4; NFPA 105-2010: 6.5	1 year after install				
						At least every 6 years thereafter				

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Q1 Semi	Q2	Q3 Semi	Q4 Annual
PE.04.01.01					Fire Protection and Suppression Testing and Inspection					
EP 2					Smoke detection shutdown devices for HVAC tested NFPA 90A-2012: 6.4.1	Annually				
EP 2					All horizontal and vertical roller and slider doors tested NFPA 80-2010: 5.2.14.3; NFPA 105-2010: 5.2.1; 5.2.2	Annually				
EP 2 (or PE.03.01.01, EP 3)					Inspection and testing of door assemblies by qualified person. Does not include nonrated doors, including corridor doors to patient care rooms and smoke barrier doors. NFPA101-2012: 7.2.1.5.10.1; 7.2.1.5.11; 7.2.1.15; NFPA 80-2010: 4.8.4; 5.2.1; 5.2.3; 5.2.4; 5.2.6; 5.2.7; 6.3.1.7; NFPA 105-2010: 5.2.1	Annually				
EP 2 (or PE.03.01.01, EP 3)					Elevators with firefighters' emergency operations NFPA 101-2012: 9.4.3; 9.4.6	Monthly				
EP 1					Documentation of maintenance testing and inspection activities for EPs 1-3 includes: activity name; date; inventory of devices, equipment or other items; frequency; contact info for person performing activity; NFPA standard; activity results NFPA 25-2011: 4.3; 4.4; NFPA 72-2010: 14.2.1; 14.2.2; 14.2.3; 14.2.4					
COMMENTS:										

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
PE.03.01.01 EP 3 and PE.04.01.01 EP 1					Emergency Power Systems are Maintained and Tested			
EP 3 or EP1					At least monthly performs functional test of emergency lighting systems and exit signs required for egress and task lighting for a minimum duration of 30 seconds, along with a visual inspection of other exit signs NFPA 101-2012: 7.9.3; 7.10.9; NFPA 99-2012: 6.3.2.2.11.5	Monthly		
EP 3 or EP1					Every 12 months performs functional test of battery powered lights on the inventory required for egress and exit signs for a duration of 1 ½ hours For new construction, renovation, or modernization battery-powered lighting in locations where deep sedation and general anesthesia are administered is tested annually for 30 minutes with test results and completion dates documented NFPA 101-2012: 7.9.3; 7.10.9; NFPA 99-2012: 6.3.2.2.11.5	Annually		
EP 3 or EP1					Functional test of Level 1 SEPSS, monthly; Level 2 SEPSS, quarterly, for 5 minutes or as specified for its class Annual test at full load for 60% of full duration of its class NFPA 111-2010: 8.4	Monthly Quarterly Annually		
					Note 1: Non-SEPSS tested per manufacturer's specifications	Per Mfr.		
					Note 2: Level 1 SEPSS defined for critical areas and equipment			
					Note 3: Class defines minimum time which SEPSS is designed to operate at rated load without recharging			

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
PE.03.01.01 EP 3 and PE.04.01.01 EP 1					Emergency Power Systems are Maintained and Tested			
EP 3 or EP1					Emergency power supply system (EPSS) inspected weekly, including all associated components and batteries NFPA 110-2010: 8.3.1; 8.3.3; 8.3.4; 8.4.1	Weekly		
EP 3 or EP1					Emergency generators tested monthly for 30 continuous minutes under load (plus cool-down) NFPA 99-2012: 6.4.4.1	Monthly		
EP 3 or EP1					Monthly load test for diesel-powered emergency generators conducted with dynamic load at least 30% of nameplate rating or meets mfr. recommended prime movers' exhaust gas temperature; **OR**	Monthly		
					Emergency generators tested once every 12 months using supplemental loads of 50% of nameplate rating for 30 minutes, followed by 75% of nameplate rating for 60 minutes for total of 1 ½ continuous hours NFPA 99-2012: 6.4.4.1	Annually		
EP 3 or EP1					All automatic and manual transfer switches monthly/12 times per year with results and completion dates documented NFPA 99-2012: 6.4.4.1	Monthly		
EP 3 or EP1					Fuel quality test to ASTM standards NFPA 110-2010: 8.3.8	Annually		
EP 3 or EP1					Generator load test once every 36 months for 4 hours NFPA 110-2010, Chapter 8	36 Months		
EP 3 or EP1					Generator 4-hour test performed at, at least 30% nameplate NFPA 110-2010, Chapter 8	36 Months		
COMMENTS:								

STANDARD - EPs	See Legend				Document / Requirement	THIS MAY BE SCORED AS CONDITIONAL OR STANDARD			Testing Dates
	C	NC	NA	IOU			Yes	No	
PE.04.01.01					Medical Gas and Vacuum Systems are Inspected and Tested				
EP 3					**Test, inspect and** maintain critical components of piped medical gas and vacuum systems, waste anesthetic gas disposal (WAGD), and support gas systems on the inventory. Inventory of critical components includes at least all source subsystems, control valves, alarms, manufactured assemblies containing patient gases, and inlets and outlets with activities, dates and results documented No prescribed frequency; recommend risk assessment if < annual NFPA 99-2012: 5.1.14.2; 5.1.15; 5.2.14; 5.3.13	Per policy			
EPs 1, 3					Location of and signage for bulk oxygen systems NFPA 99-2012: 5.1.3.5.12	On Bldg. Tour			
EPs 1, 3					Emergency oxygen supply connection NFPA 99-2012: 5.1.3.5.13	On Bldg. Tour			
EPs 1, 3					Review medical gas installation/modification/breech certification results for cross connection, purity, correct gas, and pressure NFPA 99-2012: 5.1.2; 5.1.4; 5.1.14.4.1; 5.1.14.4.6; 5.2.13	As applicable			
EP 1					Medical gas supply and zone valves are accessible and clearly labeled NFPA 99-2012: Table 5.1.11 NFPA 99-2012: 5.1.4; 5.1.11.1; 5.1.11.2; 5.1.14.3; 5.2.11; 5.3.13.3; 5.3.11	On Bldg. Tour			

STANDARD - EPs	See Legend				Document / Requirement	THIS MAY BE SCORED AS CONDITIONAL OR STANDARD			Testing Dates
	C	NC	NA	IOU			Yes	No	
PE.04.01.01					Medical Gas and Vacuum Systems are Inspected and Tested				
EP 1					Handling, transfer, storage, labeling, transfilling of cylinders NFPA 99-2012: 11.5.3.1; 11.6.1; 11.6.2; 11.6.5; 11.7.3	Per policy			
COMMENTS:									

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Q1	Q2	Q3	Q4 Annual
	C	NC	NA	IOU						
PE.03.01.01					Fire Drills					
EP 3					Fire drills once per shift per quarter in health care occupancies; Quarterly in each building defined as ambulatory health care occupancy (If available, please provide five quarters of fire drill data) NFPA 101-2012: 18/19: 7.1.7	Quarterly				
EP 3					Fire drills every 12 months from date of last drill: Business Occupancies	Annually				
EP 3					When quarterly fire drills are required, ALL are unannounced • Drills held at unexpected times and under varying conditions – at least one hour apart for each shift from quarter to quarter through four consecutive quarters • Drills include transmission of fire alarm signal and simulation of emergency fire conditions	Quarterly (See fire drill matrix)				

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Q1	Q2	Q3	Q4 Annual
PE.03.01.01					Fire Drills					
					NFPA 101-2012: 18/19: 7.1.7; 7.1; 7.2; 7.3					
PE.04.01.01 EP 1					Fire exit drills for operating rooms/surgical suites. NFPA 99-2012: 15.13.3.10.3	Annually				
PE.04.01.01 EP 1					Annual emergency procedures and fire training drills for hyperbaric facilities that include recording of time to evacuate all persons from area, involves applicable staff, and focuses on prevention and simulated extinguishment and evacuation. NFPA 99-2012: 14.2.4.5.4; 14.3.1.4.5 NFPA 99-2012: B.14.2 and B.14.3	Annually				
COMMENTS:										

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
					Manages risks associated with utility systems			
PE.03.01.01 EP 3 or PE.04.01.01 EP 1					In critical care areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, filtration efficiencies, temperature and humidity. *(form of and frequency of assessment per hospital policy)* Note: For more information about areas designed for control of airborne contaminants, the basis for design compliance is the Guidelines for Design			

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
					Manages risks associated with utility systems			
					and Construction of Health Care Facilities, based on the edition used at the time of design (if available).			
COMMENTS:								

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Yes	No
PE.04.01.05					Manages risks associated with utility systems – Water Management Program		
EP 1					Verify individual or team responsible for oversight and implementation of the water management program		
EP 2					Review water management program to verify the following components are included: • Diagram of water supply sources, treatment systems, processing steps, control measures, and end-use points • Water risk management plan identifies areas where potentially hazardous conditions may occur ○ Note: Refer to the Centers for Disease Control and Prevention's "Water Infection Control Risk Assessment (WICRA) for Healthcare Settings" tool as an example for conducting a water-related risk assessment. • Plan for addressing the use of water in areas of buildings where water may have been stagnant for a period of time • Evaluation of immunocompromised patients • Monitoring protocols and acceptable ranges for control measures		
EP 3					Verify that the water management program includes documentation of the following: • Results of all monitoring activities • Corrective actions and procedures to follow if test results are outside of acceptable limits • Corrective actions taken when control limits are not maintained		
EP 4					Verify water management program reviewed annually and when changes have been made to the water system that add risk, new equipment or at-		

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Yes	No
PE.04.01.05					Manages risks associated with utility systems – Water Management Program		
					risk systems have been added that could generate aerosols or be source for Legionella		
COMMENTS:							

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Yes	No
PE.04.01.01					Management of Medical Equipment Risks		
EP2					Non-deemed status requirement: Maintains either a written inventory of all medical equipment or a written inventory of selected equipment categorized by physical risk associated with use (including all life-support equipment) and equipment incident history. Evaluates new types of equipment before initial use to determine whether they should be included in the inventory. **OR** Deemed status requirement: Maintains a written inventory of **all** medical equipment.		
EP 2					High-risk medical equipment identified on the inventory		
EP 2					Inventory includes activities and associated frequencies for maintaining, inspecting, and testing all medical equipment on the inventory.		
COMMENTS:							

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
PE.04.01.01					Medical equipment inspection, testing and maintenance			
EP 2					All high-risk equipment. Note 1: High-risk equipment includes medical equipment for which there is a risk of serious injury or even death to a patient or staff member should it fail, which includes life-support equipment. Note 2: Required activities and associated frequencies for maintaining, inspecting, and testing of medical equipment must have a 100% completion rate.			
EP 2					Non-high-risk equipment identified on the medical equipment inventory			
EP 2					Conducts performance testing of and maintains all sterilizers			
EP 1, 2					All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99-2012: Chapter 14.			
COMMENTS:								

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
PE.04.01.01					Utility system Inspection, testing and maintenance			
EP 2					High-risk utility system components on the inventory with completion date and results of activities documented Note 1: A high-risk utility system includes components for which there is a risk of serious injury or even death to a patient or staff member should it fail, which includes life-support equipment. Note 2: Required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components must have a 100% completion rate.			

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
PE.04.01.01					Utility system Inspection, testing and maintenance			
EP 2					Infection control utility system components on the inventory with completion date and results of activities documented Note 1: Required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components must have a 100% completion rate.			
EP 2					Non-high-risk utility system components on the inventory with completion date and results of activities documented			
EP 2					Line isolation monitors (LIM), if installed, are tested at least monthly by actuating the LIM test switch. For LIM circuits with automated self-testing, a manual test is performance at least annually. NFPA 99-2012: 6.3.2; 6.3.3; 6.3.3.3.2; 6.3.4			
COMMENTS:								

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
NPG.11.01.01 and NPG.02.04.01					The hospital manages safety and security risks.			
EP 2					The hospital has written procedures to follow in the event of a security incident, including an infant or pediatric abduction.			
Note: EP's14 and 16 are covered by the clinical imaging tracer.								
EP 3					The hospital conducts an annual worksite analysis related to its workplace violence prevention program. The hospital takes actions to mitigate or resolve the workplace violence safety and security risks based upon findings from the analysis.			

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
NPG.11.01.01 and NPG.02.04.01					The hospital manages safety and security risks.			
					Note: A worksite analysis includes a proactive analysis of the worksite, an investigation of the hospital's workplace violence incidents, and an analysis of how the program's policies and procedures, training, education, and environmental design reflect best practices and conform to applicable laws and regulations.			
COMMENTS:								

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
NPG.11.01.01					The hospital collects information to monitor conditions in the environment.			
EP 3					EP 1 The hospital develops and implements processes for monitoring, internally reporting, and investigating the following: - Injuries to patients or others within the hospital's facilities - Occupational illnesses and staff injuries - Incidents of damage to its property or the property of others - Safety and security incidents involving patients, staff, or others within its facilities, including those related to workplace violence - Hazardous materials and waste spills and exposures - Fire safety management problems, deficiencies, and failures - Medical or laboratory equipment management problems, failures, and use errors - Utility systems management problems, failures, or use errors			

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Addressed in policy? Yes	No	Implemented as required? Yes	No
PE.03.02.01					Interim Life Safety Measures (ILSM)				
EP 1					ILSM policy identifying when and to what extent ILSM implemented				

STANDARD - EPs	See Legend				Document / Requirement	Addressed in policy?		Implemented as required?	
	C	NC	NA	IOU		Yes	No	Yes	No
PE.03.02.01					Interim Life Safety Measures (ILSM)				
PE.03.01.01 EP 8 and PE.03.02.01 EP 2					Alarms out of service 4 or more hours in 24 hours or sprinklers out of service more than 10 hours in 24 hours in an occupied building - Fire watch / Fire Dept. notification NFPA 101-2012: 9.6.1.6; 9.7.6; NFPA 25-2011: 15.5.2				
EP 3					Signs for alternate exits posted				
EP 4					Daily inspection of routes of egress (See also 19.7.9.2 RE: daily inspections)				
EP 5					Temporary but equivalent systems while system is impaired				
EP 6					Additional firefighting equipment provided				
EP 7					Smoke tight non-combustible temporary barriers				
EP 8					Increased surveillance implemented				
EP 9					Storage and debris removal				
EP 10					Additional training on firefighting equipment				
EP 11					Additional fire drill per shift per quarter				
EP 12					Temporary systems tested and inspected monthly				
EP 13					Additional training on building deficiencies, construction hazards, temp measures				
EP 14					Training for impaired structural or impaired compartment fire safety features				
EP 15					Other ILSM's				
COMMENTS:									

NOTE: Please complete the following during building tour

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
PE.02.01.01					The hospital manages risks related to hazardous materials and waste.			
EP 1					The hospital maintains a written, current inventory of hazardous materials and waste that it uses, stores, or generates. The only materials that need to be included on the inventory are those whose handling, use, and storage are addressed by law and regulation. (See also IC.02.01.01, EP 6; MM.01.01.03, EPs 1 and 2)			
EP 4					The hospital has written procedures, including the use of precautions and personal protective equipment, to follow in response to hazardous material and waste spills or exposures.			
EP 2					For managing hazardous materials and waste, the hospital has the permits, licenses, manifests, and safety data sheets required by law and regulation.			
COMMENTS:								

Health Care Occupancy LSC and HCFC Evaluation Tool

The Health Care Occupancy LSC and HCFC Evaluation Tool reflects the Centers for Medicare & Medicaid Services (CMS) K-tags which represent the detailed NFPA 101 Life Safety Code and NFPA 99 Health Care Facilities Code requirements that are evaluated for compliance to determine if hospitals and critical access hospitals meet the Conditions of Participation. Hospitals and critical access hospitals and surveyors must refer to the tool for the content of Code requirements as these details no longer appear in individual elements of performance under the new, streamlined Joint Commission Physical Environment (PE) standards.

The tool will assist both organizations and surveyors in identifying the hospital and critical access hospital Conditions of Participation (CoPs) and the Physical Environment requirements that relate to the K-tags. Refer to the hospital and critical access hospital crosswalks for more detailed information related to the Physical Environment CoP requirements and Joint Commission Physical Environment standards relationships.

K-tag	Code Requirement	CoP	TJC EP	Comments
SECTION 1 – GENERAL REQUIREMENTS				
K100	**General Requirements – Other** Any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01** The hospital/CAH addresses life safety from fire. **EP 3** The hospital/CAH meets the applicable provisions of the Life Safety Code (NFPA 101: 2012 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4).	
K111	**Building Rehabilitation** ***Repair, Renovation, Modification, or Reconstruction*** Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: Requirements of Chapter 18 and 19. Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6. 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 ***Change of Use or Change of Occupancy*** Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2. 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7) ***Additions***	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01** The hospital/CAH addresses building safety and facility management. **EP 1** The hospital/CAH meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2,	

K-tag	Code Requirement	CoP	TJC EP	Comments
	Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2-hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8)			
K112	**Sprinkler Requirements for Major Rehabilitation** If a non-sprinklered smoke compartment has undergone major rehabilitation the automatic sprinkler requirements of 18.3.5 have been applied to the smoke compartment. In cases where the building is not protected throughout by a sprinkler system, the requirements of 18.4.3.2, 18.4.3.3, and 18.4.3.8 are also met. Note: Major rehabilitation involves the modification of more than 50 percent, or more than 4500 ft^2 of the area of the smoke compartment. 18.1.1.4.3.3, 19.1.1.4.3.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K131	**Multiple Occupancies – Sections of Health Care Facilities** Sections of health care facilities classified as other occupancies meet all of the following: • They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. • They are separated from areas of health care occupancies by construction having a minimum two-hour fire resistance rating in accordance with Chapter 8. • The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR			
K132	**Multiple Occupancies – Contiguous Non-Health Care Occupancies** Non-health care occupancies that are located immediately next to a Health Care Occupancy but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than two-hour fire resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.4.1, 19.1.3.4.1	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K133	**Multiple Occupancies – Construction Type** Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a two-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: • The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1. • The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

<table>
<tr><th>K-tag</th><th>Code Requirement</th><th>CoP</th><th>TJC EP</th><th>Comments</th></tr>
<tr><td>K161</td><td>Building Construction Type and Height
2012 EXISTING
Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7, 19.1.6.4, 19.1.6.5
<table>
<tr><td></td><td></td><td>Construction Type</td><td></td></tr>
<tr><td>1</td><td></td><td>I (442), I (332), II (222)</td><td>Any number of stories non-sprinklered or sprinklered</td></tr>
<tr><td>2</td><td></td><td>II (111)</td><td>One story non-sprinklered Maximum 3 stories sprinklered</td></tr>
<tr><td>3</td><td></td><td>II (000)</td><td rowspan="4">Not allowed non-sprinklered Maximum 2 stories sprinklered</td></tr>
<tr><td>4</td><td></td><td>III (211)</td></tr>
<tr><td>5</td><td></td><td>IV (2HH)</td></tr>
<tr><td>6</td><td></td><td>V (111)</td></tr>
<tr><td>7</td><td></td><td>III (200)</td><td rowspan="2">Not allowed non-sprinklered Maximum 1 story sprinklered</td></tr>
<tr><td>8</td><td></td><td>V (000)</td></tr>
</table>
Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)</td><td>HAP 482.41(b)(1)(i)
CAH 485.623(c)(1)(i)</td><td>PE.03.01.01, EP 3</td><td>Determine type of building construction and where you would be able to confirm by direct observation the structure and building materials used in constructing the building (exposed areas above the ceilings or vertical pipe shafts may provide insight).

Visit areas where you can confirm by direct observation the structure and building materials used in constructing the building (exposed areas above the ceilings or vertical pipe shafts may provide insight).</td></tr>
<tr><td>K162</td><td>Roofing Systems Involving Combustibles
2012 EXISTING
Buildings of Type I (442), Type I (332), Type II (222), or Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following:
1. roof covering meets Class C requirements.
2. roof is separated from occupied building portions with a noncombustible floor assembly using not less than 2½ inches concrete or gypsum fill.
3. attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.</td><td>HAP 482.41(b)(1)(i)
CAH 485.623(c)(1)(i)</td><td>PE.03.01.01, EP 3</td><td></td></tr>
</table>

K-tag	Code Requirement	CoP	TJC EP	Comments
	19.1.6.2*, ASTM E108, ANSI/UL 790 **2012 NEW** Buildings of Type I (442), Type I (332), Type II (222), Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following: 1. roof covering meets Class A requirements. 2. roof is separated from occupied building portions with 2-hour fire resistive noncombustible floor assembly using not less than 2½ inches concrete or gypsum fill. 3. the structural elements supporting the rated floor assembly meet the required fire resistance rating of the building. 18.1.6.2, ASTM E108, ANSI/UL 790			
K163	**Interior Nonbearing Wall Construction** Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls required to have a minimum 2-hour fire resistance rating are permitted to be fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. 18.1.6.4, 18.1.6.5, 19.1.6.4, 19.1.6.5	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
SECTION 2 – MEANS OF EGRESS REQUIREMENTS				
K200	**Means of Egress Requirements – Other** Any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K211	**Means of Egress – General** Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1			
K221	**Patient Sleeping Room Doors** Locks on patient sleeping room doors are not permitted unless the key- locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K222	**Egress Doors** Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: ☐ CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 ☐ SPECIAL NEEDS LOCKINGARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 ☐ DELAYED-EGRESS LOCKING ARRANGEMENTS	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	Approved, listed delayed egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ☐ ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ☐ ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
K223	**Doors with Self-Closing Devices** Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: • Required manual fire alarm system; and • Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and • Automatic sprinkler system, if installed; and • Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K224	**Horizontal-Sliding Doors** Horizontal-sliding doors permitted by 7.2.1.14 that are not automatic-closing are limited to a single leaf and shall have a latch or other mechanism to ensure the door will not rebound. Horizontal-sliding doors serving an occupant load fewer than 10 shall be permitted, providing all of the following criteria are met: • Area served by the door has no high hazard contents. • Door is operable from either side without special knowledge oreffort. • Force required to operate the door in the direction of travel is ≤ 30 lbf to set the door in motion and ≤ 15 lbf to close or open to the required width. • Assembly is appropriately fire rated, and where rated, is self-or automatic-closing by smoke detection per 7.2.1.8, and installed per NFPA 80. • Where required to latch, the door has a latch or other mechanism to ensure the door will not rebound. 18.2.2.2.10, 19.2.2.2.10	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K225	**Stairways and Smokeproof Enclosures** Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K226	**Horizontal Exits** Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K227	**Ramps and Other Exits** Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K231	**Means of Egress Capacity** The capacity of required means of egress is in accordance with 7.3. 18.2.3.1, 19.2.3.1	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K232	**Aisle, Corridor or Ramp Width** **2012 EXISTING** The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of non-ambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 **2012 NEW** The width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet, except as modified by the 18.2.3.4 or 18.2.3.5 exceptions. 18.2.3.4, 18.2.3.5	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K233	**Clear Width of Exit and Exit Access Doors** **2012 EXISTING** Exit access doors and exit doors are of the swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. 19.2.3.6, 19.2.3.7 **2012 NEW**	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	Exit access doors and exit doors are of the swinging type and are at least 41.5 inches in clear width. In psychiatric hospitals or limited care facilities, doors are at least 32 inches wide. Doors not subject to patient use, in exit stairway enclosures, or serving newborn nurseries shall be no less than 32 inches in clear width. If using a pair of doors, the doors shall be provided with a rabbet, bevel, or astragal at the meeting edge, at least one of the doors shall provide 32 inches in clear width, and the inactive leaf of the pair shall be secured with automatic flush bolts. 18.2.3.6, 18.2.3.7			
K241	**Number of Exits – Story and Compartment** Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K251	**Dead-End Corridors and Common Path of Travel** **2012 EXISTING** Dead-end corridors shall not exceed 30 feet. Existing dead-end corridors greater than 30 feet shall be permitted to be continued to be used if it is impractical and unfeasible to alter them. 19.2.5.2 **2012 NEW** Dead-end corridors shall not exceed 30 feet. Common path of travel shall not exceed 100 feet. 18.2.5.2, 18.2.5.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K252	**Number of Exits – Corridors** Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K253	**Number of Exits – Patient Sleeping and Non-Sleeping Rooms** Patient sleeping rooms of more than 1,000 square feet or nonsleeping rooms of more than 2,500 square feet have at least two exit access doors remotely located from each other. 18.2.5.5.1, 18.2.5.5.2, 19.2.5.5.1, 19.2.5.5.2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K254	**Corridor Access** All habitable rooms not within suites have a door leading directly outside to grade or have a door leading to an exit access corridor. Patient sleeping rooms with less than eight patient beds may have one room intervening to reach an exit access corridor provided the intervening room is equipped with an approved automatic smoke detection system. 18.2.5.6.1 through 18.2.5.6.4, 19.2.5.6.1 through 19.2.5.6.4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K255	**Suite Separation, Hazardous Content, and Subdivision** All suites are separated from the remainder of the building (including from other suites) by construction meeting the separation provisions for corridor construction (18.3.6.2-18.3.6.5 or 19.3.6.2-19.3.6.5). Existing approved barriers shall be allowed to continue to be used provided they limit the transfer of smoke. Intervening rooms have no hazardous areas and hazardous areas within suites comply with 18/19.2.5.7.1.3. Subdivision of suites shall be by noncombustible or limited-combustible construction. 18.2.5.7.1.2 through 18.2.5.7.1.4, 19.2.5.7.1.2, 19.2.5.7.1.3, 19.2.5.7.1.4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K256	**Sleeping Suites** Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where ≥ 2 exits are required, one exit access door may be to a stairway, passageway or to the exterior. Suites shall be provided with constant staff supervision. Staff shall have direct visual supervision of patient sleeping rooms, from a constantly attended location or the room shall be provided with an automatic smoke detection system. Suites more than 1,000 ft^2 shall have 2 or more remote exits.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	One means of egress from the suite shall be to a corridor and one may be into an adjacent suite separated in accordance with corridor requirements. Suites shall not exceed the following size limitations: • 5,000 square feet if the suite is not fully smoke detected or fully sprinklered. • 7,500 square feet if the suite is either fully smoke detected or fully sprinklered. • 10,000 square feet if the suite is both fully smoke detected and fully sprinklered and the sleeping rooms have direct supervision from a constantly attended location. Travel distance between any point in a suite to exit access shall not exceed 100 feet and distance to an exit shall not exceed 150 feet (200 feet if building is fully sprinklered). 18.2.5.7.2, 19.2.5.7.2			
K257	**Non-Sleeping Suites** Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where ≥ 2 exits are required, one exit access door may be to a stairway, passageway or to the exterior. Suites more than 2,500 ft² shall have 2 or more remote exits. One means of egress from the suite shall be to a corridor and one may be into an adjacent suite separated in accordance with corridor requirements. Suites shall not exceed 10,000 ft². Travel distance between any point in a suite to exit access shall not exceed 100 feet and distance to an exit shall not exceed 150 feet (200 feet if building is fully sprinklered). 18.2.5.7.3, 19.2.5.7.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K261	**Travel Distance to Exits** Travel distance (excluding suites) to exits are measured in accordance with 7.6. • From any point in the room or suite to exit less than or equal to 150 feet (less than or equal to 200 feet if the building is fully sprinklered).	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	• Point in a room-to-room door less than or equal to 50feet. 18.2.6, 19.2.6			
K271	**Discharge from Exits** Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes inelevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K281	**Illumination of Means of Egress** Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K291	**Emergency Lighting** Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1	HAP 482.41(a)(1) HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d) **EP 3 applies to CAH but is not linked to a CAH CoP (Above and beyond requirement)**	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1** **PE.04.01.03, EP 1** The hospital/CAH has emergency power and lighting in, at a minimum, the following areas: • Operating rooms • Recovery rooms • Intensive care • Emergency rooms • Stairwells Battery lamps and flashlights are available in all other areas not serviced by the emergency power supply source.	

K-tag	Code Requirement	CoP	TJC EP	Comments
K292	**Life Support Means of Egress** **2012 NEW** (INDICATE N/A FOR EXISTING) Buildings equipped with or requiring the use of life support systems (electro- mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the life safety branch of the electrical system described in NFPA 99. (Indicate N/A if life support equipment is for emergency purposes only.) 18.2.9.2, 18.2.10.5	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i) HAP 482.41(c) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K293	**Exit Signage** **2012 EXISTING** Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) **2012 NEW** Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i) HAP 482.41(c) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
SECTION 3 - PROTECTION				
K300	**Protection – Other** Any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K311	**Vertical Openings – Enclosure** **2012 EXISTING** Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1-hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 **2012 NEW**	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

<table>
<tr><th>K-tag</th><th>Code Requirement</th><th>CoP</th><th>TJC EP</th><th>Comments</th></tr>
<tr><td></td><td>Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 2 hours connecting four or more stories. (1- hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.6.7.
18.3.1 through 18.3.1.5</td><td></td><td></td><td></td></tr>
<tr><td>K321</td><td>Hazardous Areas – Enclosure
2012 EXISTING
Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with ¾ hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic- closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.
Describe the floor and zone locations of hazardous areas that are deficient.
19.3.2.1, 19.3.5.9
<table><tr><th>Area</th><th>Automatic Sprinkler</th><th>Separation</th><th>N/A</th></tr><tr><td>a. Boiler and Fuel-Fired Heater Rooms</td><td></td><td></td><td></td></tr><tr><td>b. Laundries (larger than 100 sq. ft.)</td><td></td><td></td><td></td></tr><tr><td>c. Repair, Maintenance, and Paint Shops</td><td></td><td></td><td></td></tr><tr><td>d. Soiled Linen Rooms (exceeding 64 gal.)</td><td></td><td></td><td></td></tr><tr><td>e. Trash Collection Rooms (exceeding 64 gal.)</td><td></td><td></td><td></td></tr><tr><td>f. Combustible Storage Rooms/Spaces (over 50 sq. ft.)</td><td></td><td></td><td></td></tr><tr><td>g. Laboratories (if classified as Severe Hazard - see K322)</td><td></td><td></td><td></td></tr></table></td><td>HAP 482.41(b)(1)(i)
CAH 485.623(c)(1)(i)</td><td>PE.03.01.01, EP 3</td><td></td></tr>
</table>

<table>
<tr><th>K-tag</th><th>Code Requirement</th><th>CoP</th><th>TJC EP</th><th>Comments</th></tr>
<tr><td></td><td>2012 NEW
Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a ¾ hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4.
Describe the floor and zone locations of hazardous areas that are deficient.
18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7
<table>
<tr><th>Area</th><th>Automatic Sprinkler</th><th>Separation</th><th>N/A</th></tr>
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<tr><td>b. Laundries (larger than 100 sq. ft.)</td><td></td><td></td><td></td></tr>
<tr><td>c. Repair, Maintenance, and Paint Shops</td><td></td><td></td><td></td></tr>
<tr><td>d. Soiled Linen Rooms (exceeding 64 gal.)</td><td></td><td></td><td></td></tr>
<tr><td>e. Trash Collection Rooms (exceeding 64 gal.)</td><td></td><td></td><td></td></tr>
<tr><td>f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq. ft.)</td><td></td><td></td><td></td></tr>
<tr><td>g. Combustible Storage Rooms/Spaces (over 100 sq. ft.)</td><td></td><td></td><td></td></tr>
<tr><td>h. Laboratories (if classified as Severe Hazard - see K322)</td><td></td><td></td><td></td></tr>
</table></td><td></td><td></td><td></td></tr>
<tr><td>K322</td><td>Laboratories
Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard are protected by 1-hour fire resistance-rated separation, automatic sprinkler system, and are in accordance with 8.7 and with NFPA 99.
Laboratories not considered a severe hazard are protected as hazardous areas (see K321).
Laboratories using chemicals are in accordance with NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals.</td><td>HAP 482.41(b)(1)(i)
CAH 485.623(c)(1)(i)

HAP 482.41(c)
CAH 485.623(d)</td><td>PE.03.01.01, EP 3

PE.04.01.01, EP 1</td><td></td></tr>
</table>

K-tag	Code Requirement	CoP	TJC EP	Comments
	Gas appliances are of appropriate design and installed in accordance with NFPA 54. Shutoff valves are marked to identify material they control. Devices requiring medical grade oxygen from the piped distribution system meet the requirements under 11.4.2.2 (NFPA 99). 18.3.2.2, 19.3.2.2, 8.7, 8.7.4.1 (LSC) 9.3.1.2, 11.4.3.2, 15.4 (NFPA 99)			
K323	**Anesthetizing Locations** Areas designated for administration of general anesthesia (i.e., inhalation anesthetics) are in accordance with 8.7 and NFPA 99. Zone valves are: located immediately outside each life-support, critical care, and anesthetizing location of moderate sedation, deep sedation, or general anesthesia for medical gas or vacuum; readily accessible in an emergency; and arranged so shutting off any one anesthetizing location will not affect others. Area alarm panels are provided to monitor all medical gas, medical- surgical vacuum, and piped WAGD systems. Panels are at locations that provide for surveillance, indicate medical gas pressure decreases of 20 percent and vacuum decreases of 12-inch gauge HgV, and provide visual and audible indication. Alarm sensors are installed either on the source side of individual room zone valve box assemblies or on the patient/use side of each of the individual zone box valve assemblies. The EES critical branch supplies power for task illumination, fixed equipment, select receptacles, and select power circuits, and EES equipment system supplies power to ventilation system. Heating, cooling, and ventilation are in accordance with ASHRAE 170. Medical supply and equipment manufacturer's instructions for use are considered before reducing humidity levels to those allowed by ASHRAE, per S&C 13-58. 18.3.2.3, 19.3.2.3 (LSC)	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i) HAP 482.41(c) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	5.1.4.8.7, 5.1.4.8.7.2, 5.1.9.3, 5.1.9.3.4, 6.4.2.2.4.2 (NFPA 99)			
K324	**Cooking Facilities** Cooking equipment is protected in accordance with NFPA 96, *Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations*, unless: • residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. • cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or • cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
	The hospital maintains fire safety equipment and fire safety building features by inspecting the following: - Any automatic fire-extinguishing system in the kitchen every 6 months Note: For automatic kitchen fire-extinguishing systems, see NFPA 96-2011: 11.2.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	TJC EP	Comments
K325	**Alcohol Based Hand Rub Dispenser (ABHR)** ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: • Corridor is at least 6 feet wide. • Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols. • Dispensers shall have a minimum of four foot horizontal spacing. • Not more than an aggregate of 10 gallons of fluid or 1135 ouncesof aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room. • Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30. • Dispensers are not installed within 1 inch of an ignition source. • Dispensers over carpeted floors are in sprinklered smoke compartments. • ABHR does not exceed 95 percent alcohol. • Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11). • ABHR is protected against inappropriate access. 18.3.2.6, 19.3.2.6,	HAP 482.41(b)(7) CAH 485.623(c)(5)	**PE.03.01.01** The hospital/CAH addresses life safety from fire. **EP 7** When the hospital/CAH installs alcohol-based hand rub dispensers, it installs the dispensers in a manner that protects against inappropriate access.	
K331	**Interior Wall and Ceiling Finish** **2012 EXISTING** Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 **2012 NEW** Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls,	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	partitions and columns have a flame spread rating of Class A. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. Individual rooms not exceeding four persons may have a Class A or B finish. Lower half of corridor walls, not exceeding 4 feet in height, may have a Class A or B flame spread rating. 10.2, 18.3.3.1, 18.3.3.2			
K332	**Interior Floor Finish** **2012 NEW (N/A for 2012 EXISTING)** Interior finishes shall comply with 10.2. Floor finishes in exit enclosures and exit access corridors and spaces not separated by walls that resist the passage of smoke shall be Class I or II. 18.3.3.3.1, 18.3.3.3.2, 18.3.3.3.3, 10.2, 10.2.7.1, 10.2.7.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K341	**Fire Alarm System – Installation** A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, *National Electric Code,* and NFPA 72, *National Fire Alarm Code* to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring, or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K342	**Fire Alarm System – Initiation** Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5			
K343	**Fire Alarm – Notification** **2012 EXISTING** Positive alarm sequence in accordance with 9.6.3.4 are permitted in buildings protected throughout by a sprinkler system. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. 19.3.4.3, 19.3.4.3.1, 19.3.4.3.2, 9.6.4, 9.7.1.1(1) **2012 NEW** Positive alarm sequence in accordance with 9.6.3.4 are permitted. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. Annunciation and annunciation zoning for fire alarm and sprinklers shall be provided by audible and visual indicators and zones shall not be larger than 22,500 square feet per zone. 18.3.4.3 through 18.3.4.3.3, 9.6.4	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K344	**Fire Alarm – Control Functions** The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 18.3.4.4, 19.3.4.4, 9.6.1, 9.6.5, NFPA 72	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K345	**Fire Alarm System – Testing and Maintenance** A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, *National Electric Code,* and NFPA 72, *National Fire Alarm and Signaling Code.* Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	
	The hospital maintains fire safety equipment and fire safety building features by testing the following every 12 months: - Duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors on the inventory - Visual and audible fire alarms (including speakers and door-releasing devices on the inventory) - Fire alarm equipment on the inventory for notifying off-site responders - Automatic smoke-detection shutdown devices for air-handling equipment Note: For additional guidance on duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors; visual and audible fire alarms; and fire alarm equipment, see NFPA 72-2010: Table 14.4.5; 17.14.	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	
K346	**Fire Alarm – Out of Service** Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K347	**Smoke Detection** **2012 EXISTING** Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 **2012 NEW**	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	Smoke detection systems are provided in spaces open to corridors as required by 18.3.6.1 In nursing homes, an automatic smoke detection system is installed in the corridors of all smoke compartments containing resident sleeping rooms, unless the resident sleeping rooms have: • smoke detection, or • automatic door closing devices with integral smoke detectors on the room side that provide occupant notification. Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.2, 18.3.4.5.3			
K351	**Sprinkler System – Installation** **2012 EXISTING** Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, *Standard for the Installation of Sprinkler Systems.* In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft^2 and sprinkler coverage covers the closet footprint as required by NFPA 13, *Standard for Installation of Sprinkler Systems.* 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) **2012 NEW** Buildings are to be protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, *Standard for the Installation of Sprinkler Systems.* In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	protection in specific areas where State and local regulations prohibit sprinklers. Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft^2 and sprinkler coverage covers the closet footprint as required by NFPA 13, *Standard for Installation of Sprinkler Systems.* 18.3.5.1, 18.3.5.4, 18.3.5.5, 18.3.5.6, 9.7, 9.7.1.1(1), 18.3.5.10			
K352	**Sprinkler System – Supervisory Signals** Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, *National Fire Alarm and Signaling Code,* and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
	The hospital maintains fire safety equipment and fire safety building features by testing the following based on the identified timeframes: - Supervisory signal devices on the inventory, quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices; semiannually for valve supervisory switches; and annually for other supervisory initiating devices Note: For supervisory signal devices, water storage tanks and associated water storage equipment do not require testing. For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5.	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	TJC EP	Comments
K353	**Sprinkler System – Maintenance and Testing** Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, *Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.* Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	
	The hospital maintains fire safety equipment and fire safety building features by testing the following every 12 months: - For automatic sprinkler systems, main drains at system low point or at all system risers - For automatic sprinkler systems, fire pumps under flow (fire pump supervisory signals for "pump running" and "pump power loss") Note: For automatic sprinkler systems, main drains, and system risers, see NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1. Note 3: For automatic sprinkler system fire pumps, see NFPA 25-2011: 8.3.3; 8.3.3.4. The hospital maintains fire safety equipment and fire safety building features by testing the following based on the identified timeframes: - Vane-type and pressure-type water flow devices every 6 months - For automatic sprinkler systems, electric motor-driven fire pumps monthly and diesel engine-driven fire pumps every week under no-flow conditions - Hydrostatic and water flow for standpipe systems every 5 years - Automatic fire extinguishing systems (carbon dioxide systems every 12 months, halon systems every 6 months, other special systems per NFPA standards and manufacturer's recommendations) - Hydrostatic tests on standpipe occupant hoses 5 years after installation and every 3 years thereafter Note 1: For vane-type and pressure-type water flow devices, mechanical water flow devices (including but not limited to	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	TJC EP	Comments
	water motor gongs) should be tested quarterly. (For full text, refer to NFPA 25-2011: Table 5.1.1.2). For additional guidance also see NFPA 72-2010: Table 14.4.5. Note 2: For hydrostatic tests on standpipe occupant hoses, see NFPA 1962-2008: Chapter 7 and NFPA 25-2011: Chapter 6 The hospital maintains fire safety equipment and fire safety building features by inspecting the following: - For automatic sprinkler systems, all fire department water supply connections every quarter Note: For automatic sprinkler systems, see NFPA 25-2011: 13.7; Table 13.1.1.2.			
K354	**Sprinkler System – Out of Service** Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)	HAP 482.41(b)(8)(i) HAP 482.41(b)(8)(ii) CAH 485.623(c)(6)(i) CAH 485.623(c)(6)(ii)	**PE.03.01.01** The hospital/CAH addresses life safety from fire. **EP 8** When a sprinkler system is shut down for more than 10 hours, the critical access hospital either evacuates the building or portion of the building affected by the system outage until the system is back in service or establishes a fire watch until the system is back in service.	
K355	**Portable Fire Extinguishers** Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, *Standard for Portable Fire Extinguishers.* 18.3.5.12, 19.3.5.12, NFPA 10	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	The hospital maintains fire safety equipment and fire safety building features by inspecting the following: - Portable fire extinguishers at least monthly (this includes recharging every 12 months) Note 3: For portable fire extinguishers, there are many ways to document the inspections, such as using bar-coding equipment, using check marks on a tag, or using an inventory. Inspections involve a visual check to determine correct type of and clear and unobstructed access to a fire extinguisher, in addition to a check for broken parts and full charge. For additional guidance on inspection of fire extinguishers, see NFPA 10-2010: 7.1.2; 7.2.2; 7.2.4; 7.3.1.	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	
K361	**Corridors – Areas Open to Corridor** Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K362	**Corridors – Construction of Walls** **2012 EXISTING** Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. 19.3.6.2, 19.3.6.2.7 **2012 NEW** Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K363	**Corridor – Doors** **2012 EXISTING** Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1¾ inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5lbf is applied, whether or not power is applied. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 **2012 NEW** Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5lbf is applied, whether or not power is applied. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i) Score corridor door issues not addressed by highlighted text using these CoPs at PE.04.01.01 EP 5. Score issues related to yellow highlighted text at PE.04.01.01 EP 10 using the below CoPs: HAP 482.41(b)(1)(ii) CAH 485.623(c)(1)(ii)	**PE.03.01.01, EP 3** **PE.03.01.01, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes: Regardless of the provisions of the Life Safety Code, corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited on these doors.	

K-tag	Code Requirement	CoP	TJC EP	Comments
	closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485			
K364	**Corridor – Openings** Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 in^2 and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 in^2. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K371	**Subdivision of Building Spaces – Smoke Compartments** **2012 EXISTING** Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 **2012 NEW** Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	compartment to a door in the smoke barrier. Smoke subdivision requirements do not apply to any of the stories or areas described in 18.3.7.2. 18.3.7.1, 18.3.7.2			
K372	**Subdivision of Building Spaces – Smoke Barrier Construction** **2012 EXISTING** Smoke barriers shall be constructed to a ½ hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) **2012 NEW** Smoke barriers shall be constructed to provide at least a 1-hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
	The hospital maintains fire safety equipment and fire safety building features by testing the following based on the identified timeframes: - Fire and smoke dampers 1 year after installation and at least every 6 years thereafter to verify they fully close Note: For operation of fire and smoke dampers, see NFPA 90A-2012: 5.4.8; NFPA 80-2010: 19.4; NFPA 105-2010: 6.5.	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	
K373	**Subdivision of Building Spaces – Accumulation Space** Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.5.1, 18.3.7.5.2, 19.3.7.5.1, 19.3.7.5.2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K374	**Subdivision of Building Spaces – Smoke Barrier Doors** **2012 EXISTING** Doors in smoke barriers are 1¾-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 in for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 **2012 NEW** Doors in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded core wood. Required clear widths are provided per 18.3.7.6(4) and (5). Nonrated protective plates of unlimited height are permitted. Horizontal- sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels, or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.6, 18.3.7.7, 18.3.7.8	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K379	**Smoke Barrier Door Glazing** **2012 EXISTING** Openings in smoke barrier doors shall be fire-rated glazing or wired glass panels in steel frames. 19.3.7.6, 19.3.7.6.2, 8.5 **2012 NEW** Windows in smoke barrier doors shall be installed in each cross corridor swinging or horizontal-sliding door protected by fire-rated glazing or by wired glass panels in approved frames. 18.3.7.9	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K381	**Sleeping Room Outside Windows and Doors** Every patient sleeping room has an outside window or outside door. In new occupancies, sill height does not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows. Newborn nurseries and rooms intended for occupancy less than 24 hours have no outside window or door requirements. Window sills in special nursing care areas (e.g., ICU, CCU, hemodialysis, neonatal) do not exceed 60 inches above the floor. 42 CFR 403, 418, 460, 482, 483, and 485 (in CoPs)	HAP 482.41(b)(9) HAP 482.41(b)(9)(i) HAP 482.41(b)(9)(ii) CAH 485.623(c)(7) CAH 485.623(c)(7)(i) CAH 485.623(c)(7)(ii)	**PE.03.01.01 The hospital addresses life safety from fire.** **EP 9** Buildings have an outside window or outside door in every sleeping room, and for any building constructed after July 5, 2016, the sill height does not exceed 36 inches above the floor. Note 1: Windows in atrium walls are considered outside windows for the purposes of this requirement. Note 2: The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours. Note 3: The sill height in special nursing care areas of new occupancies does not exceed 60 inches.	
SECTION 4 – SPECIAL PROVISIONS				

K-tag	Code Requirement	CoP	TJC EP	Comments
K400	**Special Provisions – Other** Any LSC Section 18.4 and 19.4 Special Provisions requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K421	**High-Rise Buildings** **2012 EXISTING** High-rise buildings are protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7 within 12 years of LSC final rule effective date. 19.4.2 **2012 NEW** High-rise buildings comply with section 11.8. 18.4.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
SECTION 5 – BUILDING SERVICES				
K500	**Building Services – Other** Any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K511	**Utilities – Gas and Electric** Equipment using gas or related gas piping complies with NFPA 54, *National Fuel Gas Code*, electrical wiring and equipment complies with NFPA 70, *National Electric Code*. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K521	**HVAC** Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K522	**HVAC – Any Heating Device** Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: • is chimney or vent connected. • takes air for combustion from outside. • provides for a combustion system separate from occupied area atmosphere. 18.5.2.2, 19.5.2.2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K523	**HVAC – Suspended Unit Heaters** Suspended unit heaters are permitted provided the following are met: • Not located in means of egress or in patient rooms. • Located high enough to be out of reach of people in the area. • Has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. 18.5.2.3(1), 19.5.2.3(1)	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K524	**HVAC – Direct-Vent Gas Fireplaces** Direct-vent gas fireplaces, as defined in NFPA 54, inside of all smoke compartments containing patient sleeping areas comply with the requirements of 18.5.2.3(2), 19.5.2.3(2). 18.5.2.3(2), 19.5.2.3(2), NFPA 54	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K525	**HVAC – Solid Fuel-Burning Fireplaces** Solid fuel-burning fireplaces are permitted in other than patient sleeping areas provided: • Areas are separated by 1-hour fire resistance construction. • Fireplace complies with 9.2.2.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	• Fireplace enclosure resists breakage up to 650°F and has heat- tempered glass. Room has supervised CO detection per 9.8. 18.5.2.3(3) and 19.5.2.3(3)			
K531	**Elevators** **2012 EXISTING** Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, *Safety Code for Elevators and Escalators.* Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 **2012 NEW** Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, *Safety Code for Elevators and Escalators.* Firefighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, *Safety Code for Elevators and Escalators,* including Firefighter's Service Requirements. (Includes firefighter's Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 18.5.3, 9.4.2, 9.4.3	HAP 482.41(b)(1)(i) HAP 482.41(d)(2) CAH 485.623(c)(1)(i) CAH 485.623(b)(1)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 2**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K532	**Escalators, Dumbwaiters, and Moving Walks** **2012 EXISTING** Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* (Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters, includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.) 19.5.3, 9.4.2.2 **2012 NEW** Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. 18.5.3, 9.4.2.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K541	**Rubbish Chutes, Incinerators, and Laundry Chutes** **2012 EXISTING** (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 **2012 NEW** Rubbish chutes, incinerators, and laundry chutes shall comply with the provisions of Section 9.5, unless otherwise specified in 18.5.4.2. • The fire resistance rating of chute charging room shall not be required to exceed 1-hour. • Any rubbish chute or linen chute shall be provided with automatic extinguishing protection in accordance with Section 9.7. • Chutes shall discharge into a trash collection room used for no other purpose and shall be protected in accordance with 8.7. 18.5.4.2, 8.7, 9.5, 9.7, NFPA 82			
SECTION 7 – OPERATING FEATURES				
K700	**Operating Features – Other** Any LSC Section 18.7 and 19.7 Operating Features requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K711	**Evacuation and Relocation Plan** There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.7.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K712	**Fire Drills** Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 ***Varying conditions means: Fire drills vary by at least one hour for each shift from quarter to quarter through four consecutive quarters	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K741	**Smoking Regulations** Smoking regulations shall be adopted and shall include not less than the following provisions: (7) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (8) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (9) Smoking by patients classified as not responsible shall be prohibited. (10) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (11) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (12) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K751	**Draperies, Curtains, and Loosely Hanging Fabrics** Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K752	**Upholstered Furniture and Mattresses** Newly introduced upholstered furniture meets Class I or char length, and heat release criteria in accordance with 10.3.2.1 and 10.3.3, unless the building is fully sprinklered. Newly introduced mattresses shall meet char length and heat release criteria in accordance with 10.3.2.2 and 10.3.4, unless the building is fully sprinklered. Upholstered furniture and mattresses belonging to nursing home residents do not have to meet these requirements as all nursing homes are required to be fully sprinklered. Newly introduced upholstered furniture and mattresses means purchased on or after the LSC final rule effective date. 18.7.5.2, 18.7.5.4, 19.7.5.2, 19.7.5.4	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K753	**Combustible Decorations** Combustible decorations shall be prohibited unless one of the following is met: • Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. • Decorations meet NFPA 701. • Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. • Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). • The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 18.7.5.6, 19.7.5.6			
K761	**Maintenance, Inspection & Testing - Doors** Fire doors assemblies are inspected and tested annually in accordance with NFPA 80 *Standard for Fire Doors and Other Opening Protectives*. Fire doors that are not located in required fire barriers, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspection and testing have an understanding of the operating components of the doors. Written records of inspection and testing are maintained and are available for review. 18.7.6, 19.7.6, 8.3.3.1 (LSC), 5.2, 5.2.3 (NFPA 80)	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01, EP 2**	
	The hospital maintains fire safety equipment and fire safety building features by testing the following every 12 months: - Sliding and rolling fire doors, smoke barrier sliding or rolling doors, and sliding and rolling fire doors in corridor walls and partitions for proper operation and full closure - Fire door assemblies (inspection and testing) Note 5: For fire doors and smoke barrier doors, see NFPA 80-2010: 5.2.14.3; NFPA 105-2010: 5.2.1; 5.2.2. Note 6: For fire door assemblies, nonrated doors, including corridor doors to patient care rooms and smoke barrier doors, are not subject to the annual inspection and testing requirements of either NFPA 80 or NFPA 105. For hospitals that use Joint Commission accreditation for deemed status purposes: Nonrated doors should be routinely inspected and maintained in accordance with the facility maintenance program. For additional guidance on testing of door assemblies, see NFPA 101-2012: 7.2.1.5.10.1; 7.2.1.5.11; 7.2.1.15; NFPA 80-2010: 4.8.4; 5.2.1; 5.2.3; 5.2.4; 5.2.6;	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	TJC EP	Comments
	5.2.7; 6.3.1.7; NFPA 105-2010: 5.2.1. The hospital maintains fire safety equipment and fire safety building features by inspecting the following: - Fire door assemblies annually by a qualified individual (testing begins with a pre-test visual inspection and includes both sides of the opening)			
K754	**Soiled Linen and Trash Containers** Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is ≤ 96 gal. unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K771	**Engineer Smoke Control Systems** **2012 EXISTING** When installed, engineered smoke control systems are tested in accordance with established engineering principles. Test documentation is maintained on the premises. 19.7.7 **2012 NEW** When installed, engineered smoke control systems are tested in accordance with NFPA 92, *Standard for Smoke Control Systems*. Test documentation is maintained on the premises. 18.7.7	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K781	**Portable Space Heaters** Portable space heating devices shall be prohibited in all health care occupancies. Unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K791	**Construction, Repair, and Improvement Operations** Construction, repair, and improvement operations shall comply with 4.6.10. Any means of egress in any area undergoing construction, repair, or improvements shall be inspected daily to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241. 18.7.9, 19.7.9, 4.6.10, 7.1.10.1	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
	The hospital does not remove or minimize an existing life safety feature when such feature is a requirement for new construction. Existing life safety features, if not required by the Life Safety Code, can be either maintained or removed. (For full text, refer to NFPA 101-2012: 4.6.12.2; 4.6.12.3; 18/19.7.9)	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
PART II – HEALTH CARE FACILITIES CODE REQUIREMENTS				
K900	**Health Care Facilities Code - Other** Any NFPA 99 requirements (excluding Chapter 7, 8, 12, and 13) that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Health Care Facilities Code or NFPA standard citation, should be included in the finding.	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K901	**Fundamentals – Building System Categories** Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K902	**Gas and Vacuum Piped Systems – Other** Any NFPA 99 Chapter 5 Gas and Vacuum Systems requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding. Chapter 5 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K903	**Gas and Vacuum Piped Systems – Categories** Medical gas, medical air, surgical vacuum, WAGD, and air supply systems are designated: ☐ Category 1. Systems in which failure is likely to cause major injury or death. ☐ Category 2. Systems in which failure is likely to cause minor injury. ☐ Category 3. Systems in which failure is not likely to cause injury but can cause discomfort. Deep sedation and general anesthesia are not to be administered using a Category 3 medical gas system. 5.1.1.1, 5.2.1, 5.3.1.1, 5.3.1.5 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K904	**Gas and Vacuum Piped Systems – Warning Systems** All master, area, and local alarm systems used for medical gas and vacuum systems comply with appropriate Category warning system requirements, as applicable. 5.1.9, 5.2.9, 5.3.6.2.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K905	**Gas and Vacuum Piped Systems – Central Supply System Identification and Labeling** Containers, cylinders and tanks are designed, fabricated, tested, and marked in accordance with 5.1.3.1.1 through 5.1.3.1.7. Locations containing only oxygen or medical air have doors labeled with "Medical Gases, NO Smoking or Open Flame". Locations containing other gases have doors labeled "Positive Pressure Gases, NO Smoking or Open Flame, Room May Have Insufficient Oxygen, Open Door and Allow Room to Ventilate Before Opening." 5.1.3.1, 5.2.3.1, 5.3.10 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K906	**Gas and Vacuum Piped Systems – Central Supply System Operations** Adaptors or conversion fittings are prohibited. Cylinders are handled in accordance with 11.6.2. Only cylinders, reusable shipping containers, and their accessories are stored in rooms containing central supply systems or cylinders. No flammable materials are stored with cylinders. Cryogenic liquid storage units intended to supply the facility are not used to transfill. Cylinders are kept away from sources of heat. Valve protection caps are secured in place, if supplied, unless cylinder is in use. Cylinders are not stored in tightly closed spaces. Cylinders in use and storage are prevented from exceeding 130°F, and nitrous oxide and carbon dioxide cylinders are prevented from reaching temperatures lower than manufacture recommendations or 20°F. Full or empty cylinders, when not connected, are stored in locations complying with 5.1.3.3.2 through 5.1.3.3.3, and are not stored in enclosures containing motor-driven machinery, unless for instrument air reserve headers. 5.1.3.2, 5.1.3.3.17, 5.1.3.3.1.8, 5.1.3.3.4, 5.2.3.2, 5.2.3.3, 5.3.6.20.4, 5.6.20.5, 5.3.6.20.7, 5.3.6.20.8, 5.3.6.20.9 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K907	**Gas and Vacuum Piped Systems – Maintenance Program** Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99)	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses building safety and facility management. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	TJC EP	Comments
K908	**Gas and Vacuum Piped Systems – Inspection and Testing Operations** The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99)	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01, EP 2**	
K909	**Gas and Vacuum Piped Systems – Information and Warning Signs** Piping is labeled by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (Table 5.1.11), and operating pressure if other than standard. Labels are at intervals not more than 20 feet, are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency. 5.1.14.3, 5.1.11.1, 5.1.11.2, 5.2.11, 5.3.13.3, 5.3.11 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K910	**Gas and Vacuum Piped Systems – Modifications** Whenever modifications are made that breach the pipeline, any necessary installer and verification test specified in 5.1.2 is conducted on the downstream portion of the medical gas piping system. Permanent records of all tests required by system verification tests are maintained. 5.1.14.4.1, 5.1.14.4.6, 5.2.13, 5.3.13.4.3 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K911	**Electrical Systems – Other** Any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K912	**Electrical Systems – Receptacles** Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, playrooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K913	**Electrical Systems – Wet Procedure Locations** Operating rooms are considered wet procedure locations, unless otherwise determined by a risk assessment conducted by the facility governing body. Operating rooms defined as wet locations are protected by either isolated power or ground-fault circuit interrupters. A written record of the risk assessment is maintained and available for inspection. 6.3.2.2.8.4, 6.3.2.2.8.7, 6.4.4.2	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K914	**Electrical Systems – Maintenance and Testing** Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of ≤ 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals ≤ 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01, EP 2**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K915	**Electrical Systems – Essential Electric System Categories** ☐ Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. ☐ General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. ☐ Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1 1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K916	**Electrical Systems – Essential Electric System Alarm Annunciator** A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K917	**Electrical Systems – Essential Electric System Receptacles** Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K918	**Electrical Systems – Essential Electric System Maintenance and Testing** The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20–40-day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01, EP 2**	
K919	**Electrical Equipment – Other** Any NFPA 99 Chapter 10, *Electrical Equipment*, requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.04.01.01, EP 1** **PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K920	**Electrical Equipment – Power Cords and Extension Cords** Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non- PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K921	**Electrical Equipment – Testing and Maintenance Requirements** The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient care-related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01, EP 2**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuing training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8			
K922	**Gas Equipment – Other** Any NFPA 99 Chapter 11 Gas Equipment requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding. Chapter 11 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K923	**Gas Equipment – Cylinder and Container Storage** **≥ 3,000 cubic feet** Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. **> 300 but <3,000 cubic feet** Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. **≤ 300 cubic feet** In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of ≤ 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING". Storage is planned so cylinders are used in order of which	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
K924	**Gas Equipment – Testing and Maintenance Requirements** Anesthesia apparatus are tested at the final path to patient after any adjustment, modification or repair. Before the apparatus is returned to service, each connection is checked to verify proper gas and an oxygen analyzer is used to verify oxygen concentration. Defective equipment is immediately removed from service. Areas designated for servicing of oxygen equipment are clean and free of oil, grease, or other flammables. Manufacturer service manuals are used to maintain equipment and a scheduled maintenance program is followed. 11.4.1.3, 11.5.1.3, 11.6.2.5, 11.6.2.6 (NFPA 99)	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01, EP 2**	
K925	**Gas Equipment – Respiratory Therapy Sources of Ignition** Smoking materials are removed from patients receiving respiratory therapy. When a nasal cannula is delivering oxygen outside of a patient's room, no sources of ignition are within in the site of intentional expulsion (1-foot). When other oxygen deliver equipment is used or oxygen is delivered inside a patient's room, no sources of ignition are within the area are of administration (15-feet). Solid fuel-burning appliances is not in the area of administration. Nonmedical appliances with hot surfaces or sparking mechanisms are not within oxygen-delivery equipment or site of intentional expulsion. 11.5.1.1, TIA 12-6 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K926	**Gas Equipment – Qualifications and Training of Personnel** Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements.	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99)			
K927	**Gas Equipment – Transfilling Cylinders** Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, *Transfilling of High-Pressure Gaseous Oxygen Used for Respiration*. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K928	**Gas Equipment – Labeling Equipment and Cylinders** Equipment listed for use in oxygen-enriched atmospheres are so labeled. Oxygen metering equipment and pressure reducing regulators are labeled "OXYGEN-USE NO OIL". Flowmeters, pressure reducing regulators, and oxygen-dispensing apparatus are clearly and permanently labeled designating the gases for which they are intended. Oxygen-metering equipment, pressure reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier. Cylinders and containers are labeled in accordance with CGA C-7. Color coding is not utilized as the primary method of determining cylinder or container contents. All labeling is durable and withstands cleaning or disinfecting. 11.5.3.1 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K929	**Gas Equipment – Precautions for Handling Oxygen Cylinders and Manifolds** Handling of oxygen cylinders and manifolds is based on CGA G-4, Oxygen. Oxygen cylinders, containers, and associated equipment are protected from contact with oil and grease, from contamination, protected from damage, and handled with care in accordance with precautions provided under 11.6.2.1 through 11.6.2.4 (NFPA 99).	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	11.6.2 (NFPA 99)			
K930	**Gas Equipment – Liquid Oxygen Equipment** The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K931	**Hyperbaric Facilities** All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99. Chapter 14 (NFPA 99)	HAP 482.41(d)(2) HAP 482.41(c) CAH 485.623(b)(1) CAH 485.623(d)	**PE.04.01.01, EP 1** **PE.04.01.01, EP 2**	
K932	**Features of Fire Protection – Other** Any NFPA 99 Chapter 15 Features of Fire Protection requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding. Chapter 15 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K933	**Features of Fire Protection – Fire Loss Prevention in Operating Rooms** Periodic evaluations are made of hazards that could be encountered during surgical procedures, and fire prevention procedures are established. When flammable germicides or antiseptics are employed during surgeries utilizing electrosurgery, cautery or lasers: • packaging is non-flammable. • applicators are in unit doses. • Preoperative "time-out" is conducted prior the initiation of any surgical procedure to verify: ○ application site is dry prior to draping and use of surgical equipment.	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	○ pooling of solution has not occurred or has been corrected. ○ solution-soaked materials have been removed from the OR prior to draping and use of surgical devices. ○ policies and procedures are established outlining safety precautions related to the use of flammable germicide or antiseptic use. Procedures are established for operating room emergencies including alarm activation, evacuation, equipment shutdown, and control operations. Emergency procedures include the control of chemical spills, and extinguishment of drapery, clothing and equipment fires. Training is provided to new OR personnel (including surgeons), continuing educationis provided, incidents are reviewed monthly, and procedures are reviewed annually. 15.13 (NFPA 99) ***The preoperative time-out is addressed by the clinical surveyor.			
	The hospital labels utility system controls to facilitate partial or complete emergency shutdowns. Note 1: Examples of utility system controls that should be labeled are utility source valves, utility system main switches and valves, and individual circuits in an electrical distribution panel. Note 2: For example, the fire alarm system's circuit is clearly labeled as Fire Alarm Circuit; the disconnect method (that is, the circuit breaker) is marked in red; and access is restricted to authorized personnel. Information regarding the dedicated branch circuit for the fire alarm panel is located in the control unit. For additional guidance, see NFPA 101-2012: 18/19.3.4.1; 9.6.1.3; NFPA 72-2010: 10.5.5.2.	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

Kitchen Tracer Survey Guide – Hospital and Critical Access Hospital

The first seven sections of this tool should be completed by a clinical surveyor.

Provision of Dietary Services					
YES	NO		YES	NO	
		Do the organization's policies and procedures address the following:			Verify the following: Organized dietary service directed and staffed by qualified personnel NPG.12.01.01, EP 7 (HAP 482.28) (CAH N/A) Organized dietary service appropriate to the scope and complexity of services offered, and in accordance with accepted standards of practice. LD.13.03.01, EP 1 (HAP 482.28) (CAH N/A) Does the hospital have a full-time employee, qualified through education, training, or experience, who serves as director to oversee the daily management of food and dietetic services? NPG.12.01.01, EP 8 (HAP and CAH DPU 482.28(a)(1)(i), §482.28(a)(1)(ii), §482.28(a)(1)(iii)) (CAH N/A) Administrative and technical personnel must be competent in their assigned duties. This competency is demonstrated through education, experience and specialized training appropriate to the task(s) assigned. (HAP HR.11.01.01, EP 1, 482.28(a)(3)) (CAH HR.11.01.01 EP 1 (No CoP)) Food safety certification/license; if required, do the appropriate staff members have this? (HAP HR.11.01.01 EP 7, 482.28)(a)(3)) (CAH HR.11.01.03 EP 1, 485.608(d))
☐	☐	Meal frequency? PC.12.01.09 EP 1 (HAP 482.28(b)(1)) (CAH 485.635(a)(3)(vi))	☐	☐	
☐	☐	Diet ordering PC.12.01.01 EP 1 (HAP 482.28(b)(2)) (CAH 485.635(a)(3)(vi)) Patient tray delivery system? PC.12.01.09 EP 1 (HAP 482.28)(b)(1)) (CAH 485.635(a)(3)(vi))	☐	☐	Diet Manual; approved by medical staff and dietitian (HAP and CAH DPU PC.12.01.09 EP 2, 482.28(b)(3)) (CAH N/A)
☐	☐	Non-routine occurrences? *e.g., parenteral nutrition, change in diet orders, early/late trays*	☐	☐	Do menu options meet patient needs? PC.12.01.09 EP 1 (HAP 482.28)(b)(1)

		PC.12.01.09 EP 1 (HAP 482.28)(b)(1)) (CAH 485.635(a)(3)(vi))			(CAH 485.635(a)(3)(vi))
☐	☐		☐	☐	**Does the organization have a full-time qualified dietitian or other qualified professional?** *If a dietitian or other qualified professional is not full-time, interview staff to determine adequacy of the dietary director's qualifications.* (HAP and CAH DPU NPG.12.01.01, EP 9 482.28(a)(2)) (CAH N/A)
☐	☐	Hygiene Practices for food service personnel? IC.04.01.01 EP 3 (HAP 482.42)(a)(2)) (CAH 485.640(a)(2))			
☐	☐	Kitchen sanitation? Applies to sanitation surfaces IC.04.01.01 EP 3 (HAP 482.42(a)(2)) (CAH 485.640(a)(2)	☐	☐	QAPI integration of food/dietetic service? LD.11.01.01 EP 8 (HAP 482.21) (CAH 485.641(b)(3))
☐	☐	Safe food handling? (HAP NPG.12.01.01, EP 8, 482.28(a)(1)(ii) (CAH NPG.11.04.01, EP 1)			
☐	☐	Emergency food supplies? EM.12.01.01 EP 4 (HAP 482.15((b)(1)(i)) (CAH 485.625(b)(1)(i)			
☐	☐		**Advanced: You can ask for recent health department inspection to provide baseline for whether issues are ongoing or isolated.**		

PHYSICAL ENVIRONMENT					
YES	NO		YES	NO	
☐	☐	Are areas kept clean? PE.01.01.01 EP 3 (HAP 482.41(a)) (CAH 485.623(b)(4)	☐	☐	Is the area free of any signs of pests? If there are pests, has the organization taken steps to address the issue? PE.01.01.01 EP 3 (HAP 482.41(a)) (CAH 485.623(b)(4))
☐	☐	Kitchen equipment; is it in safe operating condition? If there is an issue, does the staff have a plan to address it? *Manufacturer's recommended periodic maintenance schedule or an acceptable Alternate Equipment Management (AEM) program should be followed.* PE.04.01.01 EP 2 (HAP 482.41(d)(2)) (CAH 485.623(b)(1)	☐	☐	Are Cookware/dishware/Dishes/ Utensils stored in a clean, dry location? *There is no requirement for a solid bottom shelf for storage of food or cooking equipment. Use of solid bottom shelving is* ***an example*** *of a strategy that would be used.* Clean items are managed as per local/state food code, e.g., protected from contamination, such as splash, dust or other contaminants. The HCO determines how items will be protected in accordance with food code. IC.06.01.01 EP 3 (HAP 482.42(a)(3)) (CAH 485.640(a)(3))
☐	☐	Is garbage/refuse properly disposed of? PE.02.01.01 EP 6 (HAP 482.41(b)(4)) (CAH 485.623(b)(2))	☐	☐	Are wet wiping cloths stored in an approved sanitizing solution & washed daily? IC.06.01.01 EP 3 (HAP 482.42(a)(3)) (CAH 485.640(a)(3))
☐	☐	Are sinks clear from items that can be contaminated from splashes? *e.g., paper-wrapped straws* IC.06.01.01 EP 3 (HAP 482.42(a)(3)) (CAH 485.640(a)(3))	☐	☐	Are food carts cleaned & sanitized *after every meal.* IC.06.01.01 EP 3 (HAP 482.42(a)(3)) (CAH 485.640(a)(3))
			Advanced: You can ask a question regarding pest control services that have been accomplished.		

REFRIGERATOR					
YES	NO		YES	NO	
☐	☐	Refrigerator temps: have they been monitored? (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)	☐	☐	Is uncooked food (chicken or other meat) stored away from cooked food to prevent contamination? *e.g., not stored over cooked food* (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)
☐	☐	Is frequency of temp checks & limits (41° or lower) maintained as per policy? (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)	☐	☐	Is prepared food covered & labeled with expiration date? (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)
☐	☐	Is there a process if the temp is inadequate? *If possible,*	☐	☐	Are open containers labeled with expiration date? (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)

		(HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)			
☐	☐	Is food stored away from soiled areas & rust? (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)	☐	☐	Are there any expired items (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)
			☐	☐	Is the locking mechanism on the door in proper working condition? PE.04.01.01 EP 2 (HAP 482.41(d)(2)) (CAH 485.623(b)(1)
☐	☐	Is food stored to allow for ventilation? (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)	☐	☐	Is staff aware of how to use safety process/mechanisms in an emergency? (HAP HR.11.01.01, EP 1, 482.28(a)(3)) (CAH HR.11.01.01 EP 1)

DRY STORAGE					
YES	NO		YES	NO	
☐	☐	Are there any expired items? ,HAP PC.12.01.09 EP 1, 482.28(b)(1)) (CAH NPG.11.04.01 EP 1)	☐	☐	Is the area clean, dry, & well ventilated? *This will help with humidity & prevent growth of mold/bacteria.* PE.04.01.01 EP 3 (HAP 482.41(d)(4)) (CAH 485.623(b)(5))
☐	☐	Are canned goods properly sealed? (HAP PC.12.01.09 EP 1, 482.28)(b)(1)) (CAH NPG.11.04.01 EP 1)	☐	☐	Is food stored away from sources of heat/light? *This helps preserve shelf life.* (HAP NPG.12.01.01, EP 8; 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1))
☐	☐	Does the kitchen have food storage items/plans for disaster preparedness? *A 96-hour stockpile isn't required for emergency operations. The kitchen should have a role in response to an event, & it should correspond with the organization's Emergency Operations Plan.* EM.12.02.09 EP 3	☐	☐	Are food containers stored off the floor & away from walls to allow for adequate circulation? e.g., 6" above floor, protected from splashes. *There is no requirement for a solid bottom shelf for storage of food or cooking equipment. The HCO determines how such containers will be protected from splash, etc. **Use of solid bottom shelving is an example of a strategy that would be used.*** (HAP NPG.12.01.01, EP 8, 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)

DRY STORAGE					
YES	NO		YES	NO	
☐	☐	Are there any expired items? ,HAP PC.12.01.09 EP 1, 482.28(b)(1)) (CAH NPG.11.04.01 EP 1)	☐	☐	Is the area clean, dry, & well ventilated? *This will help with humidity & prevent growth of mold/bacteria.* PE.04.01.01 EP 3 (HAP 482.41(d)(4)) (CAH 485.623(b)(5))

☐	☐	Are canned goods properly sealed? (HAP PC.12.01.09 EP 1, 482.28)(b)(1)) (CAH NPG.11.04.01 EP 1)	☐	☐	Is food stored away from sources of heat/light? *This helps preserve shelf life.* (HAP NPG.12.01.01, EP 8; 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1))
☐	☐	Does the kitchen have food storage items/plans for disaster preparedness? *A 96-hour stockpile isn't required for emergency operations. The kitchen should have a role in response to an event, & it should correspond with the organization's Emergency Operations Plan.* EM.12.02.09 EP 3	☐	☐	Are food containers stored off the floor & away from walls to allow for adequate circulation? e.g., 6" above floor, protected from splashes. *There is no requirement for a solid bottom shelf for storage of food or cooking equipment. The HCO determines how such containers will be protected from splash, etc.* ***Use of solid bottom shelving is an example of a strategy that would be used.*** (HAP NPG.12.01.01, EP 8, 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)

FOOD PREP ASSESSMENT - Observation					
YES	NO		YES	NO	
☐	☐	Hand hygiene during food prep; is staff using proper practices to prevent contamination of food and food surfaces, *e.g., washing after touching face or hair* IC.06.01.01 EP 3 (HAP 482.42(a)(3)) (CAH 485.640(a)(3)	☐	☐	Monitor food temp checks for hot, cold and pre-cooked items undergoing the cooling process. *Food should be cooled to 70° within 2 hours & to 41° within 4 & total cooling time should not exceed 6 hours.* (HAP NPG.12.01.01, EP 8; 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)
☐	☐	Is hand washing facilities separate from the ones used for food prep? PE.01.01.01 EP 1 (HAP 482.41(a)) (CAH 485.623(a))	☐	☐	Review temp logs – did staff maintain logs for each service during food prep? Is the process for monitoring temps in alignment with food code? *Temps are usually logged at start, midpoint & end if meal service is extended. Ensure adequate process for Potentially Hazardous Foods (PHF) and Time/Temp Controlled for Safety (TCS) Foods* (HAP NPG.12.01.01, EP 8; 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)
☐	☐	Gloves: do staff use when appropriate to prevent contamination? *e.g., handling raw meat or ready-to-eat foods*? (HAP NPG.12.01.01, EP 8; 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)			
☐	☐	Hair nets; are all staff members wearing? (HAP NPG.12.01.01, EP 8; 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)	Final cooking temps should be as follows: (HAP NPG.12.01.01, EP 8; 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)		
☐	☐	Cutting boards/prep surfaces; are they cleaned and sanitized properly to avoid contamination? E.g., one for	☐ ☐	☐ ☐	Poultry - 165° Ground meat, ground fish, eggs - 155°

		meat, one for veggies & sanitized between uses IC.06.01.01 EP 3 (HAP 482.42(a)(3)) (CAH 485.640(a)(3)) Does the staff use clean utensils with bulk foods/ice? (HAP NPG.12.01.01, EP 8; 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	Fish & other meat - 145° Precooked, cooled, then reheated - 165° Hot food hold temp - 135° or higher Cold food hold temp - 41° or below
☐	☐	Evaluate dishwasher temps/chemical monitoring processes PE.04.01.05 EP 3 (HAP 482.41(d)(2)) (CAH 485.623(b)(1))			

FREEZER For food storage
(HAP NPG.12.01.01, EP 8, 482.28(a)(1)(ii))
(CAH NPG.11.04.01 EP 1)

YES	NO		YES	NO	
☐	☐	Freezer temps: have they been monitored?	☐	☐	Is the freezer free of any ice buildup? PE.04.01.05 EP 2 (HAP 482.41(d)(2)) (CAH 485.623(b)(1))
☐	☐	Is frequency of checks & temp limits maintained as per policy? *Temps should ensure that food remains solid.*	☐	☐	Are items labeled appropriately with expiration dates? *There should be no expired items*
☐	☐	Is there a process if the temp is inadequate? *If possible, validate the process was followed.*	☐	☐	If there is pre-cooked food, is the cooling process sufficient? *See refrigerator note* above
☐	☐	Is food stored away from soiled areas & rust?	☐	☐	Is the locking mechanism on the door in proper working condition? PE.04.01.01, EP 2 (HAP 482.41(d)(2)) (CAH 485.623(b)(1))
☐	☐	Is food stored to allow for ventilation?	☐	☐	Is there a process/mechanism in place to prevent staff from being locked in? Can the mechanism be accessed, and is it in working order? *It shouldn't be blocked or have any ice buildup.*
☐	☐	Is the freezer free from any signs of freezer burn/food discoloration?			
☐	☐	Are raw foods stored properly? *There should be no signs of them dripping on other foods.*	☐	☐	Is staff aware of how to use safety process/mechanism in emergency? HR.11.01.01 EP 1

To be Completed by Life Safety Code Surveyor

LIFE SAFETY

YES	NO		YES	NO	
☐	☐	Is the kitchen in good repair? e.g., lack of broken floor tiles, delamination, flaking walls, etc. PE.01.01.01 EP 1 (HAP 482.41(a)) (CAH 485.623(a))	☐	☐	Are the gaskets intact for kitchen entry/delivery doors to prevent entry from pests? PE.01.01.01 EP 1 (HAP 482.41(a)) (CAH 485.623(a))

☐	☐	Do sprinkler heads have adequate 18" clearance? *Ensure racks perpendicular to walls do not encroach 18" open space for sprinklers. NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.1.1; NFPA 13-2010: 8.5.5.2; 8.5.5.2.1; 8.5.5.3* PE.03.01.01 EP 3 (HAP 482.41(b)(2)) (CAH 485.623(c)(1)(i))	☐	☐	Eyewash/shower station; if required, is it in good working order & located away from hazards? PE.02.01.01 EP 4
			☐	☐	Can staff access eyewash station within 10 seconds of hazardous material storage/usage area? PE.02.01.01 EP 4
Evaluate sprinkler head obstructions in BOTH refrigerators & freezers. Be wary of surface mounted fluorescent light fixtures close to sprinkler heads as this does not follow the 18" rule. *Refer to attachment for specific criteria.*			☐	☐	Has the eyewash inspection log been kept up to date? PE.02.01.01 EP 4
			☐	☐	Natural gas: does the organization use this?
☐	☐	Soda fountain machine: is the CO2 secured? PE.04.01.01 EP 1 (HAP 482.41(c)) (CAH 485.623(d))	☐	☐	Is a gas valve accessible for emergency shutoff & do staff know its location/operation? PE.02.01.01 EP 4
☐	☐	Are floor drains clear and not backed up? PE.01.01.01 EP 1 (HAP 482.41(a)) (CAH 485.623(a))	☐	☐	Is emergency shutoff valve properly labeled? PE.02.01.02, EP 4
			☐	☐	Tethering – Kitchen gas appliances with casters in new occupancies are required to have restraints or tethering. Existing occupancies with restraints/tethers need to be maintained. NFPA 54-2012, 9.6.1.2 PE.04.01.01 EP 1 (HAP 482.41(c)) (CAH 485.623(d))
☐	☐	Deep fat fryer; is there a K fire extinguisher within 30'? *NFPA 96–2011 10.10.1; NFPA 10–2010, 6.6.1; 6.6.* PE.04.01.01 EP 1 (HAP 482.41(c)) (CAH 485.623(d))	*Evaluate the hood system*		
			☐	☐	Is the hood clean with no grease buildup? *NFPA 96-2011 11.6.2* PE.04.01.01 EP 1 (HAP 482.41(c)) (CAH 485.623(d))
☐	☐	Deep fat fryer: is it installed with at least a 16" space between the fryer & surface flames from adjacent cooking equipment? *NFPA 96–2011 12.1.2.4* PE.04.01.01 EP 1 (HAP 482.41(c)) (CAH 485.623(d))	☐	☐	Are the steel filter baffles all installed with no gaps & are they in the proper direction? *NFPA 96-2011 6.2.3.1; 6.2.3.5* PE.04.01.01 EP 1 (HAP 482.41(c)) (CAH 485.623(d))
☐	☐	K fire extinguisher placard identifying need to activate the fixed suppression (ansul) system before using the extinguisher? *NFPA 96-2011 10.2.2* PE.03.01.01 EP 3 (HAP 482.41(b)(2))	☐	☐	Is grease producing equipment located properly under the hood? *NFPA 96-2011 5.2* PE.04.01.01 EP 1 (HAP 482.41(c)) (CAH 485.623(c)(1)(i))

		(CAH 485.623(c)(1)(i))			
☐	☐	Suppression system: does staff know how to use it? *Instructions for manual operations should be conspicuously posted & reviewed by staff. NFPA 96-2011 11.1.4* (HAP PE.03.01.01 EP 4, 482.41(b)(5)) (CAH HR.11.01.01 EP 1)	☐	☐	Are extinguishing heads pointed properly toward the cooking surface? PE.03.01.01 EP 3 (HAP 482.41(b)(2)) (CAH 485.623(c)(1)(i))
			☐	☐	Electrical panels; are they clear from obstruction? *There should be 36"* PE.04.01.01 EP 1 (HAP 482.41(c)) (CAH 485.623(d))
☐	☐	Compressed gas cylinders: are they properly secured? *NFPA 99-2012 11.3; 11.6.2.3* PE.04.01.01 EP 1 (HAP 482.41(c)) (CAH 485.623(d))	☐	☐	Fire Evacuation & Relocation Plan; is the staff knowledgeable? *NFPA 101-2012: 18/19.7.1; 7.2 (HAP* PE.03.01.01 EP 4, 482.41(b)(5)) (CAH HR.11.01.01 EP 1)

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Building Tour Guidance Document – Hospital and Critical Access Hospital

MAIN Fire Alarm Control Panels	
a. If panel is not working/in trouble without staff knowledge	PE.04.01.01 EP 2
b. Installed in properly protected area	PE.03.01.01 EP 3
MAIN Piped Medical Gas Panels	
a. Working condition of main medical gas alarm panels (i.e., trouble indications)	PE.04.01.01 EP 2
b. Not at a continuously attended location (e.g., PBX, ED, etc.)	PE.04.01.01 EP 1
Bulk Oxygen/Medical Gas Tank Farm or Main Medical Gas Storage Area	
a. Condition of equipment – status, open valves, piping, tanks flexible attached connections	PE.04.01.01 EP 2
b. Storage configuration and labeling (i.e., cylinder, precautionary room/are signage, full/empty)	PE.04.01.01 EP 1
c. Outdoor storage (weather protection for outside cylinders)	PE.04.01.01 EP 1
d. Proper labeling and accessibility of main control and source valves	PE.04.01.01 EP 1
e. Testing piped medical gas and vacuum systems and oxygen supply connection	PE.04.01.01 EP 1, EP 2
OR Suite - Done early in the survey to allow the organization time to correct while on site. The review of corrective action must include documentation that other areas supplied by same air handler were not negatively impacted by corrective work	
a. Pressure relationships (check during survey), air exchange rates (balance reports)	PE.04.01.01 EP 1 (Critical) PE.04.01.01, EP 3 (Non-Critical)
b. Temperature/humidity levels	PE.04.01.01 EP 1
c. Surgical fire prevention activities	PE.04.01.01 EP 1
MAIN Engineering Locations – boilers, chillers, electrical distribution hub	
a. Equipment - leaks, general maintenance issues, equipment out of service (ask about risk to patients)	PE.04.01.01 EP 2
b. Room - rated wall separation, penetrations, opening protection, fireproofing damage	PE.03.01.01 EP 3
c. Minimal storage in Air Handling Control rooms (i.e., only AHU filters)	PE.03.01.01, EP3
d. Eye wash station (and shower if required)	PE.02.01.01, EP 4
e. Open J-boxes	PE.04.01.01 EP 2
All Generators	
a. Overall condition/readiness of the generators - is it on auto start? Oil and coolant leaks, clearances, check how batteries are maintained, amount of fuel on hand, cold weather protection	PE.04.01.03 EP 3
b. Battery powered task lighting lacking	PE.04.01.01 EP 3
c. Room – rated wall separations, sealed penetrations, opening protection, fireproofing damage	PE.03.01.01 EP 3
d. Sprinkler/heat detectors (if required)	PE.03.01.01 EP 3
e. Open J-boxes	PE.04.01.01 EP 2
f. Remote annunciator alarm panel - continuously attended location (e.g., PBX, ED)	PE.04.01.01 EP 3
Automatic Transfer Switches	
a. Explore ATS's (inventory circuit diagrams, interview)	PE.04.01.01 EP 1 PE.03.01.01 EP 3
Fire Pump(s)	

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a. Equipment overall condition/readiness of the fire pump – status, valves supervised/secure, leaks	PE.04.01.01 EP 2
b. Room condition – rated separation, opening protective	PE.03.01.01 EP 3
Kitchen	
a. Sprinkler head clearance over high storage	PE.03.01.01 EP 3
b. "K" extinguisher distance with signage; staff knowledge on proper use	PE.03.01.01 EP 3
c. Range hood extinguishing system – direction of nozzles, cleanliness, proper placement of filters	PE.03.01.01 EP 3
d. Ansul Systems activates fire alarm system	PE.03.01.01 EP 3
e. Fuel source disconnects upon activation of the Ansul system	PE.03.01.01 EP 3
f. Storage configurations – separate storage rooms or open to kitchen if allowed by code exceptions	PE.03.01.01 EP 3
g. Sprinkler heads – condition, in refrigerators/freezers (if required)	PE.03.01.01 EP 3
Main Entries/Lobby	
a. No smoking signs lacking	PE.03.01.01 EP 3
b. Canopy sprinkler coverage	PE.03.01.01 EP 3
c. Exit doors acceptable locking arrangements, emergency break open features	PE.03.01.01 EP 3
Construction Areas	
a. Verify implementation of ILSMs at demolition, construction and renovation locations within the facility	PE.03.02.01 EP1
Loading Dock and Receiving Dept.	
a. Proper safety features on compactor	PE.01.01.01 EP 1
b. Sprinkler head clearance over high storage	PE.03.01.01 EP 3
Roof	
a. Water ponding under air intakes; clogged bird screens on air intakes	PE.04.01.01 EP 2
Empty Patient Rooms	
a. Call lights, blocked doors/damages, damaged medical gas outlets, oxygen tanks not in stands	PE.04.01.01 EP 2 PE.01.01.01 EP 1
b. Areas clean, excessive wall/ceiling damage	PE.01.01.01 EP 1, 3
c. Furniture safe and in good repair	PE.01.01.01 EP 2
Exit Stairs, Rated Exit Passageways, Exterior Discharge Areas	
a. Proper construction – walls/decks and opening protective	PE.03.01.01 EP 3
b. Proper door labeling; operation	PE.03.01.01 EP 3
c. Clearances/obstructions	PE.03.01.01 EP 3
d. Interior exit lighting and signage	PE.03.01.01 EP 3
e. Locking configurations	PE.03.01.01 EP 3
f. Stair not used as a chase for utilities serving other areas	PE.03.01.01 EP 3
g. Exterior public discharge surfaces and two sources lighting	PE.03.01.01 EP 3
Smoke Barriers	
a. Above-the-ceiling – smoke dampers, type and condition of penetration sealant; fireproofing damage; no support from fire sprinkler pipes; no open junction boxes	PE.03.01.01 EP 3
b. Below-the-ceiling – Automatic door closers, door coordinators, door clearances/undercuts	PE.03.01.01 EP 3
Two-hour Rated Barriers	
a. Above-the-ceiling – fire dampers, type and condition of penetration sealant; fireproofing damage; no support from fire sprinkler pipes; no open junction boxes	PE.03.01.01 EP 3
b. Below-the-ceiling – door latching, door rating labels, protective plate heights, door undercuts	PE.03.01.01 EP 3
Hazardous Areas	
a. Above-the-ceiling (if not sprinklered) - walls, penetrations; fireproofing damage; no support from sprinkler piping; no open junction boxes	PE.03.01.01 EP 3

Building Tour Guidance

b. Below-the-ceiling - sprinkler head clearances, door latching, door rating labels, protective plate heights (non-sprinkler), door undercuts, storage limitations	PE.03.01.01 EP 3
c. As applicable, check for proper eye wash units	PE.02.01.01, EP 4
Corridors	
a. Above-the-ceiling (non-sprinkler): Corridor walls to underside of deck above a, penetrations sealed; no fireproofing damage; no support from sprinkler pipes; no open junction boxes	PE.04.01.01 EP 1 PE.03.01.01 EP 3
b. Below-ceiling: Corridor door latching, door undercuts: maximum 6 inches projections, corridor clutter; exit lighting and signage	PE.03.01.01 EP 3
c. Medical gas shut-offs zone valves (labeling, access, signage)	PE.04.01.01 EP 1
Electrical Closets	
a. Storage blocking panels	PE.04.01.01 EP 2
b. Properly sealed floor, ceiling penetrations if not a shaft properly sealed wall penetrations if a shaft	PE.03.01.01 EP 3
c. Check sub-electrical panel schedules to see if they correct	PE.04.01.01 EP 1
d. Open junction boxes	PE.04.01.01 EP 2
Various Indoor Air Quality Locations Areas	
a. Sterile supply, endoscopy, bronchoscopy, cath labs	PE.04.01.01 EP 1
b. Isolation rooms	PE.04.01.01 EP 1
c. Special storage spaces with hazardous materials	PE.04.01.01 EP 1

Business and Ambulatory Occupancy Building Tour Guidance Hospital and Critical Access Hospital

This guidance is intended for the following types of occupancies/settings:

- Business occupancy locations***
- ASC's that are not deemed and have less than 4 patients that are incapable of self-preservation

***This guidance does not apply to deemed ASCs and free-standing emergency departments.

Topic	Notes	Ambulatory Scoring Location	Business Scoring Location
Means of Egress			
Locked exits	Look for exit doors that are locked or delayed that would impact exiting the building. If there is delayed egress, test the delayed egress hardware to ensure it releases in time frame posted on the door (no more than 30 seconds max).	PE.03.01.01 EP 3 The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	
Illumination	- Continuous when occupied -Is the path of egress well lit, including outside the building at the point of discharge and to the public way?	PE.03.01.01 EP 3 The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	
Battery back-up	If battery back-up lights exist, are they functional and being tested on monthly/ annual basis?	PE.04.01.01 EP 1 The hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5 and 12-6).	
Corridors			
Corridor widths	Minimum 44 inches wide in Ambulatory, In Business 44" min only if 50+ occupants, 36 inches if fewer than 50 occupants	PE.03.01.01 EP 3 The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	
Visible exit signs	Look to see there are exit signs that are visible to direct occupants out of the building.	PE.03.01.01 EP 3 The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and	

Topic	Notes	Ambulatory Scoring Location	Business Scoring Location
		Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	
Junction Boxes	Look for any open electrical junction boxes that have the cover removed.	PE.04.01.01 EP 2 The hospital maintains essential equipment in safe operating condition.	
Electrical Outlets	GFI if within 6 ft of sinks	PE.04.01.01 EP 2 The hospital maintains essential equipment in safe operating condition.	
Electrical Panel	Locking - If policy requires locking due to public access	PE.04.01.01 EP 1 The hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5 and 12-6).	
	Accurate panel legends, circuit breakers in panels need to be identified on the panel legend	PE.04.01.01 EP 1 The hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5 and 12-6).	
Safety Data Sheets (SDS)	Does the organization have an inventory of the chemicals? Do staff have access to SDS for any chemicals used in the environment? If the organization uses electronic SDS, is there a way for employees to access SDS during computer downtime?	PE.02.01.01 EPs 1, 2 EP 1 The hospital maintains a written, current inventory of hazardous materials and waste that it uses, stores, or generates. The only materials that need to be included on the inventory are those whose handling, use, and storage are addressed by law and regulation. EP 2 For managing hazardous materials and waste, the hospital has the permits, licenses, manifests, and safety data sheets required by law and regulation.	
Security/ Access	Look at how the org controls access to facility. Can the public enter parts of the facility without authorization? Backdoors unsecured etc.?	NPG.11.01.01 EP 1 The hospital controls access to and from areas it identifies as security sensitive.	
Fire Extinguishers			

Topic	Notes	Ambulatory Scoring Location	Business Scoring Location
Inspection	Fire extinguishers inspected monthly and maintained annually. This is documented on the tag or electronically.	PE.04.01.01 EP 2 The hospital maintains essential equipment in safe operating condition.	
Mounting and Visibility	- Proper mounting height between 4" and 60" off the floor - Extinguishers are conspicuously visible. Need to be able to see them or a sign of where they are.	PE.04.01.01, EP 1 The hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5 and 12-6).	
MRI	- MRI-safe fire extinguisher	PE.04.01.01, EP 1 The hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5 and 12-6).	
Biohazardous and Pharmaceutical Waste	-Is biohazard waste stored in proper containers with proper labeling -Are sharps containers locked and not overfilled Is Biohazard and pharm waste stored so public cannot access while awaiting pickup?	PE.02.01.01, EP 4 The hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials The policies and procedures address the following: - Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors - Disposal of hazardous medications - Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding - Periodic inspection of radiology equipment and prompt correction of hazards found during inspection - Precautions to follow and personally protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers and MRIs). Note 2: Hazardous gases and vapors include but are not limited to ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9).	

Topic	Notes	Ambulatory Scoring Location	Business Scoring Location
		PE.02.01.01, EP 6 The hospital has procedures for the proper routine storage and prompt disposal of trash and regulated medical waste.	
Alcohol-based hand rub (ABHR) Dispensers	- Not directly over outlets - Corridor clear width of 44 inches is not compromised by dispenser (Business) -Only allowed in corridors over 6' wide (Ambulatory) - ABHR does not exceed 95% alcohol - Maximum individual dispenser capacity is 0.32 gallon of fluid (0.53 gallon in suites or rooms separated from corridors) or 18 ounces of NFPA Level 1–classified aerosols - Dispensers have a minimum of four feet of horizontal spacing between them - Dispensers are not installed within one inch of an ignition source - Operation must comply with the manufacturer's instructions for use. - ABHR is protected against inappropriate access - Not more than an aggregate of 10 gallons of fluid or 135 ounces of aerosol are used on a single story or in a single fire compartment outside a storage cabinet, excluding one individual dispenser per room - Storing more than five gallons of fluid on a single story or in a single fire compartment complies with NFPA 30	PE.03.01.01, EP 7 When the hospital installs alcohol-based hand rub dispensers, it installs the dispensers in a manner that protects against inappropriate access.	
Eye Wash Stations	-Are there chemicals being used that require eye wash per SDS? -Is there a mixing valve on the eye wash station if need to maintain tepid temperature 60 – 100 degrees? -Can the eye wash be reached within 10 secs (approximately 55 feet) without going through a doorway? -Is there eye wash testing documentation?	PE.02.01.01, EP 4 The hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials The policies and procedures address the following: - Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors - Disposal of hazardous medications - Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding	

Topic	Notes	Ambulatory Scoring Location	Business Scoring Location
		- Periodic inspection of radiology equipment and prompt correction of hazards found during inspection - Precautions to follow and personally protective equipment to wear in response to hazardous material and waste spills or exposure	
Storage Rooms	**Existing construction** - If greater than 50 ft, they must have a one-hour fire barrier or automatic sprinkler. **New construction** storage areas – they must either have a one-hour fire barrier, or be sprinkled with a self-closing door and smoke resistive construction **Hazardous Area.** Hazardous areas include areas for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.	PE.03.01.01, EP 3 The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	
Medical Equipment	-Is the medical equipment in the medical equipment inventory? -Has the org identified the equipment as high risk or non-high risk? -Can the org tell you what type of maintenance they are doing, OEM or AEM -Is the equipment up to date on PM's?	PE.04.01.01, EP 2 The hospital maintains essential equipment in safe operating condition.	
Compounding	See MST template library		
Cylinder Storage	-Are there cylinders that are not secured? -Are they storing more than 12 E cylinders outside of a secure storage room of non-or limited- combustible construction (do not count cylinder in use)	PE.04.01.01, EP 1 The hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5 and 12-6).	
Sprinkler Heads/ System	Clearances, Cubicle Curtain Mesh	PE.03.01.01, EP 3 The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	
	Sprinkler heads are not obstructed (18" rule)	PE.03.01.01, EP 3 The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and	

Business and Ambulatory Occupancy Building Tour Guidance Hospital and Critical Access Hospital

Topic	Notes	Ambulatory Scoring Location	Business Scoring Location
		Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	
	Sprinkler heads are not damaged/dirty, escutcheon plates installed	PE.03.01.01, EP 3 The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	
Fire Drills	Documentation of quarterly (Ambulatory) or annual (Business) fire drill	PE.03.01.01, EP 3 The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	

The Joint Commission™

Infection Prevention and Control Program Assessment Tool

Required Documents and Data

- Assessment of infection risks

Note: Performed at least annually, the format is determined by the hospital.

- Results of infection control surveillance

Note: Infection control surveillance includes surveillance of healthcare–associated infections (HAIs), such as data submitted to the National Healthcare Safety Network (NHSN) for Centers for Medicare & Medicaid (CMS) or State requirements, and data on any epidemiologically important organisms or infectious diseases that have impacted the hospital during the preceding 12 months.

- Infection prevention and control policies and procedures that guide program activities and methods (in electronic or paper form)
- Documentation of completed job-specific staff education, training, and competencies on infection control and prevention
- Program documents demonstrating that the problems identified by the infection prevention and control program have been reviewed and addressed in collaboration with the hospital's quality assessment and performance improvement leaders and other leaders (for example, the medical director, nurse executive, and administrative leaders).

Note: The format of this documentation is determined by the hospital. Examples may include relevant committee meeting agendas and minutes, presentations, reports, planning documents.

- Documentation demonstrating the governing body's oversight of the program implementation and performance (for example, governing body minutes)

Table: Elements of Compliance and Scoring Guidance

Elements of Compliance	Standard(s)/EP(s)
Infection Prevention and Control Program & Leader(s)	
1. An infection preventionist(s) or infection control professional(s) has been appointed by the hospital governing body, based on the recommendation of the medical staff and nursing leaders, and is qualified through education, training, experience, or certification.	NPG.12.01.01 EP 12
2. The hospital defines the qualifications for the infection preventionist(s) or infection control professional(s), which may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control).	HR.11.02.01 EP 1
3. The infection preventionist(s)/infection control professional(s) perform the following activities in collaboration with all departments, programs, and areas involved in infection prevention and control activities: a. Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines b. Documentation of the infection prevention and control program and its surveillance, prevention, and control activities c. Competency-based training and education of hospital staff, including medical staff and, as applicable, personnel providing contracted services on infection prevention and control policies and procedures and their application	IC.04.01.01 EP 2

d. The prevention and control of healthcare–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures Note: Auditing tasks may be delegated to the appropriate staff (for example, unit-based liaisons or leaders); however, if delegation occurs, the infection preventionist(s) or infection control professional(s) must be updated on the results of auditing activities e. Communication and collaboration with all components of the hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and the water management program f. Communication and collaboration with the hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection (HLD). (For more information on competency requirements, refer to HR.11.04.01 EP 1)	
4. The infection prevention and control program reflects the scope and complexity of the hospital's services provided by addressing all locations, patient populations, and staff as evidenced by the following: a. The program's policies and procedures; prevention, control, and auditing activities; and job-specific competency-based training activities apply to all staff providing patient care, treatment, or services. b. The program's policies and procedures; prevention, control, and auditing activities; and job-specific competency-based training activities apply to all inpatient and outpatient care locations. c. The program's policies and procedures; prevention, control, and auditing activities; and job-specific competency-based training activities apply to all care, treatment, and services (for example, hemodialysis, HLD/sterilization, respiratory therapy, wound care, dietary services, and laundry services). d. The scope of surveillance is consistent with infection control standards of practice and the scope and complexity of the hospital's services. e. Policies and procedures address the special populations served by the hospital (for example, pediatric patients, patients undergoing bone marrow transplant, hemodialysis, etc.) f. New hospital locations, services, and areas (for example, new ambulatory sites) are incorporated into the infection prevention and control program activities.	IC.04.01.01 EP 5
Hospital Leadership Responsibility & Program Resources	

1. The governing body, or responsible individual, ensures that the infection prevention and control program is operational and resourced to carry out and track its activities through the following: a. Resources must be adequate to accomplish the tasks required for the infection prevention and control program. This includes the following: i. Allocating human resources to mitigate infection risks and prevent transmission of infections (for example, nursing and environmental services staffing must be adequate to carry out infection prevention and control activities). ii. Allocating material resources to mitigate infection risks and prevent transmission of infections, such as information technology, laboratory services, equipment, and supplies. iii. Allocating sufficient information resources to guide program activities, such as access to local, state, and federal public health authorities' advisories and alerts (for example, the CDC's Health Alert Network [HAN]; FDA alerts); access to manufacturers' instructions for use; access to any standards and guidelines required by applicable regulation and the guidelines and consensus standards chosen by the hospital to inform policies and procedures (for example, guidelines and standards from ASHRAE, FGI, SHEA, AAMI, AORN, APIC Text, etc.)	IC.05.01.01 EP 1

b. The governing body, or responsible individual, is ultimately accountable for the implementation, success, and sustainability of the program activities, while the medical director, nurse executive, and administrative leaders provide additional leadership support for the program. c. Hospital policies address the roles and responsibilities for infection prevention and control program within the hospital and how the various hospital committees and departments interface with the infection prevention and control program (for example, how to report infectious/communicable disease issues to the infection prevention and control program).	
2. The hospital's governing body ensures that the problems identified by the infection prevention and control program are addressed in collaboration with the hospital's quality assessment and performance improvement (QAPI) leaders, and other leaders (for example, the medical director, nurse executive, and administrative leaders) as evidenced by the following: a. The hospital's QAPI program addresses problems identified by the infection control leader(s). b. The hospital leaders, including the CEO, the medical staff leader, and the nurse executive, monitor adherence to corrective action plans, assess the effectiveness of actions taken, and verify the implementation of revised corrective actions as needed. c. The hospital's governing body, the medical staff leader, the nurse executive, and administrative leaders must ensure that staff in-service training programs address problems identified through the infection prevention and control program.	IC.05.01.01 EP 2
3. **For hospitals that use Joint Commission accreditation for deemed status purposes**: If a hospital is part of a hospital system consisting of separately certified hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member hospitals after determining that such a decision is in accordance with applicable law and regulation. The system governing body is responsible and accountable for making certain that each of its separately certified hospitals meet all of the requirements at 42 CFR 482.42(d). Each separately certified hospital subject to the system governing body demonstrates that the unified and integrated infection prevention and control program and the antibiotic stewardship program have the following characteristics: - Structured in a manner that accounts for each member hospital's unique circumstances and any significant differences in patient populations and services offered at each hospital - Establish and implement policies and procedures to make certain that the needs and concerns of each separately certified hospital, regardless of practice or location, are given due consideration - Have mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed - A qualified individual(s) with expertise in infection prevention and control and in antibiotic stewardship has been designated at the hospital as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to hospital staff	LD.11.01.01 EP 10
Program Policies and Procedures	

1. The hospital's infection prevention and control program has written policies and procedures to guide its activities and methods for preventing and controlling the transmission of infections within the hospital and between the hospital and other institutions and settings. The policies and procedures are in accordance with the following hierarchy of references: - Applicable law and regulation. Note: Relevant federal, state, and local law and regulations include but are not limited to the Centers for Medicare & Medicaid Services Conditions of Participation, the Food and Drug Administration (FDA) regulations for reprocessing single-use medical devices; Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens Standard 29 CFR 1910.1030, Personal Protective Equipment Standard 29 CFR 1910.132, and Respiratory Protection Standard 29 CFR	IC.04.01.01 EP 3

1910.134; health care worker vaccination laws; state and local public health authorities' requirements for reporting of communicable diseases and outbreaks; and state and local regulatory requirements for biohazardous or regulated medical waste generators. - Manufacturers' instructions for use. - Nationally recognized evidence-based guidelines and standards of practice, including The Centers for Disease Control and Prevention (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, or, in the absence of such guidelines, expert consensus or best practices. The guidelines are documented within the policies and procedures. Note 1: For full details on CDC Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, refer to https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html. Note 2: The hospital determines which evidence-based guidelines, expert recommendations, or best practices, or a combination thereof, it adopts in its policies and procedures.	

2. The hospital's policies and procedures for cleaning, disinfection, and sterilization of reusable medical and surgical devices and equipment address the following: - Cleaning, disinfection, and sterilization of reusable medical and surgical devices in accordance with the Spaulding classification system and manufacturers' instructions Note: The Spaulding classification system classifies medical and surgical devices as critical, semicritical, or noncritical based on risk to the patient from contamination on a device and establishes the levels of germicidal activity (sterilization, high-level disinfection, intermediate and low-level disinfection) to be used for the three classes of devices. - The use of EPA-registered disinfectants for noncritical devices and equipment according to the directions on the product labeling, including, but not limited to, indication, specified use-dilution, contact time, and method of application - The use of FDA-approved liquid sterilants for the processing of critical devices and high-level disinfectants for the processing of semicritical devices in accordance with the FDA-cleared label and device manufacturers' instructions - Required documentation for device reprocessing cycles, including but not limited to sterilizer cycle logs, the frequency of chemical and biological testing, and the results of testing for appropriate concentration for chemicals used in high- level disinfection - Resolution of conflicts or discrepancies between a medical device manufacturer's instructions and manufacturers' instructions for automated high-level disinfection or sterilization equipment - Criteria and the process for the use of immediate-use steam sterilization - Actions to take in the event of a reprocessing error or failure identified either prior to the release of the reprocessed item(s) or after the reprocessed item(s) was used or stored for later use Note: Depending on the nature of the incident, examples of actions may include quarantine of the sterilizer, recall of item(s), stakeholder notification, patient notification, surveillance, and follow-up.	IC.04.01.01 EP 4
Risk Assessment	
1. The hospital identifies risks for infection, contamination, and exposure that pose a risk to patients and staff to prioritize program activities, including the following: a. The hospital includes risks from organisms with a propensity for transmission within health care facilities based on published reports and the occurrence of clusters of patients (for example, norovirus, respiratory syncytial virus ([RSV]), influenza, measles, and organisms with antimicrobial resistance such as Carbapenem-resistant Enterobacterales ([CRE]), *Candida auris*).	NPG.05.01.01 EP 1

b. The hospital evaluates risk based on the geographical location and population it serves, for example, risk for exposure to tuberculosis (TB). c. The hospital includes community data in its risk assessment, for example, community-onset cases of muti-drug resistant organisms. d. The hospital evaluates risk based on the care, treatment, and services it provides, for example, the types of procedures, medical equipment, devices, and supplies used. e. The hospital examines the risk of potential exposure to infectious materials, blood, body fluids, secretions, or excretions to make sure PPE is appropriate and available based on the tasks performed. f. The hospital uses the information from local, state, and federal public health authorities' advisories and alerts, such as CDC' Health Alert Network (HAN) and FDA alerts, to identify infection control risks. Note: The hospital determines how it keeps current on epidemiological risks or changes.	
2. As reflected in the water management program documentation, the hospital includes a hospital risk assessment to identify where Legionella and other opportunistic waterborne pathogens (for example, Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the hospital water system.	PE.04.01.05 EP 2
3. As part of its infection control policies and procedures relevant to construction, renovation, maintenance, demolition, and repair, the hospital requires an infection control risk assessment (ICRA) to define the scope of infection risk for the projectand the need for barrier measures before a project gets underway.	PE.01.01.01 EP 1
4. The hospital reviews identified risks at least annually or whenever significant changes in risk occur.	NPG.05.01.01 EP 2
Surveillance	
1. The hospital performs and documents surveillance activities to prevent and control healthcare–associated infections (HAIs). Note: The hospital conducts surveillance and reporting in accordance with law and regulation, its risk assessment, and in accordance with recognized surveillance practices, such as those set forth by the CDC's National Healthcare Safety Network (NHSN).	IC.06.01.01 EP 3
2. Surveillance of infections and infection prevention and control activities is conducted on a hospitalwide basis. Note: This does not imply surveillance is always conducted in all areas and locations of the hospital. The expectation is that the hospital must have reliable sampling or other mechanisms in place to permit identifying and monitoring infections and communicable diseases occurring throughout the hospital's various locations or departments	IC.06.01.01 EP 3
Education, Training, and Competency Assessment	
1. The hospital provides job-specific training and education on infection prevention and control. The staff's records confirm completion of education and training. Note 1: Job-specific means that education and training are consistent with or tailored to the performed roles and responsibilities. For example, environmental services staff must be trained in the methods and procedures for surface disinfection. Note 2: The training and education must include the practical applications of infection prevention and control guidelines, policies, and procedures.	HR.11.03.01 EP 1

2. The hospital provides training to staff expected to have contact with blood or other potentially infectious material on the blood borne pathogen standards upon hire, at regular intervals, and as needed.	HR.11.03.01 EP 1
3. The hospital staff receive training in the following: a. When personal protective equipment (PPE) is necessary b. What PPE is necessary	HR.11.03.01 EP 1
c. How to properly don, doff, adjust, and wear PPE	
4. The hospital defines and assesses staff competency in infection prevention and control. Note: Competency-based training must be job-specific. For example, the staff in the sterile processing department must demonstrate competencies in the methods and procedures of sterilization, and the staff in areas that perform high-level disinfection must demonstrate competencies in the methods and procedures for high-level disinfection.	HR.11.04.01 EP 1
5. The hospital develops and implements education and training and assesses competencies for the staff who will implement protocols for high-consequence infectious diseases or special pathogens.	NPG.05.02.01, EP 2
Outbreak Management	
1. There is a process in place for reporting to public health authorities when the transmission of infection occurs; this process is consistent with state and local public health authority requirements for identification, reporting, and containing communicable diseases and outbreaks.	IC.06.01.01 EP 4
2. The hospital implements its policies and procedures for infectious disease outbreaks, including the following: - Implementing infection prevention and control activities when an outbreak is first recognized by internal surveillance or public health authorities - Reporting an outbreak in accordance with state and local public health authorities' requirements - Implementing outbreak investigation - Communicating information necessary to prevent further transmission of the infection among patients, visitors, and staff, as appropriate	IC.06.01.01 EP 4
Standard Precautions: Hand Hygiene Note: The hospital policies and procedures on hand hygiene are in accordance with either the current Centers for Disease Control and Prevention (CDC) and/or the current World Health Organization (WHO) hand hygiene guidelines, including the following:	
1. Implement a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) and/or the current World Health Organization (WHO) hand hygiene guidelines.	NPG.05.03.01 EP 1
2. Set goals for improving compliance with hand hygiene guidelines.	NPG.05.03.01 EP 1
3. Improve compliance with hand hygiene guidelines based on established goals.	NPG.05.03.01 EP 1
4. Supplies necessary for adherence to hand hygiene (such as alcohol-based hand rub, soap, water, and a sink) are readily accessible in all areas where patient care is being delivered including but not limited to patient care areas and food and medication preparation areas.	IC.06.01.01 EP 3

5. Alcohol-based hand rub is readily accessible and placed in appropriate locations where it can be accessed by the staff, patients, and visitors. The locations may include the following: a. Entrances to patient rooms b. At the bedside c. Staff workstations d. Other convenient locations	IC.06.01.01 EP 3
6. Hospital staff use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient b. Before performing an aseptic task (for example, placing an indwelling device) or handling invasive medical devices c. Before moving from work on a soiled body site to a clean body site on the same patient d. After touching a patient or the patient's immediate environment e. After contact with blood, body fluids or contaminated surfaces f. Immediately after glove removal	IC.06.01.01 EP 3

7. Hospital staff perform hand hygiene using soap and water when hands are visibly soiled (for example, blood, body fluids) or after caring for a patient with known or suspected *C. difficile* or norovirus during an outbreak. Note: In all other situations, alcohol-based hand rub is preferred.	IC.06.01.01 EP 3
8. Hospital staff do not wear artificial fingernails and/or extenders when having direct contact with patients in accordance with hospital policy. Note: If following the *CDC Guideline for Hand Hygiene in Health-Care Settings*: when having direct contact with patients at high risk of infection (for example, those in intensive care units or ORs). If following the *WHO Guidelines on Hand Hygiene*: when having direct contact with patients.	IC.06.01.01 EP 3
Standard Precautions: Environmental Cleaning and Disinfection Note: Environmental cleaning and disinfection is performed in accordance with hospital policies and procedures to maximize prevention of infection and communicable disease including the following:	
1. The hospital implements routine and targeted cleaning of environmental surfaces as indicated by the level of patient contact and degree of soiling, including the following: a. Surfaces in the patient care environment and areas are cleaned and disinfected on a regular basis, using an EPA- registered disinfectant. Note: High-touch surfaces (for example, bed rails, over-bed table, bedside commode, lavatory surfaces in patient bathrooms) are cleaned and disinfected more frequently than minimal-touch surfaces. b. Spills of blood or other potentially infectious materials are promptly cleaned and decontaminated, using appropriate EPA-registered hospital disinfectants.	IC.06.01.01 EP 3
2. Cleaners and disinfectants, including disposable wipes, are used in accordance with manufacturers' instructions (for example, dilution, storage, shelf-life, contact time).	IC.06.01.01 EP 3
3. Mop heads and cleaning cloths are laundered at least daily using appropriate laundry techniques (for example, following manufacturers' instructions when laundering microfiber items).	IC.06.01.01 EP 3
4. The hospital has established and follows a schedule for areas/equipment (for example, refrigerators, ice machines, eye wash stations, scrub sinks) to be cleaned regularly.	IC.06.01.01 EP 3

5. After a patient vacates a room and before the bed linens and towels are replaced, all potentially contaminated surfaces in the room are thoroughly cleaned and disinfected.	IC.06.01.01 EP 3
6. Undamaged hospital bed mattress covers are cleaned and disinfected according to manufacturers' instructions. Any damaged, worn, or visibly stained hospital bed mattress or mattress covers are removed from service and cleaned, disinfected, refurbished, or discarded in accordance with manufacturers' instructions and hospital procedures.	IC.06.01.01 EP 3
Standard Precautions: Injection and Sharps Safety Note: Injection practices and sharps safety and disposal are performed in accordance with The Centers for Disease Control and Prevention (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings and hospital policies and procedures to maximize prevention of infection and communicable disease including the following:	
1. Injections are prepared using aseptic technique in an area that has been cleaned and separated from potential sources of contamination (for example, visible blood, body fluids, sinks or other water sources).	IC.06.01.01 EP 3
2. Single-dose or single-use vials, ampules, bags or bottles of parenteral solution, fluid infusion or administration sets (for example, intravenous tubing) are used for one patient only.	IC.06.01.01 EP 3
3. Diaphragms of medication vials are disinfected before inserting a device into the vial.	IC.06.01.01 EP 3
4. Needles and syringes are used for one patient only (this includes manufactured prefilled syringes and cartridge devices such as insulin pens).	IC.06.01.01 EP 3
5. The same lancing/fingerstick device is <u>not</u> used for more than one individual, even if the lancet is changed.	IC.06.01.01 EP 3
6. If multidose vials are used for more than one patient, medication vials do not enter the immediate patient treatment area (for example, operating room, patient room, anesthesia carts). Note: If multi-dose vials enter the immediate patient treatment area, they must be dedicated for single patient use and discarded immediately after use.	IC.06.01.01 EP 3
7. Immediately or as soon as possible after use, contaminated sharps are discarded in puncture-resistant, leakproof (on the sides and bottom) sharps containers, and sharps containers are replaced when the fill line is reached.	IC.06.01.01 EP 3
Standard Precautions: Risk Assessment with Appropriate Use of Personal Protective Equipment Note: Appropriate personal protective equipment (PPE) is used in accordance with hospital policies and procedures to maximize prevention of infection and communicable disease including the following:	
1. Staff have immediate access to PPE and are able to select, put on, remove, and dispose of PPE in a manner that protects themselves, the patient, and others.	IC.06.01.01 EP 3
2. Gloves are worn when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin, or contaminated equipment could occur. The staff change gloves and perform hand hygiene before moving from a contaminated body site to a clean body site.	IC.06.01.01 EP 3
3. A gown is worn that is appropriate to the task to protect skin and prevent soiling of clothing during procedures and activities that could cause contact with blood, body fluids, secretions, or excretions.	IC.06.01.01 EP 3

4. Protective eyewear and a mask or a face shield are worn to protect the mucous membranes of the eyes, nose and mouth during procedures and activities that could generate splashes or sprays of blood, body fluids, secretions, and excretions. Note: Masks, goggles, face shields, and combinations of each are selected according to the need anticipated by the task performed.	IC.06.01.01 EP 3
5. PPE removal and disposal: PPE, other than respirators, are removed and discarded upon completing a task before leaving the patient's room or care area. If a respirator is used, it should be removed and discarded (or reprocessed if reusable) after leaving the patient room or care area and closing the door. Disposable gloves are removed and discarded upon completion of a task or when soiled during the process of care.	IC.06.01.01 EP 3
6. Face masks (procedure or surgical) are worn by staff who are placing a catheter or injecting materials into the epidural or subdural space (for example, during myelogram, epidural, or spinal anesthesia).	IC.06.01.01 EP 3
Standard Precautions: Minimizing Potential Exposures. **Preparedness for High-Consequence Infectious Diseases or Special Pathogens.**	
1. Respiratory hygiene and cough etiquette instructional signage or handouts are posted and tissues, masks, and hand hygiene supplies available at the points of entry to minimize potential exposures to or transmission of respiratory infection. Note: Points of entry may include the emergency department, urgent care, and ambulatory clinics	IC.06.01.01 EP 3
2. The hospital has developed and implemented protocols for high-consequence infectious diseases or special pathogens. The protocols are readily available for use at the point of care and address the following:	NPG.05.02.01, EP 1

- Identify: Procedures for screening at the points of entry to the hospital for respiratory symptoms, fever, rash, and travel history to identify or initiate evaluation for high-consequence infectious diseases or special pathogens Note: Points of entry may include the emergency department, urgent care, and ambulatory clinics. - Isolate: Procedures for transmission-based precautions - Inform: Procedures for informing public health authorities and key hospital staff - Required personal protective equipment and proper donning and doffing techniques - Infection control procedures to support continued and safe provision of care while the patient is in isolation and to reduce exposure among staff, patients, and visitors using the hierarchy of controls Note: See the Glossary for a definition of hierarchy of controls. - Procedures for waste management and cleaning and disinfecting patient care spaces, surfaces, and equipment	
Standard Precautions: Reprocessing of Reusable Medical Equipment Note: Reprocessing of reusable medical equipment is performed in accordance with the Spaulding classification system, manufacturers' instructions, and hospital policies and procedures.	
1. Only devices labeled as reusable are reprocessed directly by the hospital onsite or offsite via a reprocessing vendor. If the hospital elects to reuse any devices labeled for single use by the manufacturer, these devices are reprocessed by an entity that is registered with the FDA as a third-party reprocessor and cleared by the FDA to reprocess the specific device in question. The hospital has documentation from the third-party reprocessor confirming this is the case.	IC.06.01.01 EP 3

2. Manufacturers' instructions for medical devices and equipment are available to the staff performing reprocessing. The hospital may use posters or other condensed methods to provide critical information to staff performing reprocessing to ensure reprocessing consistent with the instructions for use.	IC.05.01.01 EP 1
3. Reusable non-critical medical equipment (for example, blood glucose meters and other point-of-care devices, blood pressure cuffs, oximeter probes) are cleaned and disinfected according to manufacturers' instructions after each use or when visibly soiled.	IC.06.01.01 EP 3
4. Hydrotherapy equipment (for example, Hubbard tanks, tubs, whirlpools, spas, birthing tanks) are drained, cleaned, and disinfected using an EPA-registered disinfectant according to manufacturers' instructions after each patient use.	IC.06.01.01 EP 3
5. Responsibility for cleaning and disinfection of reusable noncritical patient-care equipment and devices is clearly designated.	IC.06.01.01 EP 3
High-level disinfection:	
6. All reusable semi-critical items receive at least high-level disinfection prior to reuse, in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
7. Flexible endoscopes are inspected for damage and leak tested as part of each reprocessing cycle, in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
8. Items are thoroughly pre-cleaned according to manufacturers' instructions and visually inspected for residual soil prior to high- level disinfection. For instruments with lumens (for example, endoscopes), pre-cleaning of devices must include all channels using cleaning brushes of appropriate size.	IC.06.01.01 EP 3
9. Manufacturers' instructions are followed for the following: a. Enzymatic cleaners or detergents b. Reusable cleaning brushes c. Chemicals used in high-level disinfection, including instructions for preparation, testing for appropriate concentration, and replacement (for example, prior to expiration) Note: The results of testing for appropriate concentration are documented to ensure minimal effective concentration of the active ingredient. d. Disinfection temperatures and length of time e. Device rinsing following high-level disinfection	IC.06.01.01 EP 3

f. If automated reprocessing equipment is used, manufacturers' recommended connectors are used to assure that all endoscope channels are appropriately disinfected.	
10. Devices are dried thoroughly prior to storage/reuse in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
11. After high-level disinfection, devices are stored in a manner that protects them from damage or contamination.	IC.06.01.01 EP 3
12. The hospital has a system in place to identify which endoscope was used on a patient for each procedure.	IC.06.01.01 EP 3
Sterilization:	
13. All reusable critical items are sterilized prior to reuse, in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
14. Items are thoroughly pre-cleaned according to manufacturers' instructions and visually inspected for residual soil prior to sterilization. Note: For instruments with lumens, pre-cleaning of devices must include all channels using cleaning brushes of appropriate	IC.06.01.01 EP 3

size.	
15. Enzymatic cleaner or detergent is used and discarded according to manufacturers' instructions.	IC.06.01.01 EP 3
16. Cleaning brushes are single-use, disposable items or, if reusable, cleaned and either high-level disinfected or sterilized (per manufacturers' instructions) at least daily.	IC.06.01.01 EP 3
17. After pre-cleaning, items are appropriately wrapped-packaged for sterilization (for example, the package system selected is compatible with the sterilization process being performed, hinged instruments are open, and instruments are disassembled if indicated by the manufacturer).	IC.06.01.01 EP 3
18. The sterilization process is monitored by using a combination of mechanical, chemical, and biological indicators to ensure the effectiveness of the sterilization process. Indicators are used in accordance with the sterilizer or sterilizer accessory (pouch, casket, tray, etc.) manufacturers' instructions.	IC.06.01.01 EP 3
19. For dynamic air removal–type sterilizers (for example, prevacuum steam sterilizers), an air removal test (Bowie-Dick test) is performed each day the sterilizer is used to verify efficacy of air removal in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
20. Sterile packs are labeled with the sterilizer used, the cycle or load number, the date of sterilization, and, if applicable, the expiration date.	IC.06.01.01 EP 3
21. Logs for each sterilizer cycle are current and include results from each load, in accordance with the hospital policies and procedures. Note: For the absence of policies and procedures, score IC.04.01.01 EP 4	IC.06.01.01 EP 3
22. After sterilization, medical devices and instruments are stored so that sterility is not compromised.	IC.06.01.01 EP 3
23. Sterile packages are inspected for integrity and compromised packages are repackaged and reprocessed prior to use.	IC.06.01.01 EP 3
24. If immediate-use* steam sterilization (IUSS) is performed, all of the following criteria are met: a. Work practices ensure proper cleaning and decontamination, inspection, and arrangement of the instruments into the recommended sterilizing trays or other containment devices before sterilization. b. Once clean, the item is placed within a container intended for immediate use. c. The sterilizer cycle and parameters used are selected according to the manufacturers' instructions for use for the device, container, and sterilizer. d. The sterilizer function is monitored with mechanical monitors and chemical and biologic indicators that are validated for use with the sterilization cycle and in accordance with the device and sterilizer manufacturers' instructions. e. The processed item must be transferred immediately*, using aseptic technique, from the sterilizer to the actual point of use, the sterile field in an ongoing surgical procedure. *"Immediate use" is defined as the shortest possible time between a sterilized item's removal from the sterilizer and its aseptic transfer to the sterile field. A sterilized item intended for immediate use is not stored for future use, nor held from one case to another.	IC.06.01.01 EP 3

25. Immediate-use steam sterilization is not performed on the following devices: a. Implants (except in documented emergency situations when no other option is available) Note: If IUSS must be used for an implantable device, the name of the patient/patient's unique identifier and any other information needed to accurately link the instrument processed using IUSS back to the patient must be recorded. b. Post-procedure decontamination of instruments used on patients who may have Creutzfeldt-Jakob disease or similar disorders c. Devices that have not been validated with the specific cycle employed d. Single-use devices that are sold sterile	IC.06.01.01 EP 3
26. Staff follow hospital policies and procedures in the event of a reprocessing error or failure identified either prior to the release of the reprocessed item(s) or after the reprocessed item(s) was used or stored for later use. Note: Depending on the nature of the incident, examples of actions may include quarantine of the sterilizer, recall of item(s), stakeholder notification, patient notification, surveillance, and follow-up. Note: For the absence of policies and procedures, score IC.04.01.01 EP 4.	IC.06.01.01 EP 3
Transmission-Based Precautions Note: Transmission-based precautions are applied in accordance with hospital policies and procedures to maximize prevention of infection and communicable disease including the following:	
1. The hospital implements transmission-based precautions based on the patient's clinical presentation and likely infection diagnoses (for example, syndromes suggestive of transmissible infections such as diarrhea, meningitis, fever and rash, respiratory infection) and adjusts or discontinues precaution per policies and procedures and clinical information. Note: Implementation of transmission-based precautions may differ based on the patient care settings (inpatient, outpatient, long-term care), facility design characteristics, and the type of patient interaction.	IC.06.01.01 EP 3
2. Personal protective equipment and supplies are available and located near point of use.	IC.06.01.01 EP 3
3. Personal protective equipment is put on/donned and removed/doffed properly.	IC.06.01.01 EP 3
4. Signs indicating that a patient is on transmission-based precautions are clear and visible.	IC.06.01.01 EP 3
5. If a patient is on transmission-based precautions and must leave their room for medically necessary purposes, there are methods and processes in place to communicate that patient's status and to prevent transmission of infectious disease.	IC.06.01.01 EP 3
6. A NIOSH-approved particulate respirator (N95 or higher) is worn by staff when entering the airborne infection isolation room (AIIR) for patients with confirmed or suspected TB. Hospital policies are followed for other pathogens requiring AIIR.	IC.06.01.01 EP 3
Temporary Invasive Medical Devices for Clinical Management	
1. Staff adhere to invasive medical devices insertion, maintenance, and discontinuation practices, in accordance with hospital policies and procedures. Note: Examples of invasive medical devices include vascular catheters, indwelling urinary catheter, ventilator.	IC.06.01.01 EP 3
2. The hospital follows its policies and procedures for appropriate indications for urinary catheters.	IC.06.01.01 EP 3
3. The hospital promptly removes any intravascular catheter that is no longer essential, in accordance with its policies and procedures.	IC.06.01.01 EP 3

Note: For the absence of policies and procedures, score IC.04.01.01 EP 3.	

Occupational Health	
1. The hospital implements policies and procedures to minimize the risk of communicable disease exposure and acquisition among its staff, in accordance with law and regulation. The policies and procedures address the following: - Screening and medical evaluations for infectious diseases - Immunizations - Staff education and training - Management of staff with potentially infectious exposures or communicable illnesses Note: For the absence of policies and procedures, score IC.04.01.01 EP 3.	IC.06.01.01 EP 5
2. The hospital has a respiratory protection program that details required worksite-specific procedures and elements for required respirator use.	IC.06.01.01 EP 5
3. Fit testing is provided at regular intervals to staff at risk.	IC.06.01.01 EP 5
4. Following an exposure incident, post-exposure evaluation and follow-up, including prophylaxis as appropriate, is available to the individual and performed by or under the supervision of a practitioner. Note: An exposure incident refers to a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that result from the performance of an individual's duties.	IC.06.01.01 EP 5
5. Hospital policies and procedures are followed for management of staff with potentially infectious exposures or communicable illnesses (for example, regarding contact with patients or food preparation and handling).	IC.06.01.01 EP 5
Hemodialysis Note: Infection prevention practices during hemodialysis procedure are performed in accordance with hospital policies and procedures including the following:	
1. Staff wear appropriate PPE (gloves, gowns, face, and eye protection) and perform hand hygiene throughout the procedure.	IC.06.01.01 EP 3
2. Staff perform appropriate central line care, including preparing catheter hubs prior to accessing for hemodialysis, connecting, and disconnecting from bloodlines after the procedure.	IC.06.01.01 EP 3
3. During the priming process, blood lines do not come into contact with contaminated prime waste.	IC.06.01.01 EP 3
4. For tasks requiring aseptic technique, the staff avoid contamination of gloves and other clean/sterile items, for example avoiding touching contaminated surfaces.	IC.06.01.01 EP 3
5. Environmental surface disinfection is performed, when no patient is present, including the following: a. The dialysis station b. Priming buckets c. Reusable equipment	IC.06.01.01 EP 3
6. Disposable supplies are discarded after the patient has departed the dialysis station in accordance with the local regulated medical waste law and regulation.	IC.06.01.01 EP 3
7. The hospital adheres to the policies and procedures to determine and document the hepatitis status of a dialysis patient. Note: For the absence of policies and procedures, score IC.04.01.01 EP 3	IC.06.01.01 EP 3

8. The hospital adheres to manufacturers' instructions and hospital policies and procedures for cleaning and disinfection of the dialysis machine used for the treatment of a patient with hepatitis B. Note: For the absence of policies and procedures, score IC.04.01.01 EP 4	IC.06.01.01 EP 3

Laundry & Linen Note: Laundry is processed in a manner consistent with law and regulation and hospital policies and procedures to maximize prevention of infection and communicable disease including the following:	
1. Soiled textiles/laundry are handled with minimum agitation to avoid contamination of air, surfaces, and persons.	IC.06.01.01 EP 3
2. Soiled laundry is contained in leak-proof bags or containers at the point of use. Note: Hamper covers are not required in patient care areas.	IC.06.01.01 EP 3
3. Healthcare textiles are protected from environmental contamination during transport and storage. Note: Textiles/linens are covered if stored in a clean area in the inpatient unit or may be uncovered if stored in a dedicated clean storage area.	IC.06.01.01 EP 3
4. The receiving area for contaminated textiles is clearly separated from clean laundry areas and is maintained at negative pressure compared with the clean areas of the laundry in accordance with FGI construction standards in effect during the time of facility construction.	PE.04.01.01 EP 3
Dietary Services/Kitchen Note: Practices for the prevention of foodborne infections and diseases are performed in accordance with the federal, state, and local codes, law and regulation on food operations, and hospital policies and procedures.	
1. The hospital has written policies and procedures on sanitary and hand hygiene practices for its dietary services and kitchen staff.	IC.04.01.01 EP 3
2. The hospital provides a clean and sanitary environment in food storage, preparation, serving, and dishware storage areas, consistent with law, regulation, and food sanitation code. Note: Examples may include: a. Cutting boards, prep surfaces, work areas, trays and equipment are cleaned properly to avoid contamination and sanitized between uses. b. Different cutting boards/prep surfaces are used for meat, vegetables, and other food items. c. Handwashing sinks are available. d. Sinks are clear of items that can be contaminated by splashes. e. Raw food and ingredients are prepared and stored in a manner that prevents cross contamination with other foods (for example, to avoid dripping, liquid pooling, splashing). f. Dishes and utensils are air dried and stored in a manner that prevents cross contamination. g. Food carts are sanitized after every meal. h. Wet wiping cloths are stored in an approved sanitizing solution and washed daily.	IC.06.01.01 EP 3
3. The dietary services and kitchen staff comply with hand hygiene practices.	IC.06.01.01 EP 3

4. The hospital prepares food and nutrition products using proper sanitation and temperature, including the following: a. Food service staff wear hair or beard coverings, in accordance with hospital policies and procedures, b. Food service staff adhere to hand hygiene in accordance with hospital policies and procedures. c. The hospital monitors the food's temperature for hot and cold items during meal service. d. The hospital maintains proper temperature of refrigerated or warmed foods during preparation. e. The hospital follows the proper process for thawing of foods. f. The hospital monitors final cooking temperatures.	CAH NPG.11.04.01 EP 1 HAP NPG.12.01.01 EP 8
5. The hospital stores food and nutrition products, including those brought in by patients or their families, using proper sanitation: a. Food is protected from contamination during storage. b. Food storage areas such as a refrigerator, cupboards, drawers, and bins are not soiled and protected from splashes and free of odors.	CAH NPG.11.04.01 EP 1 HAP NPG.12.01.01 EP 8
6. The hospital manages foodborne outbreak(s) and reports outbreak(s) to public health authorities, in accordance with law and regulation and hospital policies and procedures.	IC.06.01.01 EP 4
Surgical Services Note: Surgical services are performed in accordance with hospital policies and procedures including the following:	
1. Staff perform a surgical scrub before donning sterile gloves for surgical procedures using either an antimicrobial surgical scrub agent or an FDA-approved alcohol-based antiseptic surgical hand rub. After surgical scrub, hands and arms are dried with a sterile towel (if applicable), and sterile surgical gown and gloves are donned in the OR.	LD.13.03.01 EP 1
2. Staff in the surgical area adhere to aseptic and sterile technique.	LD.13.03.01 EP 1
3. Staff and visitors wear surgical attire (e.g., scrubs) and surgical caps/hoods covering all head and facial hair in semi restricted and restricted areas. Note: Restricted areas include ORs, procedure rooms, and the clean core (sterile supply) area. The semi restricted areas include the peripheral support areas of the surgical suite.	LD.13.03.01 EP 1
4. Surgical masks are worn fully covering the mouth and nose by all staff in restricted areas where open sterile supplies or scrubbed staff are located.	LD.13.03.01 EP 1
5. The sterile field is maintained, including the following: • Items used within the sterile field are sterile. • Items introduced into the sterile field are opened, dispensed, and transferred in a manner to maintain sterility. • The sterile field is prepared in the location where it will be used and as close as possible to time of use. • Movement in or around sterile field is done in a manner to maintain sterility.	LD.13.03.01 EP 1
6. Traffic in and out of the OR is kept to a minimum and limited to essential staff.	LD.13.03.01 EP 1
7. All horizontal surfaces (for example, furniture, surgical lights, booms, equipment) are damp dusted before the first procedure of the day using a clean, lint-free cloth and an EPA-registered hospital detergent/disinfectant.	LD.13.03.01 EP 1
8. High-touch environmental surfaces are cleaned and disinfected between patients.	LD.13.03.01 EP 1
9. ORs are terminally cleaned after the last procedure of the day (including weekends) and each 24-hour period during regular work week. Terminal cleaning includes wet-vacuuming or mopping the floor with an EPA-registered disinfectant.	LD.13.03.01 EP 1
10. Anesthesia equipment surfaces that are touched by staff while providing patient care or while handling contaminated items are cleaned and low-level disinfected between use on patients according to manufacturers' instructions.	LD.13.03.01 EP 1
11. Exterior surfaces of anesthesia equipment that are not knowingly contaminated during patient care are terminally low-level disinfected at the end of the day according to manufacturers' instructions.	LD.13.03.01 EP 1
12. Internal components of the anesthesia machine breathing circuit are cleaned per manufacturers' instructions and hospital policies and procedures.	LD.13.03.01 EP 1

13. Reusable noncritical items (for example, blood pressure cuffs, ECG leads, tourniquets, oximeter probes) are cleaned and disinfected between patients.	LD.13.03.01 EP 1

Imaging Document Review Guide

The following documents and data need to be made available to the surveyor for review, based on the imaging modalities provided by your organization. Note: It is not necessary for you to copy these documents for the surveyor, just ensure that they are available for review. This document will assist you with compiling those documents.

1. Facilities and Equipment:

   - ☐ Equipment quality control (QC) and performance maintenance (PM) activities for CT, MRI, PET, and NM equipment, with the dates completed (last 12 months) (NPG.13.03.01 EP 4)

   - ☐ CT annual equipment performance evaluation: NPG.13.03.01 EP 5
     Must be documented, done by medical physicist, and include:
     - Image uniformity
     - Slice thickness accuracy
     - Alignment light accuracy
     - Table travel accuracy
     - Radiation beam width
     - High contrast resolution
     - Low contrast resolution
     - Geometric or distance accuracy
     - CT number accuracy and uniformity
     - Artifact evaluation

   - ☐ MRI annual equipment performance evaluation: NPG.13.03.01 EP 6
     Must be documented, done by medical physicist or MRI scientist, and include
     - Image uniformity for all coils used clinically
     - Signal to noise ratio (SNR) for all coils used clinically
     - Slice thickness accuracy
     - Slice position accuracy
     - Alignment light accuracy
     - High contrast resolution
     - Low contrast resolution
     - Geometric or distance accuracy
     - Magnetic field homogeneity
     - Artifact evaluation

   - ☐ NM annual equipment performance evaluation: PE.05.01.01 EP 1
     Must be documented, done by medical physicist or nuclear medicine physicist, and include
     - Image uniformity / system uniformity
     - High contrast resolution / system spatial resolution
     - Artifact evaluation
     - Sensitivity
     - Energy resolution
     - Count rate performance

   - ☐ PET annual equipment performance evaluation: PE.05.01.01 EP 2
     Must be documented, done by medical physicist or nuclear medicine physicist, and include
     - Image uniformity / system uniformity
     - High contrast resolution / system spatial resolution
     - Low contrast resolution or detectability
     - Artifact evaluation

   - ☐ Image Acquisition Display Monitor Performance Evaluations for CT, MRI, NM, PET-PE.05.01.01 EP 3
     Must be performed as part of annual equipment performance evaluations and include:
     - Maximum and minimum luminance

- Luminance uniformity
- Resolution
- Spatial accuracy

Often documented in the CT, MRI, NM, PET, and Fluoro annual equipment performance evaluation

- CT Dose Verification NPG.13.03.01 EP 5
  - Annual report from medical physicist on the CTDI vol for adult and pediatric brain and abdomen protocols for each diagnostic CT imaging system

- Lead Apron Assessment PE.02.01.01, EP 4
  - Inventory and inspection for cracks, tears, integrity

2. Radiation Protection and Radiopharmaceutical Management

   Radiation Protection and Radiopharmaceutical Management
   - Records of radiopharmaceutical receipt and disposition MM.13.1.1 EP 6

3. Clinical Policies and Protocols
   - Critical Tests: Written procedures or protocols, and data collected on the timeliness of reporting critical results of tests and diagnostic procedures NPG.01.02.01 EP 1

   - CT Protocols: Protocols must be based on current standards of practice and address clinical indication, contrast administration, pediatric or adult, patient size and body habitus, expected radiation dose range. Must include input from interpreting physician, lead imaging technologist, and medical physicist and be reviewed at timeframes established by hospital NPG.13.2.1 EP 3

   - MRI Safety: Policies address: claustrophobia, noise protection, metal detection, patient emergencies while in scanner, restricting access to scanner for all people not trained in MRI safety NPG.12.03.01 EP 2 and EP 3
4. Reporting and Performance Improvement
   - Data collected on thermal injuries during MRI NPG.13.04.01 EP 1
   - Data collected on incidents and injuries where ferromagnetic objects unintentionally entered MRI scan room NPG.13.04.01 EP 1
   - Data collected on incidents where radiation dose (CTDIvol, DLP, SSDE) exceeded the expected range Identified in the imaging protocol NPG.13.04.01 EP 2

5. Staff Competencies
   - Credential files for all diagnostic medical physicists who work with CT. NPG.13.1.1 EP 2
   - Credential files including certification and annual training on dose optimization for CT techs NPG.13.1.1 EP 3
   - Credential files including annual training for all MRI techs on safe MRI practices NPG.13.1.1 EP 4

6. Leadership
   - Documentation / Radiology Director: must be a qualified MD or DO. MS.17.01.03, EP 5
   - Documentation / Nuclear Medicine: must be a qualified MD or DO. LD.13.1.7 EP 3
   - Documentation / Radiation Safety Officer: must be designated. NPG.13.2.1 EP 1
   - Documentation of Medical Staff Approval (usually at Med Exec Comm Meeting) for:
     Qualifications of radiology staff who use equipment and administer procedures MS.16.01.01, EP11
     Nuclear Medicine Director's specifications for the qualifications, training, functions, of nuclear medicine staff MS.16.01.01, EP 12

7. Medical Records:
   - Reports, including medical record number, documenting radiopharmaceutical dose received for 5 recent inpatients. RC.12.01.01, EP 2

- Reports, including medical record number, documenting contrast dose and radiation dose for 5 recent inpatients. RC.12.01.01, EP 2
- Reports, including medical record number, documenting fluoroscopy radiation dose for 5 recent inpatients. RC.12.01.01 EP 2

Performance Improvement Evaluation Tool

Use this tool as a checklist to verify that data is being collected on the items below. This review should be performed prior to conducting the Organization Quality and Performance Improvement group interview. Surveyor(s) will inform the hospital staff of the specific PI activities, projects, and proactive monitoring activities that will be discussed during the interview.

QAPI Program Attributes					
Evaluation of	**Compliance Met/Not Met Notes**	**JC HAP**	**JC CAH**	**HAP CoP**	**CAH CoP**
☐ Quality assurance/performance improvement (QAPI) program **documents** to verify the program meets the following requirements: ○ Includes processes for systematically examining the quality of care delivered and implementing specific improvement projects on an ongoing basis ○ Facilitates the continuous study and improvement of processes and service delivery ○ Takes a proactive approach to improve their performance (for example, the hospital analyzes risks and near misses, and focuses on prevention and reduction of future errors or adverse events) ○ Is based on, and reflects, the size and complexity of the organization and services ○ Is hospital wide (including services under contract or arrangement) ▪ All hospital departments and services are included in the QAPI program		**LD.11.01.01, EP 8** **LD.12.01.01, EP 1** **PI.14.01.01, EP 1**	**LD.12.01.01, EP 1** **LD.11.01.01, EP 8** **PI.11.01.01, EP 1**	**482.21**	**485.641(a)** **485.641(b)(1)** **485.641(b)(2)** **485.641(b)(3)** **485.641(b)(4)** **485.641(b)(5)** **485.641(c)**

▪ Documentation shows participation by all contracted services ▪ Written contracts include QAPI requirements and roles and responsibilities of the contractor ☐ Is data driven ▪ Documentation indicates which data are used to make QAPI program decisions ☐ Focuses on quality indicators or measures related to improved health outcomes, as well as the prevention and reduction of medical errors ○ Does the program focus on nonclinical measures, such as employee satisfaction data, as opposed to clinical measures, such as infection control incidence rates and/or nationally recognized quality indicators? ☐ Evidence of continuous data collection (or collection of data on an ongoing basis), data analysis (with identified areas for improvement), and implementation of changes, including ongoing monitoring of changes for effectiveness. ☐ Evidence that the governing body is engaged in oversight of QAPI program ☐ Evidence of services provided under an arrangement or contract are included in its QAPI program.					

Data Collection & Analysis					
Evaluation of	**Compliance Met/Not Met Notes**	**JC HAP**	**JC CAH**	**HAP CoP**	**CAH CoP**
□ Ask QAPI staff to provide a list of the quality indicators they are currently tracking. Verify that the o List includes the tracking of adverse events. o Quality indicator data include patient care data and other relevant data, such as that received from Medicare quality reporting (hospital readmissions and hospital-acquired conditions) and performance programs. o Quality indicators are reflective of the hospital's patient population. □ Ask QAPI staff to provide evidence (measurement data) of measurable improvements in the quality indicators it has selected for its program. o Verify that improvements are ongoing (several data analyses showing improvement over time) and not just one-time events. o If the evaluation did not show improvements or sustained improvements, is there evidence that the hospital implemented a revised or new solution? □ Ask to see evidence that the governing body has specified the frequency and detail of QAPI program data collection.		**LD.12.01.01, EP 2** **PI.11.01.01, EP 2** **PI.12.01.01, EP 3**	**LD.12.01.01, EP 2** **PI.11.01.01, EP 2** **PI.14.01.01, EP 1**	**482.21(a)** **482.21(b)** **482.21(b)(1)** **482.21(b)(2)(i)** **482.21(b)(3)**	**485.641(d)(1)** **485.641(d)(2)** **485.641(d)(3)** **485.641(e)**

○ Look at governing body meeting minutes. ○ Do QAPI program reviews include this information? □ Verify that the hospital is using the data being collected to monitor the safety and quality of care. ○ Select a sample of data being collected and ask the governing body or other appropriate leaders to explain how the collection of the particular data is used to monitor quality and safety. □ Verify that the hospital is using the data being collected to identify opportunities for improvement. ○ Select a sample of data being collected and ask the governing body or other appropriate leaders to give examples of how the specific data has identified opportunities for improvement. ○ Ask to see documented evidence of the opportunities the hospital has identified for improvement based on the collection of data.					
Quality Improvement Activities					
Evaluation of	**Compliance Met/Not Met Notes**	**JC HAP**	**JC CAH**	**HAP CoP**	**CAH CoP**
□ A list of current or recent performance improvement activities. ○ Ask about the actions taken, post action measurement to		**LD.12.01.01, EP 2**	**LD.12.01.01, EP 2** **LD.11.01.01**	**482.21(b)(2)** **482.21(b)(2)(ii)**	**485.641(d)(1)** **485.641(d)(2)**

determine improvement, and measurement to determine sustained improvement. o Evidence that the hospital tracks data for the identified indicators, which may include but are not limited to **blood product transfusion reactions, drug reactions, errors in medication administration**, and **infection control–related errors and events**. □ Ask the governing body or the leaders who oversee the QAPI program to provide evidence o That its improvement activities are focused on **high-risk, high-volume, or problem-prone areas**. o Does it have any data (either derived from its own QAPI data collection or public data) **on incidence, prevalence**, or **severity** to support its choices? o Does it have evidence that the activities **affect health outcomes** through improving quality of care or patient safety?		**PI.12.01.01, EP 4** **PI.14.01.01, EP 1**	**EP 8**	**482.21(c)(1)** **482.21(c)(3)**	**485.641(d)(3)** **485.641(e)** **485.641(c)**
Patient Safety, Medical Errors & Adverse Events					
Evaluation of . . .	**Compliance Met/Not Met Notes**	**JC HAP**	**JC CAH**	**HAP CoP**	**CAH CoP**
□ Verify that the hospital has a medical error and adverse patient event reporting policy. □ Select a sample of several **(at least three)** adverse events or errors the hospital has tracked and ask to see written evidence showing that it has used a		**PI.11.01.01, EP 2** **PI.12.01.01, EP 1** **PI.12.01.01, EP 3**		**482.21(a)(1)** **482.21(a)(2)** **482.21(c)(2)** **482.21(e)(3)**	

systematic approach (for example, root cause analysis) to ○ Analyze the cause of the events and errors, ○ Implement changes based on the identified causes to prevent further events or errors, ○ Conduct periodic data collection to verify if the changes resulted in improvements, and ○ Analyze the post-implementation data to assess whether the improvement (if there was an improvement) was sustained over time. □ Ask QAPI staff for a demonstration of the system and explain how the system is able to organize the reported data for meaningful analysis. ○ Can the system organize the data by type of error or adverse event, and by actual or near misses? ○ Can the system organize the data by dates to show trends over time? ○ Can the system organize the data by shift, by unit where the error occurred, and so on? *During inpatient/outpatient tracer activities:* □ Look for evidence of the medical error/adverse event reporting system. *During HR/Competency/MedStaff Review* □ Look for evidence of hospital-wide staff education and training		**LD.12.01.01, EP 3**			

regarding what errors and adverse events must be reported and how to report them. Review the materials used for education and training. o Are there records to show staff received the training? *Please refer to SPG Module 482.21 for *Prospective hospitals applying for initial certification in Medicare*					
Performance Improvement Projects					
Evaluation of	**Compliance Met/Not Met Notes**	**JC HAP**	**JC CAH**	**HAP CoP**	**CAH CoP**
□ Ask QAPI leader and staff to provide a list of distinct performance improvement projects it is currently conducting and has conducted within the last three years to verify that the hospital is conducting annual QAPI projects. □ Ask to see documentation showing why each project was conducted and evidence to support the progress being made on each project. □ Ask the governing body or responsible leaders to explain how the selection (number and scope) of the specific projects is in alignment with the hospital's complexity and the scope of services it provides. □ Consider the size of the facility and the intensity of its services, such as critical care services/units, complex surgeries,		**PI.11.01.01, EP 3** **PI.12.01.01, EP 2** **PI.14.01.01, EP 1**		**§482.21(d)**	

transplant services, maternal/child health services, and oncology services, including radiation and chemotherapy.					
Executive Responsibilities					
Evaluation of	**Compliance Met/Not Met Notes**	**JC HAP**	**JC CAH**	**HAP CoP**	**CAH CoP**
Ask to see **evidence** that the governing body, hospital CEO, medical staff (or its executive committee), and other administrative officials are **providing oversight** for the QAPI program. o Are there QAPI **meeting minutes** that document their attendance? o Do the governing body **meeting agendas** provide evidence that the QAPI program has been addressed? o Do the governing body meeting minutes include evidence of QAPI discussions? o Are there documents such as annual QAPI program reviews that include signatures from the governing body? □ Ask to see **evidence** that the governing body, medical staff (or its executive committee), and administrative officials do the following: o Approve the number of distinct QAPI projects to be conducted annually. o Review the results of QAPI data collection, analyses, activities, and projects and make decisions based on such review.		**LD.12.01.01, EP 3** **PI.14.01.01, EP 1**	LD.11.01.01 EP 8	**§482.21(e)**	485.641(c)

☐ For those services the hospital provides under arrangement or contract, ask to see **evidence that the contractor is actively involved in the QAPI program.** ○ Do the governing body, medical staff, and administrative officials periodically receive and review **quality data from the contractor**? ○ Is the contracted service involved in any current or past hospital QAPI projects? ○ Does the contract or agreement include the hospital's expectations regarding the **contractor's roles and responsibilities for QAPI**? ○ Does the data from the contractor demonstrate positive outcomes related to the services provided? *During inpatient/outpatient tracer activities:* ☐ Ask staff if they are aware of the hospital's expectations for safety and how they learned about these. ○ Do they know their roles and responsibilities in quality assessment and performance improvement?					
Providing Adequate Resources					
Evaluation of	**Compliance Met/Not Met Notes**	**JC HAP**	**JC CAH**	**HAP CoP**	**CAH CoP**
Document Review **General**		**LD.12.01.01 , EP 3**		**482.21(e)**	

□ Ask QAPI leader and staff to see detailed evidence of the resources (for example, staff, staff time, education, information systems) that are provided to support required QAPI functions. □ For QAPI services provided under contract, ask to see evidence that contracted services have been incorporated into the QAPI program and that there is governing body oversight of these services and the QAPI program. **Personnel/Credential File** □ Ask to see evidence that staff are qualified to engage in their respective QAPI responsibilities. o Have all staff been educated and trained on how to report errors and adverse events? o Have staff who are required to conduct data collection and analysis received training or possess experience in these functions?					
Unified and integrated QAPI program for multi-hospital systems					
Evaluation of	**Compliance Met/Not Met Notes**	**JC HAP**	**JC CAH**	**HAP CoP**	**CAH CoP**
If the hospital is part of a multihospital system: □ Ask if there are any descriptions of the unified and integrated QAPI program. o Does the program include governing body expectations for each certified hospital? o Does it take into account each member hospital's unique circumstances and any significant differences in		**LD.11.01.01, EP 9**	**LD.11.01.01, EP 9**	**482.21(f)** **482.21(f)(1)** **482.21(f)(2)**	**485.641 (f)**

patient populations and services offered in each hospital? □ Ask to see policies and procedures that guide the unified and integrated QAPI program to ensure that the following requirements are met: o The needs and concerns of each separately certified hospital, regardless of practice or location, are given due consideration. o The unified and integrated QAPI program has procedures in place to ensure that issues localized to particular hospitals are duly considered and addressed. □ Ask to see reports provided to the governing body about QAPI performance. o Do such reports reveal the performance of each certified hospital? □ Ask staff if their system governing body has elected to have a unified and integrated QAPI program. o Did the system check state and local laws to determine if a unified program was acceptable? □ Ask leaders and QAPI staff at each individual hospital how they participate in the unified and integrated program and if it addresses their unique circumstances.					

Emergency Management (EM) Discussion Tool

This EM Discussion Tool complements the EM Documentation Review tool and is intended to provide an overview of EM-discussion and related topics

Introduction of EM Leadership & other Team Members

Interview

- ☐ Ask participants to introduce themselves and briefly describe their role in emergency planning and preparedness and their role in incident command (if applicable). (not scored)
- ☐ Ask who has **authority and oversight of the EM program** and ask them to describe how they support the EM program and program lead. (NPG.03.01.01, EP 1)
- ☐ Ask leaders to describe how the **EM (or similar) committee** is defined and represented (NPG.03.01.01, EP 3) and how the committee plans, evaluates, and maintains the EM program (NPG.03.01.01, EP 4)

Personnel/Credential File

- ☐ Review the EM program lead's job description, qualifications, and responsibilities (NPG.03.01.01, EP 2)

Part 1: EM Program and Hazard Vulnerability Analysis (HVA)

CMS CoP 482.625 & 482.625 (a) 1-2

Interview

- ☐ Ask leaders to describe the hospital's **emergency preparedness program** and how the hospital used an all-hazards approach when developing its program. (EM.09.01.01, EP 1)
- ☐ Ask leaders to **identify the hazards** (for example, natural, human-made, facility, geographic) that were identified in the hospital's **risk assessment** and how the risk assessment was conducted. (EM.11.01.01, EP 2)

Document Review

- ☐ See Part 1 - required written documentation in the Documentation Review Tool to assess compliance with EPs

Part 2: Emergency Operations Plan (EOP)

CMS CoP 482.625 (a) 3-4

Interview

- ☐ Ask leaders to describe plans for the following:
  - The **patient populations** that would be at risk during an emergency event (EM.12.01.01, EP 2)
  - **Services they will continue to provide**, services that cannot be provided, and plans for continued operations during an emergency or disaster incident. (EM.13.01.01, EP 1)
  - **Succession plans** (EM.13.01.01, EP 3) and process for **delegating authority** (EM.13.01.01, EP 4)

- ☐ Ask leaders to describe their process for **cooperation and collaboration** with local, tribal, regional, state, and federal emergency preparedness officials (EM.12.01.01, EP 6)

- ☐ Ask leaders to describe the **incident command structure** (NPG.03.02.01, EP 1)
  - Activation procedures (NPG.03.02.01, EP 2)
  - Primary and alternate command sites (NPG.03.02.01, EP 3).

Document Review

- ☐ See Part 2 - required written documentation in the Documentation Review Tool to assess compliance with EPs

Part 3: EM Policies and Procedures
CMS CoP 482.625 (b) & 482.625 (b) 1-8

Interview

- ☐ Ask leaders to describe policies/procedures for the following:
  - Providing **subsistence needs** for staff and patients (food, water, medical, pharmaceutical supplies) (EM.12.01.01, EP 4)
  - How they **monitor and track resources** needed during an emergency (EM.12.02.09, EP 1) and how the plan to replenish or conserve resources during an emergency (EM.12.02.09, EP 2)
- ☐ Ask leaders to describe policies/procedures for the following:
  - **Shelter in place and evacuation** procedures (EM.12.01.01, EP 3)
  - **Coordinating care/transferring** to other hospitals (transportation arrangements, care considerations, staff responsibilities, evacuation locations). (EM.12.02.05, EP 1)
  - Role in providing care at **alternate care sites (1135 waiver)** (EM.12.01.01, EP 7)
  - **Tracking systems** used to locate patients and staff. (EM.12.02.07, EP 2)
- ☐ Ask leaders to describe staffing strategies:
  - Use of **volunteers or emergency staffing** agencies for surge events? (EM.12.02.03, EP 1)
  - Procedures for reporting in, **roles and responsibilities**, integration of staffing agencies (EM.12.02.03, EP 2)
  - Managing **volunteer licensed practitioners** (NPG.03.02.03)
    - Documenting/ verifying and licensure primary source verification (EP 1)
    - Granting disaster privileges to disaster volunteer physicians (EP 2)
  - **Supporting staff needs** (housing, transportation, family support needs, mental health and wellness) (NPG.03.02.03, EP 3)
- ☐ Ask leaders to describe policies/procedures for the following:
  - **Managing non-ill & non-injured persons** presenting during a disaster (NPG.03.02.04, EP 1)
  - Coordination with local mortuaries/medical examiners **surge of unidentified or deceased** patients. (NPG.03.02.04, EP 2)
  - Coordinating and planning **safety and security** during an emergency (NPG.03.02.05, EP 1)
  - Planning for **96-hour sustainability** of resources and assets (NPG.03.02.06, EP 1)
  - Planning for **disaster recovery** assessments and restoration (NPG.03.03.01, EP 1)
  - **Family reunification** procedures (NPG.03.03.01, EP 2)

Document Review

- ☐ See Part 3 - required written documentation in the Documentation Review Tool to assess compliance with EPs

Part 4: Communications Plan
CMS CoP 482.625 (c) & 482.625 (c) 1-7

Interview

- ☐ Ask leaders to describe communications plan and procedures as follows:
  - How they maintain **contact lists** (EM.12.02.01, EP 1)
  - How they **communicate with relevant authorities** & provide occupancy (EM.12.02.01, EP 3)
  - Methods for **sharing / releasing** patient information (EM.12.02.01, EP 4)
  - **Primary and alternate** methods for communicating (EM.12.02.01, EP 5)
  - Providing coordinated messages to staff, patients, external stakeholders (NPG.03.02.02, EP 1)
  - Use of warning and notifications procedures specific to emergencies or disaster incidents (NPG.03.02.02, EP 2)

Document Review

- ☐ See Part 4 - required written documentation in the Documentation Review Tool to assess compliance with EPs

Part 5: EM Training and Testing (Exercises)

CMS CoP 482.625 (d) & 482.625 (d) 1-2

Interview

- ☐ Ask the following related to the education and training program:
  - Ask leaders to describe the EM education and training program (EM.15.01.01, EP 1)
  - Ask various staff about the hospital's **initial education & training received**-verify staff knowledge (EM.15.01.01, EP 2)
  - Ask various staff about **ongoing education & training received** (at least every 2 years) (EM.15.01.01, EP 3)
  - Ask leaders with **incident command** responsibilities to describe **education and training** they have received (NPG.03.04.01, EP 1)
- ☐ Ask the following related to emergency preparedness exercises:
  - Ask leaders to describe the annual exercises they are **planning** to conduct, why they were selected, and how staff and management are involved (EM.16.01.01, EP 1)
  - Discuss the previously documented **annual exercises** (at least 2 exercises per year) (EM.16.01.01, EP 2); *and*
  - Discuss exercises conducted at the freestanding outpatient care buildings (if applicable)
  - Note: one exercise per year is required to test staff roles/responsibilities at these sites (NPG.03.05.01, EP 1)
- ☐ In response to an emergency or disaster incident (real or simulated), ask leaders to describe their role in **evaluating after-action reports**, identified opportunities for improvement, and recommendations needed to improve the EM Program (NPG.03.06.01, EP 1)

Document Review

- ☐ See Part 5 - required written documentation in the Documentation Review Tool to assess compliance with EPs

Personnel/Credential File

- ☐ Review a sample of staff training files to verify that staff have received initial and subsequent (at least every 2 years) emergency preparedness training. Note: For ease of demonstrating compliance that the hospital has updated its training program at least every 2 years, hospitals should retain, at a minimum, the past 2 cycles (generally 4 years) of emergency training documentation for both training and exercises.

Part 6: Emergency Generator and Fuel

CMS CoP 482.625 (e) & 482.625 (e) 1-3

Interview

- ☐ Ask hospital or facility leaders to describe how they determined the **emergency power and stand-by systems** based on their risk assessment /HVA. (EM.12.02.11, EP 1)

- ☐ Ask hospital or facility leaders to describe
  - How they monitor and track **onsite fuel sources** (EM.12.02.09, EP 1) to power emergency generators and how they will **replenish** fuel sources (EM.12.02.09, EP 2)
  - Plans for how they will **keep emergency power systems operational** (EM.12.02.11, EP 3) during the duration of emergencies, unless it evacuates.
  - Providing **alternate sources of energy** to maintain temperatures, emergency lighting, fire detection systems and sewage/waste disposal (EM.12.02.11, EP 4)

Document Review

- ☐ See Part 6 - required written documentation in the Documentation Review Tool to assess compliance with EPs

Part 7: Integrated Healthcare Systems (if applicable)
CMS CoP 482.625 (f) & 482.625 (f) 1-4

Interview

- ☐ Verify if the hospital has opted to be part of its health care system's unified and integrated emergency preparedness program **(EM.09.01.01, EP 2)**
- ☐ Ask leaders to describe how the program is updated (at least every 2 years) based on changes within the health care system **(EM.17.01.01, EP 3)**

Document Review

- ☐ See Part 7 - required written documentation in the Documentation Review Tool to assess compliance with EPs

Emergency Management (EM) Documentation Review Tool – HAP/CAH

This EM Documentation Review Tool complements the EM Discussion Tool and is intended to provide a checklist of required written documentation

Assessment Item	Applicability	Joint Commission Standards	CMS CoP	Comments
Part 1: Emergency Management Program				
☐ Written emergency management program (may be incorporated with EOP or other policies and procedures) (See listed items to ensure comprehensive program requirements)	All hospitals and CAHs	**EM.09.01.01, EPs 1 & 3**	HAP 482.15 CAH485.625	**Current Review Date:** _____ **Updated at least every 2 years? (EM.17.01.01, EP 3)** **Yes No**
Part 1: Hazard Vulnerability Analysis (HVA)				
☐ Written all-hazards HVA that include: ☐ Facility-based and community-based risk assessment ☐ Strategies for addressing events identified by the risks ☐ HVA includes All-hazards: • Natural hazards • Human-caused hazards • Technological hazards • Hazardous materials • Emerging infectious diseases	All hospitals and CAHs	**EM.11.01.01, EPs 1-4**	HAP 482.15 (a)(1) - (a)(2) CAH485.625 (a)(1) - (a)(2)	**Current Review Date:** _____ **Updated at least every 2 years? (EM.17.01.01, EP 3)** **Yes No**
Part 2: Emergency Operations Plan (EOP)				
☐ Written EOP that include: • Addresses patient population & persons at-risk • Type of services provided in an emergency • Continuity of operations • Delegation of authority • Leadership succession • Cooperation and collaboration with external authorities	All hospitals and CAHs	**EM.12.01.01, EPs 1 -2 & 6** **EM.13.01.01, EPs 1-4**	HAP 482.15 (a), (a)(3) - (a)(4) CAH485.625 (a), (a)(3) - (a)(4)	**Current Review Date:** _____ **Updated at least every 2 years? (EM.17.01.01, EP 3)** **Yes No**
Part 3: EM Policies and Procedures				
☐ Written Policies & Procedures that include: ☐ Provision of subsistence needs for staff and patients • food, water, medical and pharmaceutical supplies ☐ Alternate sources of energy to maintain: • temperatures to protect patient health & safety & safe and sanitary storage of provisions • emergency lighting, • fire detection, extinguishing and alarm systems ☐ Sewage and waste disposal ☐ System to track location of on-duty staff and sheltered patients	All hospitals and CAHs	**EM.12.01.01, EPs 1, 3, 4 & 7** **EM.12.02.01, EP 5** **EM.12.02.03, EPs 1 & 2** **EM.12.02.05, EP 1** **EM.12.02.07, EP 2** **EM.12.02.11,**	HAP 482.15 (b), (b)(1) – (b)(8) CAH485.625 (b), (b)(1) - (b)(8)	**Current Review Date:** _____ **Updated at least every 2 years? (EM.17.01.01, EP 3)** **Yes No**

Assessment Item	Applicability	Joint Commission Standards	CMS CoP	Comments
☐ Safe evacuation from the hospital (needs of evacuees, staff responsibilities, transportation, evacuation location(s) ☐ Means to shelter in place ☐ System of medical documentation to preserve PHI ☐ Use of volunteers and other staffing strategies ☐ Arrangements and/or agreements with other hospitals and providers to receive patients if needed ☐ Role of the hospital in providing care and treatment at alternate care sites under an 1135 waiver		**EP 4** **IM.11.01.01. EP 1** **PE.03.01.01, EP 4**		
Part 4: Communications plan				
☐ Written communication plan that includes: ☐ Names & contact information for: • Staff • Entities providing services under arrangement • Patient physicians • Other hospitals • Volunteers ☐ Contact information for: • Federal, state, tribal agencies • Other sources of assistance ☐ Primary and alternate means for communicating with: • Hospital staff • Federal, state, tribal agencies ☐ Method for sharing information & medical documentation with other healthcare providers ☐ Means of providing/releasing information under 45 CFR 164.510(b)(1)(ii) ☐ Means of providing information about occupancy needs and ability to provide assistance	All hospitals and CAHs	**EM.09.01.01, EP 3** **EM.12.01.01, EP 1** **EM.17.01.01, EP 3** **EM.12.02.01, EPs 1, 3 - 5** **EM.12.02.05, EP 1**	HAP 482.15 (c), (c)(1) – (c)(7) CAH485.625 (c), (c)(1) - (c)(7)	**Current Review Date:** _____ **Updated at least every 2 years? (EM.17.01.01, EP 3)** **Yes No**
Part 5: EM Education & Training				
☐ Written education and training program Documented education & training occurs: ☐ Initially to all new/existing staff, those providing services under contract, volunteers ☐ At least every 2 years ☐ Staff demonstrate knowledge in EM procedures ☐ Conducts training when: • When roles & responsibilities change	All hospitals and CAHs	**EM.15.01.01, EPs 1, 2, 3** **EM.16.01.01, EP 1**	HAP 482.15 (d), (d)(1) - (d)(1)(v) CAH485.625 (d), (d)(1) - (d)(1)(v)	**Current Review Date:** _____ **Updated at least every 2 years? (EM.17.01.01, EP 3)** **Yes No**

Assessment Item	Applicability	Joint Commission Standards	CMS CoP	Comments
• When significant revisions are made to P&Ps • When procedural changes are made during an event				
Part 5: EM Testing (Exercises)				
☐ Two annual emergency exercises are documented and conducted as follows: ☐ Participation in one operational-based exercise (full-scale community (if avail) or a functional facility-based) ***and*** ☐ One additional exercise of choice operations-based or discussion-based ☐ Has exemption from conducting its next operations-based exercise due to a real event in which the EOP was activated	Applies to all hospitals and CAHs	**EM.16.01.01, EP 2**	HAP 482.15 (d)(2) - (d)(2)(ii)(C) CAH485.625 (d)(2) - (d)(2)(ii)(C)	**Exercise Date(s) #1** **Exercise Date(s) #2** **Additional Exercise Date(s):**
Part 5: EM Program Evaluation				
☐ Documents and reviews of all emergency exercises, emergency or disaster incidents (After-action reports) ☐ Documentation, review, & update of improvement plans, actions taken, and any revisions made to plans/policies and procedures	Applies to all hospitals and CAHs	**EM.17.01.01, EP 1**	HAP 482.15 (d)(2)(iii) CAH485.625 (d)(2)(iii)	**Current Review Date:** _____ **Updated at least every 2 years? (EM.17.01.01, EP 3)** **Yes No**
Part 6: Emergency & Standby Power Systems (may be incorporated with LS document review/LS building tour)				
☐ A written plan for managing essential or critical utilities during an emergency that includes: • Emergency & standby power systems • Emergency generator location • Emergency generator inspection & testing • Emergency generator fuel source	Applies to all hospitals and CAHs	**EM.12.02.09, EPs 1 - 2** **EM.12.02.11, EPs 1–3** **PE.03.01.01, EP 3** **PE.04.01.01, EP 1** **PE.04.01.03, EP 3**	HAP 482.15 (e)(1) - (e)(3) CAH485.625 (e)(1) – (e)(3)	**Current Review Date:** _____ **Updated at least every 2 years? (EM.17.01.01, EP 3)** **Yes No**
Part 7: Unified and Integrated EM Program (if applicable)				
If hospital is part of health care system and chooses to participate in a unified and integrated emergency management program: ☐ Program accounts for the hospital's unique circumstances, patient population, and services offered	Applies to Hospitals and CAHs that are part of a system that has a unified	**EM.09.01.01, EPs 2-3** **EM.11.01.01, EPs 3-4**	HAP482.15 (f), (f)(1) - (f)(5)	**Current Review Date:** _____ **Updated at least every 2 years? (EM.17.01.01, EP 3)**

Assessment Item	Applicability	Joint Commission Standards	CMS CoP	Comments
☐ Documented community-based & individual facility-based risk assessment ☐ Unified and integrated EOP ☐ Integrated P&Ps ☐ Coordinated communication plan ☐ Training and testing program ☐ Reviews and evaluates exercises and emergency events ☐ Documentation of improvement plans, actions taken, revisions to plans/policies and procedures	and integrated EM program	**EM.12.01.01, EPs 1, 2 & 6** **EM.13.01.01, EPs 1-4** **EM.15.01.01, EP 1** **EM.16.01.01, EP 1**	CAH485.625 (f), (f)(1) - (f)(5)	**Yes No**

Program Specific Tracer – Suicide Prevention, including Ligature and Other Safety Risks Assessment

Applies to: **Critical Access Hospital accreditation program, including psychiatric distinct part units**

Duration
60 minutes (takes place as part of an individual tracer)

Participants

Clinical surveyors
Life Safety Code® Surveyor

Organization:

- Staff who have been involved in the individual's care, treatment, or services
- Facility manager(s)
- Safety Management Coordinator
- Nurse Leader or chief nursing officer
- Medical Director or chief medical officer

See revised elements of performance at NPG.08.01.01

Rationale:
The rate of suicide is increasing in America.[1] Now the 11th leading cause of death,[2] suicide claims more lives than traffic accidents[3] and more than twice as many as homicides.[4] At the point of care, providers often do not detect the suicidal thoughts (also known as suicide ideation) of individuals (including children and adolescents) who eventually die by suicide, even though most of them receive health care services in the year prior to death,[5] usually for reasons unrelated to suicide or mental health.[5-7] Timely, supportive continuity of care for those identified as at risk for suicide is crucial, as well.[8]

Objectives-

The surveyor will do the following:

- Evaluate the effectiveness of the organization's suicide prevention strategy.
- Identify process and system level issues contributing to suicide attempts and/or death by suicide.
- Evaluate the effectiveness of the organization's processes for designing and maintaining buildings and the patient care environment in a manner to prevent suicides and self-harm behaviors.
- Evaluate the effectiveness of the organization's processes for identifying, assessing, and resolving or mitigating ligature, suicide, and self-harm risks present in the environment.
- Assess the organization's ability to implement and maintain activities to mitigate against environmental risks, through clinical program activities such as suicide risk assessment, precautions, one-to-one monitoring when appropriate, contraband searches, patient observation checks, etc.
- Educate the organization on potential actions to take to address any identified ligature or suicide and self-harm vulnerabilities. All TJC resources can be found at www.jointcommission.org, Knowledge Library> Resource Centers > Suicide Prevention.

Before

- Determine where patients are being treated for psychiatric conditions or may be at risk for suicide or self-harm within the hospital.
  - Dedicated spaces are those used only for psychiatric care, this includes locked, Psychiatric Inpatient Units, and may include temporary housing in the Emergency Department or other inpatient care areas that are dedicated for use for psychiatric care as determined by the organization.
  - Non-dedicated spaces include all other units/areas that may treat or house a patient at high risk for suicide.

- The following items are needed for this activity:
  - Risk assessment(s) for environment and existing mitigation plans for any dedicated space. Plan/process to remove non-essential items for non-dedicated spaces.
  - Related policies on patient safety and suicide risk assessment and treatment
  - Any state or national guidelines they are using in the risk assessment process

- Together, identify any questions the team needs answers to, based on review of the risk assessment(s), mitigation plans, policies on patient safety and suicide risk assessment, and state or national guidelines the organization is using. Determine a strategy to gather the needed information.

- Plan interaction and communication with the entire team during survey to review any ligature, suicide, or self-harm issues or unusual observations identified.

During

Life Safety and clinical surveyors will determine how to best explore these issues, either as a team or by splitting up, to perform individual tracers and continuing the building tour.

Life Safety Surveyor

- Dedicated Spaces: Assess ligature (patient rooms/bathrooms), and other suicide and self-harm safety risks (all areas accessible to patients) during the building tour activity. Trace their presence back through the organization's environmental risk assessment.
- Non-dedicated spaces: Assess plan/process to prepare a room or space for a high-risk suicidal patient, including who is responsible, what items should be removed and resources available to guide staff. Validate compliance.

Clinical Surveyor

- Select a patient who:
  - Currently receiving services AND
  - is identified as a high risk for suicide OR
  - had a previous attempt at suicide

- Review the patient record to attain an understanding of services provided and patient specific issues.
- Interview the clinical staff working with the patient and explore the following issues:
  - Triage process – trace this patient from the time the organization is first involved with the patient.
  - Initial Screen and Assessment process –comprehensively trace from the initial risk screening and assessment through to treatment planning with a focus on mitigation strategies.
  - Reassessment process – trace the triggers for and frequency of reassessment of the risk for suicide as defined in policy and implementation of same.
  - Care planning process – trace from the assessment through to the individualization of care planning, including mitigation strategies relative to suicide risk and preventative care.
  - Continuum of care – evaluate the communication and coordination process with other staff, family, and significant others involved with care relative to the patient's level of suicide risk.

  - Education - evaluate education provided to the patient and family about ongoing care with respect to the suicide risk, including information for crisis situations.
  - Human Resource components – evaluate orientation, training and competency assessment of staff who care for patients at risk for suicide based on job duties and responsibilities.

  - Interview other staff, (e.g. security, counselors) and ask about their training and processes related to caring for suicidal patients.

- Staffing – trace from staffing levels through to implementation of the organization's safety observations to evaluate adequacy of staffing patterns to support mitigation plans.

After

- Consider the pervasiveness of identified issues and evaluate possible systems issues.
- Trace specific aspects of care, treatment and services for other patients/individuals served, as applicable, to evaluate extensiveness of identified problems
- Seek additional information, such as assessments of other high-risk patients, the organization's history of patient safety events and the process for root cause analysis, or the process for monitoring compliance with its own policies, if necessary, during an Issue Resolution session.
- Discuss findings with the organization at the conclusion of the tracer activity and/or at the next daily briefing.

Documentation Instructions

- For dedicated spaces, the surveyor will document observations of ligature risks identified in patient rooms or bathrooms if they have not been identified on the risk assessment or self-harm or safety risks if they have not been identified on the risk assessment at NPG.08.01.01 and CoP 482.13 following the standard procedure using quantification, precise description, and all required elements of documentation.
- Clinical and Life Safety surveyors will collaborate on an analysis of ligature, suicide, and self-harm risks observed during the survey. Note: This analysis must be completed while the team is present on-site.
    - Evaluate existing plans the facility has for removing these risks.
    - Evaluate the organization's environmental risk assessment process.
- If the organization attempts to correct findings during the survey, the review of the corrective action must include:
    - The actions taken to remove risks in total, or
    - The mitigation plan the organization is implementing.
- Findings of ligature, suicide, or self-harm will be evaluated according to the SAFER rating methodology in terms of Likelihood to Harm and Scope.
    - Risks have been identified, but not yet mitigated, and what actions have been implemented to operationally mitigate the risk.
    - Stratify level of risk based on identifying high, moderate, and low hazardous areas, such as private rooms, and out of sight areas such as stair enclosures, and places where patients may be alone, versus common use areas where staff are present.
- The survey team and organization will discuss all the mitigating efforts available and determine which will be implemented until the deficiency has been resolved. **This plan for mitigation of the risks on an interim basis must be documented as part of the requirement for improvement (RFI).**
- **Condition-Level Deficiencies: Level of deficiency is evaluated based on manner (prevalence) and degree (level of risk) of both environmental and clinical deficiencies.**
- **Immediate Threat to Life Consideration:** If the survey team has concerns about the organization's ability to put effective clinical or environmental mitigation in place, then the process for evaluating an ITHS should be initiated (contact SIG on call).

Workplace Violence Evaluation Tool

This is a guide to addressing the Workplace Violence Prevention requirements during the survey.

PRE-SURVEY: Gather and Review

Review all pertinent documents submitted or provided by the organization.

Standard NPG.02.04.01: The critical access hospital has a workplace violence prevention program
EP 3: The critical access hospital conducts an annual worksite analysis related to its workplace violence prevention program. The critical access hospital takes actions to mitigate or resolve the workplace violence safety and security risks based on findings from the analysis.
Note: A worksite analysis includes a proactive analysis of the worksite, an investigation of the critical access hospital's workplace violence incidents, and an analysis of how the program's policies and procedures, training, education, and environmental design reflect best practices and conform to applicable laws and regulations.

TJC Process:

The worksite analysis is an assessment of the environmental factors along with the procedures and operations that occur within that workspace to identify hazards, conditions, operations, and situations that could lead to potential violence based on a proactive assessment as well as events that have occurred.

Explore during interviews with leadership and/or LSC Building Tour:

- Is there evidence of multidisciplinary team input to complete the worksite analysis?
- Is mitigation/correction included in the analysis?

Resource: This is **NOT REQUIRED** but provides a good example: Occupational Safety and Health Administration, United States Department of Labor. (2016). "OSHA 3148-06R 2016: Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers." https://www.osha.gov/Publications/osha3148.pdf

Explore during individual tracers and staff/leadership interviews:

- Is there evidence the hospital personnel are aware of the workplace violence prevention program and actions taken to address identified risks?

Surveyor notes:

NPG.11.01.01: The critical access hospital manages security risks.
EP 3: The critical access hospital develops and implements a process(es) for continually monitoring, internally reporting, and investigating the following:
- Injuries to patients or others within the critical access hospital's facilities and grounds
- Occupational illnesses and staff injuries
- Incidents of damage to its property or the property of others
- Safety and security incidents involving patients, staff, or others within its facilities, including those related to workplace violence

- Hazardous materials and waste spills and exposures
- Fire safety management problems, deficiencies, and failures
- Medical or laboratory equipment management problems, failures, and use errors
- Utility systems management problems, failures, or use errors.

Note 1: All the incidents and issues listed above may be reported to staff in quality assessment, improvement, or other functions. A summary of such incidents may also be shared with the person designated to coordinate safety management activities.

Note 2: Review of incident reports often requires that legal processes be followed to preserve confidentiality. Opportunities to improve care, treatment, or services, and to prevent similar incidents, are not lost as a result of following the legal process.

TJC Process:

During interviews with leadership or Organization Quality and Performance Improvement session (can be completed during the Safety Culture assessment discussion or when reviewing hospital data to inform PI):

- Are workplace violence incidents, per our WPV definition, included in the hospital's safety/security incident reporting system?
- Does the organization have an established investigation process for WPV events?
    - PLEASE NOTE: The level of investigation is based upon the magnitude of events and organization processes. A root cause analysis is NOT required by TJC for each event. See Sentinel Events (SE) chapter of the manual.

Explore during individual tracers and staff/leadership interviews:

Is there evidence that hospital personnel are aware of the process for internally reporting workplace violence incidents? Can they describe what happens after an incident is reported? Have relevant report data been shared with them? (See also HR.11.03.01, EP 5)

Surveyor notes:

Standard NPG.02.04.01: The critical access hospital has a workplace violence prevention program.
EP 2: As part of its workplace violence prevention program, the critical access hospital provides training, education, and resources (at time of hire, annually, and whenever changes occur regarding the workplace violence prevention program) to leaders, staff, and licensed practitioners. The critical access hospital determines what aspects of training are appropriate for individuals based on their roles and responsibilities. The training, education, and resources address prevention, recognition, response, and reporting of workplace violence as follows:
- What constitutes workplace violence
- Education on the roles and responsibilities of leadership, clinical staff, security personnel, and external law enforcement

- Training in de-escalation, nonphysical intervention skills, physical intervention techniques, and response to emergency incidents
- The reporting process for workplace violence incidents

TJC Process:

During competency and medical staff credentialing activity and staff interviews during tracers:

- Are leadership, staff, and licensed practitioners educated regarding the events that need to be reported per the TJC definition?
- Are they aware of their roles/responsibilities during/after event?
- Does staff know how to report an incident? Ease of access of reporting system?
- Evaluate that training and education was completed per the organization's policy/plan.

Surveyor notes:

NPG.02.04.01: The critical access hospital has a workplace violence prevention program.
EP 1: The critical access hospital has a workplace violence prevention program led by a designated individual and developed by a multidisciplinary team that includes the following:

- Policies and procedures to prevent and respond to workplace violence
- A process to report incidents in order to analyze incidents and trends
- A process for follow up and support to victims and witnesses affected by workplace violence, including trauma and psychological counseling, if necessary
- Reporting of workplace violence incidents to the governing body

TJC Process:

Can be incorporated in the Leadership Session when safety culture assessment is discussed:

- Is there a designated individual to ensure that key components of the WPV program are in place?
    - Policies and procedures
    - Reporting system/structure (including the governing body)
    - Response/action plans based upon risks identified in worksite analysis and reported events

Surveyor notes:

Excellent Health Outcomes for All Evaluation Tool (HAP/CAH)

This is a guide to addressing the requirements for excellent health outcomes for all during the survey.

PRE-SURVEY: Gather and Review

Review all pertinent documents submitted or provided by the organization.

Standard NPG.04.01.01: Improving health outcomes for all the hospital's patients is a quality and safety priority.

TJC Process:

Differences in health outcomes between groups of patients is a patient safety issue and a quality of care problem. Although racial and ethnic differences in care have received the most attention, studies have shown that health care quality and health outcomes are often worse for certain groups of people, including the elderly, people living in rural communities, Veterans, pregnant women, people with disabilities, those living in poverty, people with lower educational attainment, and others that may face barriers to high quality care. Like medication errors, health care-acquired infections, and falls, health care disparities must be examined, the root causes understood, and the causes addressed with targeted interventions. Organizations need established leaders and standardized structures and processes in place to identify opportunities to achieve the optimal delivery of care, treatment and services for all. These efforts should be fully integrated with existing quality improvement activities within the organization like other priority issues such as infection prevention and control, antibiotic stewardship, and workplace violence.

Explore during interviews with leadership:

- Discuss how the organization has prioritized improving health outcomes for all as a quality and safety issue.

Explore during Individual Tracers and staff/leadership interviews:

- Is there evidence the hospital personnel are aware of the efforts to improve health outcomes for all?

Surveyor notes:

Standard NPG.04.01.01: Improving health outcomes for all the hospital's patients is a quality and safety priority.
EP 1: The hospital designates an individual(s) to lead activities to improve health outcomes for all the hospital's patients.
Note: Leading the hospital's activities to improve health outcomes for all may be an individual's primary role or part of a broader set of responsibilities.

TJC Process:

Explore during interviews with leadership:

- Identify the designated individual that is leading the organization's efforts to improve health outcomes for all.
- How was the individual selected?
- What is the scope of the individual's responsibilities?

- If the individual oversees improving health outcomes for all at multiple locations, how do they coordinate the efforts to address specific health outcome issues at each location?

Surveyor notes:

Standard NPG.04.01.01: Improving health outcomes for all the hospital's patients is a quality and safety priority.
EP 2: The hospital assesses the patient's health-related social needs (HRSNs) and provides information about community resources and support services.
Note 1: Hospitals determine which HRSNs to include in the patient assessment. Examples of a patient's HRSNs may include the following:
- Access to transportation
- Difficulty paying for prescriptions or medical bills
- Education and literacy
- Food insecurity
- Housing insecurity

Note 2: HRSNs may be identified for a representative sample of the hospital's patients or for all the hospital's patients.

TJC Process:

Explore during interviews with leadership:

- Discuss how the organization assesses patients' health-related social needs.
  - Which patients are asked about their health-related social needs? How did the organization identify which patients to assess for health-related social needs (for example, OB, pediatrics, specific diagnosis)?
  - Which health-related social needs are being assessed?
- How has the organization identified community resources and services that address the health-related social needs of its patients?
- How does the organization provide information about community resources and services to patients with health-related social needs?

Explore during Individual Tracers and staff/leadership interviews:

- Determine whether the patient's health-related social needs were assessed.
  - Are health-related social needs being assessed for the subpopulation identified by the organization?
- If a health-related social need was identified, ask whether the patient was given information on available resources to address the health-related social need.
  - Verify that resource information was provided to the patient.

Surveyor notes:

Standard NPG.04.01.01: Improving health outcomes for all the hospital's patients is a quality and safety priority.
EP 3: The hospital identifies health care disparities in its patient population by stratifying quality and safety data using the sociodemographic characteristics of the hospital's patients.
Note 1: Hospitals may focus on areas with known disparities identified in the scientific literature (for example, organ transplantation, maternal care, diabetes management) or select measures that affect all patients (for example, experience of care and communication).
Note 2: Hospitals determine which sociodemographic characteristics to use for stratification analyses. Examples of sociodemographic characteristics may include the following:
- Age
- Gender
- Preferred language
- Race and ethnicity
- Veterans
- Patients in rural communities
- Physical, mental, and cognitive disabilities

TJC Process:

Explore during the Organization Quality and Performance Improvement session

Note: this process mirrors that for other requirements related to data collection, trending, action planning (LD, PI chapters).

- Review the organization's stratified quality measures.
- How did the organization determine which quality measures to focus on and which sociodemographic characteristics to use in their analysis?

Surveyor notes:

Standard NPG.04.01.01: Improving health outcomes for all the hospital's patients is a quality and safety priority.
EP 4: The hospital develops a written action plan that describes how it will improve health outcomes for all by addressing at least one of the health care disparities identified in its patient population.

TJC Process:

Explore during the combined Organization Quality and Performance Improvement session:

Note: this process mirrors that for other requirements related to data collection, trending, action planning (LD, PI chapters).

- Review the organization's written action plan for improving health outcomes for all.
  - How did the organization identify which health care disparity (or disparities) to address?
  - Verify written action plan for at least 1 of the health care disparities identified.

Surveyor notes:

Standard NPG.04.01.01: Improving health outcomes for all the hospital's patients is a quality and safety priority.
EP 5: The hospital acts when it does not achieve or sustain the goal(s) in its action plan to improve health outcomes for all.

TJC Process:

Explore during the combined Organization Quality and Performance Improvement session:

Note: this process mirrors that for other requirements related to data collection, trending, action planning (LD, PI chapters).

- Review the revisions to the written action plan if the organization's goal(s) to improve health outcomes for all is not achieved or sustained.
- How did the organization determine which area(s) to improve?

Surveyor notes:

Standard NPG.04.01.01: Improving health outcomes for all the hospital's patients is a quality and safety priority.
EP 6: At least annually, the hospital informs key stakeholders, including leaders, licensed practitioners, and staff, about its progress to improve health outcomes for all.

TJC Process:

Explore during interviews with leadership:

- Discuss how information about the organization's activities to improve health outcomes for all is disseminated within the organization (for example, quarterly meetings, newsletters, web page).

Explore during Individual Tracers and staff/leadership interviews:

- Ask staff how they receive information about the organization's progress to improve health outcomes for all its patients. How frequently is the information disseminated?

Surveyor notes:

Antibiotic Stewardship Evaluation Tool (HAP/CAH)

This is a guide to addressing the Antibiotic Stewardship requirements during the survey.

PRE-SURVEY: Gather and Review

Review all pertinent documents submitted or provided by the organization.

Standard MM.18.01.01: The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.

TJC Process:

Optimizing the use of antibiotics is a patient safety priority, and antibiotic stewardship programs play a critical role in supporting appropriate antibiotic prescribing practices and reducing antibiotic resistance. The revisions to Standard MM.09.01.01 include a combination of updates to align with federal regulations and recommendations from scientific and professional organizations, editorial changes, additional notes to clarify expectations, and EPs that will now apply to all accredited hospitals (deeming lead-in statements have been deleted).

Explore during interviews with leadership:

- Discuss how the organization supports its antibiotic stewardship program.

Explore during Individual Tracers and staff and leadership interviews:

- Is there evidence the hospital personnel are aware of the antibiotic stewardship program and its efforts to reduce antibiotic resistance?

Surveyor notes:

Standard MM.18.01.01: The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.
EP 1: The antibiotic stewardship program reflects the scope and complexity of the critical access hospital services provided.

TJC Process:

Explore during interviews with antibiotic stewardship program leadership:

- *The scope of the antibiotic stewardship program.*
- *How does the leader ensure that the program covers the complexity of the hospital's services?*
- *What evidence is available to demonstrate the program is suitable for the scope and complexity of the services provided by the hospital?*

Surveyor notes:

Standard MM.18.01.01: The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.
EP 2: The critical access hospital demonstrates that an individual (or individuals), who is qualified through education, training, or experience in infectious diseases and/or antibiotic stewardship, is appointed by the governing body as the leader(s) of the antibiotic stewardship program and that the appointment is based on the recommendations of medical staff leadership and pharmacy leadership.

TJC Process:

Explore during interviews with hospital leadership and the program leader:
- *Identify the leader(s) of the antibiotic stewardship program.*
- *How does the organization determine the individual(s) is qualified to lead the antibiotic stewardship program?*
- *If Board members are present during the session, ask how they are involved in decisions about the leader(s) of the antibiotic stewardship program.*
- *Ask the program leader(s) about their qualifications to oversee antibiotic stewardship for the hospital.*

During the Competency Assessment Session:
- *Request the antibiotic stewardship program leader(s) personnel file for review to determine whether they are qualified through ongoing education, training, experience, or certification to oversee the antibiotic stewardship program.*
- *Ask to see the policies and procedures that govern the antibiotic stewardship program to determine they address the roles and responsibilities for antibiotic stewardship and use within the hospital, how the various hospital committees and departments interface with the program, and how to optimize antibiotic use.*
- *Review the criteria the hospital used to determine the resources necessary to operate effectively and ensure the resource allocation matches the determined needs.*

Surveyor notes:

Standard MM.18.01.01: The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.
EP 3: The leader(s) of the antibiotic stewardship program is responsible for the following:
- Developing and implementing a critical access hospitalwide antibiotic stewardship program that is based on nationally recognized guidelines to monitor and improve the use of antibiotics
- Documenting antibiotic stewardship activities, including any new or sustained improvements
- Communicating and collaborating with the medical staff, nursing leadership, and pharmacy leadership, as well as with the critical access hospital's infection prevention and control and quality assessment and performance improvement programs on antibiotic use issues

- Providing competency-based training and education for critical access hospital personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the critical access hospital, on the practical applications of antibiotic stewardship guidelines, policies, and procedures

TJC Process:

Explore during the combined Organization Quality and Performance Improvement session or medication safety individual tracer:

- Review the organization's guidelines about appropriate antibiotic prescribing practices.
- Ask about how medical/nursing/pharmacy staff are involved in the antibiotic stewardship program.

Explore during the Competency and Medical Staff Credentialing and Staff Interviews:

- Review the competency-based training addressing the organization's antibiotic stewardship guidelines, policies, and procedures.

Surveyor notes:

Standard MM.18.01.01: The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.
EP 4: The governing body ensures all antibiotic use issues identified by the antibiotic stewardship program are addressed in collaboration with the critical access hospital's QAPI leadership.

TJC Process:

Explore during the Organization Quality and Performance Improvement session or Leadership Session:
- *Interview program leader(s) to confirm that the hospital's infection control program and antibiotic stewardship program are being coordinated with their QAPI leadership, medical staff, nursing services, and pharmacy services.*
- *Determine through interview if identified infection control and antibiotic use problems are reported to the hospital's leadership.*
- *Verify that hospital leaders take steps to assure that corrective actions are implemented and successful.*
- *If the antibiotic stewardship program's data analysis shows improvements are needed, verify that an action plan is in place.*

Surveyor notes:

Standard MM.18.01.01: The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.
EP 5: The critical access hospitalwide antibiotic stewardship program:
-Demonstrates coordination among all components of the critical access hospital responsible for antibiotic use and resistance, including, but not limited to, the infection prevention and control program, the quality assessment and performance improvement program, the medical staff, nursing services, and pharmacy services.
-Documents the evidence-based use of antibiotics in all departments and services of the critical access hospital.
-Documents any improvements, including sustained improvements, in proper antibiotic use.

TJC Process:

Explore during Individual Tracer Activity through interviews:
- *Ask staff that work in various departments and services who prescribe antibiotics about the antibiotic stewardship program and if they are aware of any improvements that have been made to the hospital's antibiotic prescribing practices.*
- *Ask staff that work in various departments and services who prescribe antibiotics how the hospital promotes the evidence-based use of antibiotics.*

Explore during the Organization Quality and Performance Improvement session or medication safety individual tracer:
- *Review the hospital's antibiotic stewardship policies and procedures for evidence that the hospital has a process in place for coordination among all components of the hospital responsible for antibiotic use and resistance, including, but not limited to, the antibiotic stewardship program, the infection prevention and control program, the QAPI program, the medical staff, nursing services, and pharmacy services.*
- *Ask about any improvements in proper antibiotic use that have been achieved and sustained.*

Surveyor notes:

Standard MM.18.01.01: The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.
EP 6: The antibiotic stewardship program adheres to nationally recognized guidelines, as well as best practices, for improving antibiotic use.

TJC Process:

Explore during the Organization Quality and Performance Improvement session or individual tracer activity:
- *Ask staff who prescribe antibiotics about the nationally recognized guidelines that have been implemented as part of the hospitalwide antibiotic stewardship program.*
- *Verify that core elements of best practices have been included within the hospitalwide antibiotic stewardship program, including hospital leadership commitment, accountability, pharmacy expertise, tracking, reporting, education, and appropriate interventions or actions being taken to improve antibiotic use to reduce adverse events, prevent emergence of resistance, and ensure better outcomes for patients in this setting.*

Surveyor notes:

Standard MM.18.01.01: The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.
EP 7: The governing body ensures that systems are in place and operational for the tracking of all antibiotic use activities in order to demonstrate the implementation, success, and sustainability of such activities.

TJC Process:

Explore during the Organization Quality and Performance Improvement session or Leadership Session:

- *Interview program leaders to confirm that the hospital's infection control program and antibiotic stewardship program are being coordinated with their QAPI leadership, medical staff, nursing services, and pharmacy services.*
- *Review the hospital policies and governing body meeting minutes for record of support for the infection control and antibiotic stewardship programs.*
- *Verify that the hospital policies are being followed for the tracking of all infection surveillance, prevention and control, and the monitoring of hospital antibiotic use activities.*

Surveyor notes:

Standard NPG.14.06.01: The critical access hospital has an active antibiotic stewardship program.
EP 1: The critical access hospital has a multidisciplinary committee that oversees the antibiotic stewardship program.
Note 1: The committee may be composed of representatives from the medical staff, pharmaceutical services, the infection prevention and control program, nursing services, microbiology, information technology, and the quality assessment and performance improvement program.
Note 2: The committee may include part-time or consultant staff. Participation may occur on site or remotely.

TJC Process:

Explore during the Organization Quality and Performance Improvement session or Medication Safety Individual Tracer:

- *How does the multidisciplinary committee oversee the antibiotic stewardship program?*
- *Which disciplines are represented on the multidisciplinary committee (the composition is determined by the hospital)?*
- *What is the scope of the multidisciplinary committee's oversight?*
- *What is the frequency of committee meetings?*

Surveyor notes:

Standard NPG.14.06.01: The critical access hospital has an active antibiotic stewardship program.
EP 2: The antibiotic stewardship program monitors the critical access hospital's antibiotic use by analyzing data on days of therapy per 1000 days present or 1000 patient days, or by reporting antibiotic use data to the National Healthcare Safety Network's Antimicrobial Use Option of the Antimicrobial Use and Resistance Module.

TJC Process:

Explore during the Organization Quality and Performance Improvement session or Medication Safety Individual Tracer:

- *Verify that data about the hospital's antibiotic use is collected and monitored.*

Surveyor notes:

Critical Access Hospital National Performance Goals Evaluation Module

This is a guide to surveying selected National Performance Goals that are not already addressed in other topic-specific survey tools (for example, Antibiotic Stewardship Evaluation Tool, Excellent Health Outcomes for All Evaluation Tool, Workplace Violence Prevention Tool).

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
NPG.01.01.01 The hospital has a process in place to correctly identify patients when providing care, treatment, and services. **NPG.01.01.01, EP 1** The hospital has a process in place to correctly identify patients when providing care, treatment, and services. This includes using at least two patient identifiers. The hospital does not use the patient's room number or physical location as an identifier. Note: Examples of patient identifiers may include but are not limited to the following: - Assigned identification number (for example, medical record number) - Telephone number or another person-specific identifier - Electronic identification technology coding, such as bar coding or RFID, that includes two or more person-specific identifiers This includes using at least two patient identifiers. The hospital does not use the patient's room number or physical location as an identifier. **NPG.01.01.01, EP 2** The hospital labels containers used for blood and other specimens in the presence of the patient. **NPG.01.01.01, EP 3** The hospital uses distinct methods of identification for newborn patients. Note: Examples of methods to prevent misidentification may include the following: - Distinct naming systems could include using the mother's first and last names and the newborn's gender (for example: "Smith, Judy Girl" or "Smith, Judy Girl A" and "Smith, Judy Girl B" for multiples). - Standardized practices for identification banding (for example, using two body sites and/or bar coding for identification).	**Interview** ☐ Interview staff in areas where care and treatment is provided to ascertain the processes surrounding two patient identifiers. ☐ Interview patients if possible in these areas as well, to determine if adherence to hospital policy is followed. Determine if patients are educated to this process for understanding and safety. **Document Review** ☐ Review hospital policy and procedures. Determine if data is collected and if there are any PI activities associated with internal reporting of events. **Observation** ☐ Observe care processes to determine is staff are adhering to requirements.

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
- Establish communication tools among staff (for example, visually alerting staff with signage noting newborns with similar names).	
NPG.01.02.01 The hospital reports critical results of tests and diagnostic procedures on a timely basis. **NPG.01.02.01, EP 1** The hospital develops and implements written procedures for managing the critical results of tests and diagnostic procedures that address the following: - The definition of critical results of tests and diagnostic procedures - By whom and to whom critical results of tests and diagnostic procedures are reported - The acceptable length of time between the availability and reporting of critical results of tests and diagnostic procedures **NPG.01.02.01, EP 2** The hospital evaluates the timeliness of reporting the critical results of tests and diagnostic procedures.	**Interview** ☐ Ask the responsible staff about the process for critical results to determine knowledge of processes. **Document Review** ☐ Review policy and procedures related to reporting of critical results of tests and diagnostic procedures. ☐ Review data collected and any PI to ascertain the activities of the hospital. ☐ Review required documentation within patient medical records, according to hospital policy.
NPG.01.04.01 The hospital has a process for hand-off communication. **NPG.01.04.01, EP 1.** The hospital follows a process to receive or share patient information when the patient is referred to internal providers of care, treatment, and services. **NPG.01.04.01, EP 2.** The hospital's process for hand-off communication provides for the opportunity for discussion between the giver and receiver of patient information. Note: Such information may include the patient's condition, care, treatment, medications, services, and any recent or anticipated changes to any of these.	**Interview** ☐ Ask staff about the patient hand-off process and what information is shared between the giver and receiver. ☐ Ask staff who the hand-off process applies to internally.
NPG.01.05.01 The hospital improves the safety of clinical alarm systems. **NPG.01.05.01, EP 1** Identify the most important alarm signals to manage based on the following: - Input from the medical staff and clinical departments - Risk to patients if the alarm signal is not attended to or if it malfunctions	**Purpose** Make improvements to ensure that alarms on medical equipment are heard and responded to on time. **Interview** ☐ Interview CEO, CMO, CNO, and other formal leaders such as board members to understand the process taken to establish hospital priorities, including risk analysis and recommendations from

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
- Whether specific alarm signals are needed or unnecessarily contribute to alarm noise and alarm fatigue - Potential for patient harm based on internal incident history - Published best practices and guidelines **NPG.01.05.01, EP 2** Establish policies and procedures for managing the alarms identified in NPG.01.05.01, EP 1 above that, at a minimum, address the following: - Clinically appropriate settings for alarm signals - When alarm signals can be disabled - When alarm parameters can be changed - Who in the organization has the authority to set alarm parameters - Who in the organization has the authority to change alarm parameters - Who in the organization has the authority to set alarm parameters to "off" - Monitoring and responding to alarm signals - Checking individual alarm signals for accurate settings, proper operation, and detectability.	medical staff and clinical departments in determining alarm system safety as a hospital priority. ☐ Interview patients to identify if alarm signals are answered and are timely. **Document Review** ☐ Review board meeting minutes to determine hospital priorities. ☐ Review policy and procedures that were analyzed from EP 2. • Is there evidence that medical staff and clinical departments had input. • What risks were identified if alarm signal is not attended or it malfunctions • Were specific alarm signals reviewed for unnecessary noise or contribute to alarm fatigue • What published best practices and guidelines were used in the review for policy and procedures ☐ Request internal list of incident reports that were associated to alarm signals, noise and fatigue; has the hospital made changes if incidents were associated with alarms? **Observation** ☐ During survey activities in patient care areas, listen for alarms and signals. Are staff and providers responding according to risks both clinically and environmentally.
NPG.01.05.02 The hospital recognizes and responds to changes in a patient's condition. Note: Hospitals are not required to create rapid response teams or medical emergency teams in order to meet this standard. The existence of these types of teams does not mean that all of the elements of performance are automatically achieved. **NPG.01.05.02, EP 1** The hospital develops and implements written criteria describing early warning signs of a change or deterioration in a patient's condition and the appropriate action to take.	**Interview** ☐ Ask staff about the available criteria and guidance that describe early warning signs of a change or deterioration in a patient's condition and how they should respond. ☐ Ask staff about the education and training they have received about the early warning signs of changes in patient condition and how to respond. **Document Review**

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
	Review the written criteria that describes early warning signs of a change or deterioration in patient condition in the form that is available to staff. **Observation** Ask staff to demonstrate how they access the change in patient condition early warning signs criteria and guidance.
NPG.01.05.03 Resuscitative services are available throughout the hospital. **NPG.01.05.03, EP 1** The hospital provides resuscitative services based on national standards of care, guidelines, and the hospital's policies, procedures, or protocols. **NPG.01.05.03, EP 2** Resuscitation equipment is available for use based on the needs of the population served. Note: For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available. **NPG.01.05.03, EP 3** The hospital provides education and training to staff involved in the provision of resuscitative services. The hospital determines which staff complete this education and training based on their job responsibilities and hospital policies and procedures. The education and training are provided at the following intervals: - At orientation - A periodic basis thereafter, as determined by the hospital - When staff responsibilities change Note 1: Topics may cover resuscitation procedures or protocols; use of cardiopulmonary resuscitation techniques, devices, or equipment; and roles and responsibilities during resuscitation events. Note 2: The hospital determines the format and content of education and training (for example, a skills day, a mock code).	**Interview** ☐ Ask staff members about their responsibilities during resuscitation and about the education and training on resuscitation that the hospital has provided. Ask how frequently education and training on resuscitation are provided. ☐ Ask staff if patient population appropriate resuscitation equipment is available and accessible when needed. **Observation** ☐ Verify resuscitation equipment is available, properly maintained, and staff responsible in the use of the equipment are competent **Document Review** **Personnel Files** Review personnel files of staff who per hospital policy should have resuscitative services education and training for evidence of completion at the required intervals.
NPG.01.05.04 The hospital develops and implements processes for post-resuscitation care.	**Interview** ☐ Ask staff if they are aware of any hospital policies, procedures, or protocols for interdisciplinary post-cardiac arrest care.

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NPG.01.05.04, EP 1 The hospital develops and implements policies, procedures, or protocols based on current scientific literature for interdisciplinary post–cardiac arrest care. Note 1: Post–cardiac arrest care is aimed at identifying, treating, and mitigating acute pathophysiological processes after cardiac arrest and includes evaluation for targeted temperature management and other aspects of critical care management. Note 2: This requirement does not apply to hospitals that do not provide post–cardiac arrest care. **NPG.01.05.04, EP 2** The hospital develops and implements policies, procedures, or protocols based on current scientific literature to determine the neurological prognosis for patients who remain comatose after cardiac arrest. Note 1: Because any single method of neuroprognostication has an intrinsic error rate, current guidelines recommend that multiple testing modalities be incorporated into the hospital's routine procedures and protocols to improve decision-making accuracy. Note 2: This requirement does not apply to hospitals that do not provide post–cardiac arrest care.	☐ Ask staff if the hospital has policies, procedures, or protocols on determining the neurological prognosis for patients who remain comatose after cardiac arrest. **Document Review** Confirm the hospital has post cardiac arrest care policies, procedures, or protocols available.
NPG.01.05.05 The hospital reviews resuscitation cases to identify opportunities for improvement. **NPG.01.05.05, EP 1** An interdisciplinary committee reviews cases and data to identify and suggest practice and system improvements in resuscitation performance. Note 1: Review examples could include the following: - How often early warning signs of clinical deterioration were present prior to in-hospital cardiac arrest in patients in nonmonitored or non–critical care units - Timeliness of staff's response to a cardiac arrest - Quality of cardiopulmonary resuscitation (CPR) - Post–cardiac arrest care processes	**Interview** ☐ Clinical leaders to determine if there is an interdisciplinary committee review of resuscitation cases. ☐ Ask about the data being collected and analyzed and if any improvements have been made in resuscitation performance as a result.

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- Outcomes following cardiac arrest Note 2: The review functions may be designated to an existing interdisciplinary committee.	
NPG.01.06.01 The hospital conducts a preprocedure verification process. **NPG.01.06.01, EP 1** The hospital implements a preprocedure process to verify the correct procedure, for the correct patient, at the correct site. Note: The patient is involved in the verification process when possible. **NPG.01.06.01, EP 2** The hospital identifies the items that must be available for the procedure and uses a standardized list to verify their availability. At a minimum, these items include the following: - Relevant documentation (for example, history and physical, signed procedure consent form, nursing assessment, and preanesthesia assessment) - Labeled diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly displayed - Any required blood products, implants, devices, and/or special equipment for the procedure Note: The expectation of this element of performance is that the standardized list is available and is used consistently during the preprocedure verification. It is not necessary to document that the standardized list was used for each patient.	**Interview** ☐ In procedural areas, inquire with staff and licensed practitioners if there is a preprocedure verification process. • Can staff describe the steps and who is involved in the verification process? • Are they able to articulate their own responsibilities in the process? • What happens if the described process does not occur? Are they encouraged or feel safe to speak up? • If possible, interview a patient to determine if they were involved in the process. **Document Review** ☐ Review documents related to procedural services and care of the patient. This may include but is NOT limited to anesthesia policies, surgical services procedures, medical staff bylaws. ☐ Review patient medical records for those requirements as determined by the organization. **Observation** ☐ Observe patient care service in procedural areas to verify hospital processes related to preprocedure verification.
NPG.01.06.02 The hospital marks the procedure site. **NPG.01.06.02, EP 1** The hospital identifies those procedures that require marking of the incision or insertion site. At a minimum, sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety.	**Interview** ☐ In procedural areas, inquire with staff and licensed practitioners about the site marking processes established by the hospital and what their role is within the procedure. • Can they identify what procedures require marking and those that do not? • What happens if a patient refuses site marking?

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Note: For spinal procedures, in addition to preoperative skin marking of the general spinal region, special intraoperative imaging techniques may be used for locating and marking the exact vertebral level. **NPG.01.06.02, EP 2** The procedure site is marked before the procedure is performed and, if possible, with the patient involved. **NPG.01.06.02, EP 3** The procedure site is marked by a licensed practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed. In limited circumstances, the licensed practitioner may delegate site marking to an individual who is permitted by the organization to participate in the procedure and has the following qualifications: - An individual in a medical postgraduate education program who is being supervised by the licensed practitioner performing the procedure; who is familiar with the patient; and who will be present when the procedure is performed - A licensed individual who performs duties requiring a collaborative agreement or supervisory agreement with the licensed practitioner performing the procedure (that is, an advanced practice registered nurse [APRN] or physician assistant [PA]); who is familiar with the patient; and who will be present when the procedure is performed. Note: The hospital's leaders define the limited circumstances (if any) in which site marking may be delegated to an individual meeting these qualifications. **NPG.01.06.02, EP 4** The method of marking the site and the type of mark is unambiguous and is used consistently throughout the hospital. Note: The mark is made at or near the procedure site and is sufficiently permanent to be visible after skin preparation and draping. Adhesive markers are not the sole means of marking the site. **NPG.01.06.02, EP 5** A written, alternative process is in place for patients who refuse site marking or when it is technically or anatomically impossible or impractical to mark the site (for example, mucosal surfaces or perineum). Note: Examples of other situations that involve alternative processes include the following:	**Document Review** ☐ Review documents related to procedural services and care of the patient. This may include but is NOT limited to: anesthesia policies, surgical services procedures, medical staff bylaws. ☐ Review patient medical records for those requirements as determined by the organization. **Observation** ☐ Observe patient care in procedural areas to verify hospital processes related to procedural site marking.

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- Minimal access procedures treating a lateralized internal organ, whether percutaneous or through a natural orifice - Teeth - Premature infants, for whom the mark may cause a permanent tattoo	
NPG.01.06.03 The hospital performs a time-out before the procedure. **NPG.01.06.03, EP 1** The hospital conducts a time-out immediately before starting the invasive procedure or making the incision. **NPG.01.06.03, EP 2** The time-out has the following characteristics: - It is standardized, as defined by the hospital. - It is initiated by a designated member of the team. - It involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the operating room technician, and other active participants who will be participating in the procedure from the beginning. **NPG.01.06.03, EP 3** When two or more procedures are being performed on the same patient, and the person performing the procedure changes, the hospital performs a time-out before each procedure is initiated. **NPG.01.06.03, EP 4** During the time-out, the team members agree, at a minimum, on the following: - Correct patient identity - The correct site - The procedure to be done **NPG.01.06.03, EP 5** The hospital documents the completion of the time-out. Note: The hospital determines the amount and type of documentation.	**Interview** ☐ In procedural areas, inquire with staff and licensed practitioners about the time out process • Who leads the time out? • What happens when the process is not followed according to hospital policy and procedure? **Document Review** ☐ Review documents related to procedural services and care of the patient. This may include but is NOT limited to: anesthesia policies, surgical services procedures, medical staff bylaws. ☐ Review patient medical records for those requirements as determined by the organization. **Observation** ☐ Observe patient care in procedural areas to verify hospital processes related to the time out process. **Note:** The purpose of the time-out is to conduct a final assessment that the correct patient, site, and procedure are identified. This requirement focuses on those minimum features of the time-out. Some believe that it is important to conduct the time-out before anesthesia for several reasons, including involvement of the patient. A hospital may conduct the time-out before anesthesia or may add another time-out at that time. During a time-out, activities are suspended to the extent possible so that team members can focus on active confirmation of the patient, site, and procedure. A designated member of the team initiates the time-out and it includes active communication among all relevant members of the

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	procedure team. The procedure is not started until all questions or concerns are resolved. The time-out is most effective when it is conducted consistently across the hospital.
NPG.02.01.01 The mission, vision, and goals guide the hospital's actions. **NPG.02.01.01, EP 1** The governing body, senior managers, and leaders of the organized medical staff work together to create the hospital's mission, vision, and goals, which guide the leaders' actions. The mission, vision, and goals are communicated to staff and the population(s) served.	**Interview** ☐ Ask senior leaders about the creation of the organization's current mission, vision, and goals. Determine who was involved in the creation. ☐ Ask leaders and staff at all levels of the organization about how the mission, vision and goals influence day-to-day activity throughout the organization. **Observation** ☐ Look for evidence that the organization's mission, vision, and goals are being communicated throughout the organization.
NPG.02.02.01 The hospital addresses conflicts of interest and ethics. **NPG.02.02.01, EP 1** The governing body, senior managers, and leaders of the organized medical staff work together to define in writing conflicts of interest that could affect safety and quality of care, treatment, and services. **NPG.02.02.01, EP 2** The governing body, senior managers, and leaders of the organized medical staff work together to develop a written policy that defines how conflicts of interest will be addressed. **NPG.02.02.01, EP 3** Conflicts of interest are disclosed as defined by the hospital. **NPG.02.02.01, EP 4** Senior managers and leaders of the organized medical staff work with the governing body to develop and implement an ongoing process for managing conflict among leadership groups that has the potential to adversely affect patient safety or quality of care. **NPG.02.02.01, EP 5** The hospital develops and implements a process that allows staff, patients, and families to address ethical issues or issues prone to conflict.	**Interview** ☐ Ask leaders about the organization's policy and process for managing conflicts of interest among leadership groups. ☐ Ask leaders about the organization's process for staff, patients, and families to raise ethical issues and issues prone to conflict. **Document Review** ☐ Review the organization's written description of conflicts of interest that could affect safety and quality of care, treatment, and services. ☐ Review the organization's written policy on how conflicts of interest will be addressed.

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NPG.02.03.01 The hospital's leaders design work processes to focus individuals on safety and quality issues. **NPG.02.03.01, EP 1** The leaders implement a hospitalwide patient safety program as follows: - One or more qualified individuals or an interdisciplinary group manage the safety program. - All departments, programs, and services within the hospital participate in the safety program. - The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as close calls ["near misses"] or good catches) to hazardous conditions and sentinel events. **NPG.02.03.01, EP 2** The leaders encourage external reporting of significant adverse events, including voluntary reporting programs in addition to mandatory programs. Note: Examples of voluntary programs include Joint Commission's Sentinel Event Database and the US Food and Drug Administration (FDA) MedWatch. **NPG.02.03.01, EP 3** As part of the safety program, the leaders create procedures for responding to system or process failures. Note: Responses might include continuing to provide care, treatment, and services to those affected, containing the risk to others, and preserving factual information for subsequent analysis. **NPG.02.03.01, EP 4** The leaders provide and encourage the use of systems for internal reporting of a system or process failure, or the results of a proactive risk assessment, without the risk of retaliation. Note: This EP is intended to minimize staff reluctance to report errors in order to help an organization understand the source and results of system and process failures. The EP does not conflict with holding individuals accountable for errors due to negligence. **NPG.02.03.01, EP 5** The hospital conducts thorough and credible comprehensive systematic analyses (for example, root cause analyses) in response to sentinel events as described in the "Sentinel Event Policy" (SE) chapter of this manual.	**Interview** ☐ Discuss the Safety Culture in the organization including: • How well the leaders understand the assessment tool, scope of assessment in the organization, response rates, and reported results. • Does the organization have benchmarks? Are these Internal and/or external benchmarks • What quality improvement projects have been undertaken to improve your scores on safety culture? • Does the Board set expectations for improving safety culture? • Does the organization include safety culture improvement goals in performance expectations for leaders and middle management? ☐ Discuss the code of conduct that leaders developed and adopted for physicians and staff. • Is it the same for everyone? • Describe your policy and procedures for dealing with intimidating behaviors, especially by physicians. • What has been done to try to eradicate intimidating behavior? • How do staff report intimidating behavior? • How widespread is disrespectful behavior in your organization? ▪ Does the organization measure it? ▪ How do you deal with serial violators? ▪ Do you use the same process for all caregivers?

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NPG.02.03.01, EP 6 The leaders make support systems available for staff who have been involved in an adverse or sentinel event. Note: Support systems recognize that health care workers who are involved in sentinel events may be negatively affected by the event and require support. Support systems provide staff with help and support as well as additional resources through the human resources function or an employee assistance program. Support systems also focus on the process rather than blaming the involved individuals. **NPG.02.03.01, EP 7** At least every 18 months, the hospital selects one high-risk process and conducts a proactive risk assessment. Note: For suggested components, refer to the Proactive Risk Assessment section at the beginning of this chapter. **HospitNPG.02.03.01, EP 8** To improve safety and to reduce the risk of medical errors, the hospital analyzes and uses information about system or process failures and the results of proactive risk assessments. **NPG.02.03.01, EP 9** Communication processes are effective in doing the following: - Fostering the safety of the patient and their quality of care - Supporting a culture of safety and quality - Meeting the needs of internal and external users - Informing those who work in the hospital of changes in the environment - Disseminating lessons learned from comprehensive systematic analyses (for example, root cause analyses), system or process failures, and proactive risk assessments to all affected staff. **NPG.02.03.01, EP 10** Leaders evaluate the effectiveness of communication methods. **NPG.02.03.01, EP 11** Leaders regularly evaluate the culture of safety and quality using valid and reliable tools. Possible issues are identified by the culture of safety evaluation. Proposed improvements are prioritized and implemented.	▪ Are your disciplinary procedures equitable and transparent? • How do you decide if discipline should be used in evaluating errors? ▪ Did the individual depart from agreed and available safe practices or protocols (foresight test)? ▪ Were there mitigating circumstances? • Would another person from the same professional group, with similar training and experience, behave in the same way in similar circumstances (substitution test)? ▪ Were there deficiencies in training, experience or supervision? ▪ Were there mitigating circumstances? ☐ In the event an error occurs, and a patient is harmed: • Do you have a process in place to determine whether this was a system error or whether the person responsible should be held accountable? • How do you separate blameless errors (for learning) from blameworthy errors (for discipline, equitably applied to all groups)? • What process do you have in place for reporting a “close call” or an error that occurred but did not reach the patient? ▪ How often is this used? ▪ Can you give me a recent example? • Do you conduct root cause analyses of all “near misses?” **Document Review** ☐ Process/tool used to conduct a safety culture assessment

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NPG.02.03.01, EP 12 Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety. **NPG.02.03.01, EP 13** Leaders create and implement a process for managing behaviors that undermine a culture of safety.	☐ Current and past results of the safety culture assessment; changes made based on results
NPG.05.02.01 The hospital implements processes to support preparedness for high-consequence infectious diseases or special pathogens. NPG.05.02.01 EP 1 The hospital develops and implements protocols for high-consequence infectious diseases or special pathogens. The protocols are readily available for use at the point of care and address the following: - Identify: Procedures for screening at the points of entry to the hospital for respiratory symptoms, fever, rash, and travel history to identify or initiate evaluation for high-consequence infectious diseases or special pathogens - Isolate: Procedures for transmission-based precautions - Inform: Procedures for informing public health authorities and key hospital staff - Required personal protective equipment and proper donning and doffing techniques - Infection control procedures to support continued and safe provision of care while the patient is in isolation and to reduce exposure among staff, patients, and visitors using the hierarchy of controls - Procedures for managing waste and cleaning and disinfecting patient care spaces, surfaces, and equipment Note 1: Points of entry may include the emergency department, urgent care, and ambulatory clinics. Note 2: See the Glossary for a definition of hierarchy of controls. NPG.05.02.01 EP 2 The hospital develops and implements education and training and assesses competencies for staff who will implement protocols for high-consequence infectious diseases or special pathogens.	Interview ☐ Interview staff in the emergency department, urgent care settings about the hospital process for screening for fever, respiratory symptoms, rash, and travel history (the hospital may utilize active and/or passive screening processes, such as staff at the point of entry asking specific questions, posting visual alerts at the entrances of clinics on signs and symptoms that patients/visitors should report to staff when they first register for care, etc.) ☐ Ask who receives education and training on high-consequence infectious diseases or special pathogens and how frequently education and training are provided. ☐ Ask staff members in the intake or triage areas about their responsibilities for screening and education and training that the hospital has provided. Document Review ☐ Review hospital protocols for high-consequence infectious diseases or special pathogens and whether the protocols address the required elements.
NPG.05.03.01 The hospital complies with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines and/or the current World Health Organization (WHO) hand hygiene guidelines.	Interview ☐ Discuss with staff and providers in all areas of patient care and services the hand hygiene guidelines established in the organization.

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NPG.05.03.01, EP 1 The hospital implements a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) and/or the current World Health Organization (WHO) hand hygiene guidelines. The program sets goals for improving compliance with hand hygiene based on established goals.	• Include activities they have identified within the area of survey activities. • Discuss scenarios where safety culture may be identified. For example, hospital staff entering patient rooms- do staff AND patients feel safe to speak up if hand hygiene is not performed? ☐ Interview patients and ask if they observe hand hygiene procedures being performed, if so ask when? **Document Review** ☐ Request and review documents related to the hand hygiene program. These may include but are not all inclusive, hand hygiene-- policy, data and PI activities, Infection Control Plan and Risk assessment and goals. **Observation** ☐ Observe care being provided in all areas of the organization, are staff and providers following hand hygiene procedures adopted by the organization?
NPG.06.01.01 Pain assessment and pain management, including safe opioid prescribing, are identified as an organizational priority. **NPG.06.01.01, EP 1** The hospital has a leader or leadership team that is responsible for pain management and safe opioid prescribing, as well as developing and monitoring performance improvement activities. **NPG.06.01.01, EP 2** The hospital provides nonpharmacologic pain treatment modalities. **NPG.06.01.01, EP 3** The hospital provides staff with educational resources and programs to improve pain assessment, pain management, and the safe use of opioid medications based on the identified needs of its patient population. **NPG.06.01.01, EP 4** The hospital provides information to staff on available services for consultation and referral of patients with complex pain management needs.	**Interview** ☐ Ask leaders how they have made pain assessment, pain management, and safe opioid prescribing an organizational priority ☐ Ask leaders how they provide staff with educational resources to improve pain assessment, pain management, and the safe use of opioids Ask staff about: ☐ Hospital processes for collecting patient-level data on pain assessment, pain management and safe-opioid prescribing such as: • Hospital process for identifying patients at high risk for adverse outcomes related to opioid treatment.

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NPG.06.01.01, EP 5 The hospital identifies opioid treatment programs that can be used for patient referrals. **NPG.06.01.01, EP 6** The hospital facilitates licensed practitioner and pharmacist access to the Prescription Drug Monitoring Program databases. Note: This element of performance is applicable in any state that has a Prescription Drug Monitoring Program database, whether querying is voluntary or is mandated by state regulations for all patients prescribed opioids. **NPG.06.01.01, EP 7** Hospital leadership works with its clinical staff to identify and acquire the equipment needed to monitor patients who are at high risk for adverse outcomes from opioid treatment.	• Hospital process for monitoring patients identified as high risk when receiving opioids. • How they screen, assess, and reassess patients for pain, non-pharmacologic approaches they offer. Ask physicians and other licensed practitioners about: ☐ Knowledge of pain assessment, pain management, and safe opioid prescribing initiatives by the hospital and any resources that have been made available. • Has the hospital provided access to and criteria that prompts accessing the Patient Drug Monitoring Database? • What non-pharmacologic modalities are available to patients and how were these modalities determined? • What information has leadership provided on available services for consultation and referral of patients with complex pain management needs? • What opioid treatment programs are available for patient referrals? **Document Review** ☐ Review documentation that demonstrates leadership making pain assessment, pain management, and safe opioid prescribing an organizational priority. Examples may include budget items or plans, strategic plans and performance improvement plans
NPG.06.02.01 The hospital assesses and manages the patient's pain and minimizes the risks associated with treatment. **NPG.06.02.01, EP 1** The hospital has defined criteria to screen, assess, and reassess pain that are consistent with the patient's age, condition, and ability to understand. **NPG.06.02.01, EP 2** The hospital screens patients for pain during emergency department visits and at the time of admission.	**Interview** Ask staff about: ☐ Hospital processes for collecting patient-level data on pain assessment, pain management and safe-opioid prescribing such as: • Hospital process for identifying patients at high risk for adverse outcomes related to opioid treatment.

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NPG.06.02.01, EP 3 The hospital treats the patient's pain or refers the patient for treatment. Note: Treatment strategies for pain may include nonpharmacologic, pharmacologic, or a combination of approaches. **NPG.06.02.01, EP 4** The hospital develops a pain treatment plan based on evidence-based practices and the patient's clinical condition, past medical history, and pain management goals. **NPG.06.02.01, EP 5** The hospital involves the patient in the pain management treatment planning process through the following: - Developing realistic expectations and measurable goals that the patient understands for the degree, duration, and reduction of pain - Discussing the objectives used to evaluate treatment progress (for example, relief of pain and improved physical and psychosocial function) - Providing education on pain management, treatment options, and safe use of opioid and nonopioid medications when prescribed **NPG.06.02.01, EP 6** The hospital monitors patients identified as being high risk for adverse outcomes related to opioid treatment. **NPG.06.02.01, EP 7** The hospital reassesses and responds to the patient's pain through the following: - Evaluation and documentation of response(s) to pain intervention(s) - Progress toward pain management goals, including functional ability (for example, ability to take a deep breath, turn in bed, walk with improved pain control) - Side effects of treatment - Risk factors for adverse events caused by the treatment **NPG.06.02.01, EP 8** The hospital educates the patient and family on discharge plans related to pain management, including the following: - Pain management plan of care - Side effects of pain management treatment	• Hospital process for monitoring patients identified as high risk when receiving opioids. • How they screen, assess, and reassess patients for pain, non-pharmacologic approaches they offer. Ask patients and when appropriate, family members about: ☐ How the staff involved them in their pain management, plan of care, what their pain management plan of care includes (non-pharmacologic, pharmacologic or a combination of approaches). ☐ Their level of understanding of discharge instructions related to the pain management plan of care including side effects of pain management treatment, activities of daily living in the home environment that may exacerbate pain including strategies to address these issues. **Document Review** ☐ Review patient clinical records for: • Screening, assessments, and reassessments of the patient's pain. • A pain treatment plan and involvement of the patient in the planning process. • Documentation of patient monitoring for pain and their response to pain management interventions, including effectiveness, side effects and risk factors for adverse events caused by the treatment. • Documentation of any patient and family education related to pain management throughout the stay and at the time of discharge.

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- Daily living activities, including the home environment, that might exacerbate pain or reduce effectiveness of the pain management plan of care and strategies to address these issues - Safe use, storage, and disposal of opioids when prescribed	
NPG.06.03.01 The hospital collects data on pain assessment and management. **NPG.06.03.01, EP 1** The hospital analyzes data collected on pain assessment and pain management to identify areas that need change to increase safety and quality for patients.	**Interview** ☐ Discuss with staff, as appropriate, at the unit level: • Data collection processes and responsibilities (for example but not limited to: medication management, blood and blood product use, resuscitation, restraints and seclusion, pain assessment, pain management, other) ☐ Ask leaders and staff responsible for the organization's quality assessment and performance improvement activities about the patient safety-related data monitoring that is taking place. Determine if pain assessment, pain management, including non-pharmacologic approaches, and safe opioid use are being monitored.
NPG.07.01.01 The hospital respects the patient's right to receive information in a manner the patient understands. **NPG.07.01.01, EP 1** The hospital respects the patient's right to and need for effective communication. **NPG.07.01.01, EP 2** The hospital provides interpreting and translation services, as necessary. Note: For hospitals that elect Joint Commission's Primary Care Medical Home option: Language interpreting options may include trained bilingual staff, contract interpreting services, or employed language interpreters. These options may be provided in person or via telephone or video. The documents translated, and the languages into which they are translated, are dependent on the primary care medical home's patient population. **NPG.07.01.01, EP 3** The hospital communicates with the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient's needs.	**Interview** ☐ Ask staff about the availability of tools and resources to assist with patient communication, such as: Access to language interpreters, access to translated documents, the potential for involvement of interpreter on care team **Observation** ☐ Look for staff use of available tools and resources to identify and address patient communication needs, such as language identification tools, language interpreter services, communication boards, use of teach back techniques to address health literacy needs, patient access to the nurse call button.

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NPG.07.02.01 The hospital honors the patient's right to give or withhold informed consent. **NPG.07.02.01, EP 1** The hospital develops and implements a written policy on informed consent that describes the following: - Specific care, treatment, and services that require informed consent. - Circumstances that would allow for exceptions to obtaining informed consent. - Process used to obtain informed consent. - Physicians or other licensed practitioners permitted to conduct the informed consent discussion in accordance with law and regulation. - How informed consent is documented in the patient record. Note: Documentation may be recorded in a form, in progress notes, or elsewhere in the record. - When a surrogate decision-maker may give informed consent. **NPG.07.02.01, EP 2** The informed consent process includes a discussion about the following: - Patient's proposed care, treatment, and services. - Potential benefits, risks, and side effects of the patient's proposed care, treatment, and services; the likelihood of the patient achieving their goals; and any potential problems that might occur during recuperation. - Reasonable alternatives to the patient's proposed care, treatment, and services. The discussion encompasses risks, benefits, and side effects related to the alternatives and the risks related to not receiving the proposed care, treatment, and services.	**Interview** ☐ Ask staff, including physicians and other practitioners about the process they follow when a patient's care, treatment, and services requires informed consent. • What do they explain and discuss with the patient? • How do they document informed consent in the patient's medical record? • What happens when a patient is unable to provide informed consent? ☐ Ask a patient who is scheduled for a procedure about the process they experienced when they were asked to consent to the procedure. **Document Review** **General** ☐ Confirm that the hospital has a written policy on patient informed consent and that it addresses all the EP requirements. **Patient Clinical Record** Patient informed consent documented per hospital policy
NPG.07.03.01 The hospital assesses the patient who may be a victim of possible abuse, neglect, and exploitation. **NPG.07.03.01, EP 1** The hospital uses written criteria to identify those patients who may be victims of physical assault, sexual assault, sexual molestation, domestic abuse, elder or child abuse, neglect, and exploitation. Patients are	**Interview** ☐ Ask staff about the criteria that guides them in identifying potential victims of abuse, neglect, and exploitation. • How do they access these criteria and guidance? • Has the organization offered staff education on how to recognize signs of possible abuse, neglect and exploitation and how to follow-up?

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evaluated upon entry into the hospital and on an ongoing basis. Note: Criteria can be based on age, sex, and circumstance. **NPG.07.03.01, EP 2** To assist with referrals of possible victims of abuse, neglect, and exploitation, the hospital maintains a list of private and public community agencies that can provide or arrange for assessment and care. **NPG.07.03.01, EP 3** The hospital educates staff about how to recognize signs of possible abuse, neglect, and exploitation and about their roles in follow-up. **NPG.07.03.01, EP 4** The hospital internally reports cases of possible abuse, neglect, and exploitation. **NPG.07.03.01, EP 5** When the hospital serves a population of patients that need protective services (for example, guardianship or advocacy services, conservatorship, or child or adult protective services), it provides resources to help the family and the courts determine the patient's needs for such services.	• What resources and information does the organization have available for staff to offer possible victims? • What process does staff follow when they suspect a patient may be a victim of abuse, neglect, and exploitation? **Document Review** Review the organization's policy and procedures on patient abuse, neglect and exploitation.
NPG.07.04.01 The hospital treats the patient in a dignified and respectful manner. **NPG.07.04.01, EP 1** The hospital respects the patient's cultural and personal values, beliefs, and preferences. **NPG.07.04.01, EP 2** The hospital accommodates the patient's right to religious and other spiritual services.	**Interview** ☐ Ask patients or family members how the organization identified and addressed oral and written communication needs with them and, if necessary, how language services were provided ☐ Ask patients or family members if staff inquired about their race and ethnicity and informed them of their rights to religious and other spiritual services. ☐ Ask staff about organization expectations for treatment of patients and observance of patient rights. **Observation** During tracer activity throughout the organization, observe and listen to how staff interact with and care for patients.
NPG.09.01.01 The hospital uses standardized procedures for managing tissues. **NPG.09.01.01, EP 1** The hospital develops and implements standardized written procedures for the acquisition, receipt, storage, and issuance of tissues.	**Interview** ☐ Interview laboratory personnel to discuss: • Process for ensuring that the source facility is licensed (state) and/or registered (federal) (EP 2) • Coordination of tissue ordering, receipt, storage, handling and issuance – validate that these processes are being done

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NPG.09.01.01, EP 2 The hospital confirms that tissue suppliers are registered with the US Food and Drug Administration (FDA) as a tissue establishment and maintain a state license when required.
Note 1: This element of performance does not apply to autologous tissue- or cellular-based products considered tissue for the purposes of these standards but classified as medical devices by the FDA.
Note 2: The supplier's FDA registration status may also be checked annually by using the FDA's online database: https://www.fda.gov/vaccines-blood-biologics/biologics-establishment-registration/findtissueestablishment.
 	
NPG.09.01.01, EP 3 The hospital follows the tissue suppliers' or manufacturers' written directions for transporting, handling, storing, and using tissue.
 	
NPG.09.01.01, EP 4 The hospital maintains daily records to demonstrate that tissues requiring a controlled environment are stored at the required temperatures.
Note 1: Types of tissue storage include room temperature, refrigerated, frozen (for example, deep freezing colder than -40°C), and liquid nitrogen storage.
Note 2: Tissues requiring no greater control than "ambient temperature" (defined as the temperature of the immediate environment) for storage would not require temperature monitoring.
 	
NPG.09.01.01, EP 5 The hospital continuously monitors the temperature of refrigerators, freezers, nitrogen tanks, and other storage equipment used to store tissues.
Note 1: Continuous temperature recording is not required but may be available with some continuous temperature monitoring systems.
Note 2: For tissue stored at room temperature, continuous temperature monitoring is not required.
 	
NPG.09.01.01, EP 6 Refrigerators, freezers, nitrogen tanks, and other storage equipment used to store tissues at a controlled temperature have functional alarms and an emergency backup plan. Note: For tissue stored at room temperature, alarm systems are not required.
 	
NPG.09.01.01, EP 7 In Department of Defense hospitals, Veterans Affairs medical centers, and other federally administered health care agencies, notification to the organ procurement organization of patients who have died or
	according to manufacturer or source facility written directions (EP 3)
	• Physical Environment (EPs 4-6)
	  ○ Storage – continuous temperature (refrigerator and freezer, not room or ambient storage), functional alarms, emergency backups
	  ○ Documentation of tissue temperatures
	  ○ Acceptance of tissue from source:
	  ▪ Process for ensuring package integrity
	  ▪ Transportation temperature
	  • No thermometer needed but do need to know if shipping containers were validated.
	
	Document Review
	☐ Daily records for tissue storage temperatures
	☐ Temperature monitoring logs for tissue storage equipment

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whose death is imminent is done according to procedures approved by the respective agency.	
NPG.09.02.01 The hospital traces all tissues bi-directionally. **NPG.09.02.01, EP 1** The hospital's records allow any tissue to be traced from the donor or tissue supplier to the recipient(s) or other final disposition, including discard, and from the recipient(s) or other final disposition back to the donor or tissue supplier. **NPG.09.02.01, EP 2** The hospital identifies, in writing, the materials and related instructions used to prepare or process tissues.	**Document Review** ☐ Record keeping on tissues • Donor/source facility to final disposition (discarded, returned to source facility or transplanted/implanted to recipient) traceability and vice versa. ○ Source facility information ○ Pre-transplant/implant documentation ○ Post transplant/implant documentation ○ Return information to source facility
NPG.09.03.01 The hospital investigates adverse events related to tissue use or donor infections. **NPG.09.03.01, EP 1** The hospital has a written procedure to investigate tissue adverse events, including disease transmission or other complications that are suspected of being directly related to the use of tissue. The procedure includes the following at a minimum: - Investigating disease transmission or other complications that are suspected of being directly related to the use of tissue - Reporting of a post-transplant infection or adverse event related to the use of tissue to the tissue supplier as soon as the hospital becomes aware - Sequestering of tissue whose integrity may have been compromised or that is reported by the tissue supplier as a suspected cause of infection - Identifying and informing tissue recipients of infection risk when donors are subsequently found to have human immunodeficiency virus (HIV), human T-lymphotropic virus-I/II (HTLV-I/II), viral hepatitis, or other infectious agents known to be transmitted through tissue.	**Interview** ☐ Ask laboratory staff responsible for tissue storage and issuance about adverse events investigation and implementation of procedures for: • Tracking and investigation of tissue transplant infections • Reporting of infections to source • Sequestering other associated tissue, if contamination is suspected • Identification and notification to recipients of suspected infections **Document Review** Confirm that the organization has written procedures to investigate tissue adverse events and that it includes at a minimum those elements identified in the EP.
NPG.10.01.01 Policies and procedures for waived tests are established, current, approved, and readily available. **NPG.10.01.01, EP 1** The person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate, or	**Interview** ☐ Interview the waived testing director or supervisor whose name appears on the CLIA certificate, or a qualified designee about • Policies and procedures for waived testing

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a qualified designee, establishes written policies and procedures for waived testing that address the following: - Clinical usage and limitations of the test methodology - Need for confirmatory testing (for example, recommendations made by the manufacturer for rapid tests) and result follow-up recommendations (for example, a recommendation to repeat the test when results are higher or lower than the reportable range of the test) - Specimen type, collection, and identification, and required labeling - Specimen preservation, if applicable - Instrument maintenance and function checks, such as calibration - Storage conditions for test components - Reagent use, including not using a reagent after its expiration date - Quality control (including frequency and type) and corrective action when quality control is unacceptable - Test performance - Result reporting, including not reporting individual patient results unless quality control is acceptable - Equipment performance evaluation Note 1: Policies and procedures for waived testing are made available to testing personnel. Note 2: The designee should be knowledgeable by virtue of training, experience, and competence about the waived testing performed. **NPG.10.01.01, EP 2** Policies or procedures for each waived test are consistent with manufacturers' instructions for use and include specific operational policies (that is, detailed quality control protocols and any other institution-specific procedures regarding the test or instrument).	○ Do they reflect manufacturers' instructions for use and include specific operational policies? • How these policies and procedures are made available to testing personnel. **Document Review** Confirm that waived testing policies and procedures address all the required items from the EP.
NPG.10.02.01 Staff performing waived tests are competent. **NPG.10.02.01, EP 1** Staff who perform waived testing have been trained for each test that they are authorized to perform. The training for each waived test	**Interview** □ Ask staff who are performing waived testing about their orientation and training as well as their competency assessment for performing the specific test(s).

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is documented. Note: This includes training on the use and maintenance of instruments. **NPG.10.02.01, EP 2** Competence for waived testing is assessed according to hospital policy at defined intervals, but at least at the time of orientation and annually thereafter. Competency is assessed using at least two of the following methods per person per test: - Performance of a test on a blind specimen - Periodic observation of routine work by the supervisor or qualified designee - Monitoring of each user's quality control performance - Use of a written test specific to the test assessed This competency is documented. Note 1: When a licensed practitioner performs waived testing that does not involve an instrument and the test falls within their specialty, the hospital may use the medical staff credentialing and privileging process to document evidence of training and competency in lieu of annual competency assessment. In this circumstance, individual privileges include the specific waived tests appropriate to the scope of practice that they are authorized to perform. At the discretion of the person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate or according to hospital policy, more stringent competency requirements may be implemented. Note 2: Provider-performed microscopy (PPM) procedures are not waived tests.	• How often is their competency in performing waived testing assessed? **Document Review** **Personnel Files** ☐ Confirm through documentation that staff who perform waived testing have been trained for each test they perform. ☐ Confirm through documentation that staff competence for waived testing has been assessed according to hospital policy at defined intervals, but at least at orientation and annually thereafter. • Does documentation reflect that staff competency was assessed using at least two of the methods presented in the EP?
NPG.11.01.01 The hospital manages security risks. **NPG.11.01.01, EP 1** The hospital controls access to and from areas it identifies as security sensitive. **NPG.11.01.01, EP 2** The hospital develops and implements written policies and procedures to follow in the event of a security incident, including an infant or pediatric abduction. **NPG.11.01.01, EP** 3 The hospital develops and implements a process(es) for continually monitoring, internally reporting, and investigating the following: - Injuries to patients or others within the hospital's facilities and grounds	**Interview** ☐ Ask organization staff about the areas that are considered security sensitive and require controlled access. ☐ Ask about the methods of controlled access that are being used throughout the organization and the effectiveness. ☐ Ask about the organization's internal safety and security reporting process. • How accessible (ease of locating and use) is the reporting process to staff? • Is staff encouraged to report both actual and potential for safety and security issues?

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- Occupational illnesses and staff injuries - Incidents of damage to its property or the property of others - Safety and security incidents involving patients, staff, or others within its facilities, including those related to workplace violence - Hazardous materials and waste spills and exposures - Fire safety management problems, deficiencies, and failures - Medical or laboratory equipment management problems, failures, and use errors - Utility systems management problems, failures, or use errors Note 1: All the incidents and issues listed above may be reported to staff in quality assessment, improvement, or other functions. A summary of such incidents may also be shared with the person designated to coordinate safety management activities. Note 2: Review of incident reports often requires that legal processes be followed to preserve confidentiality. Opportunities to improve care, treatment, and services, or to prevent similar incidents, are not lost as a result of following the legal process. **NPG.11.01.01, EP** 4 The hospital coordinates administrative and clinical decisions for patients under legal or correctional restrictions on the following: - Use of seclusion and restraint for nonclinical purposes - Imposition of disciplinary restrictions - Restriction of rights - Plan for discharge and continuing care, treatment, and services - Length of stay.	☐ Ask leaders and staff to describe: • How they monitor safety and security throughout the organization (e.g., unit-, department-, building/site-level) and with what frequency. • The process that is followed to investigate and address safety and security incident reports. ☐ Ask leaders and staff about the processes that are followed when the organization is providing care to patients under legal or correctional restrictions. How does the organization coordinate administrative and clinical decisions for these patients? **Document Review** Review organization written policies and procedures related to security incidents, including infant or pediatric patient abduction. **Observation** During individual tracer and other building tour activity, visit areas that are subject to controlled access to observe the security measures that are in place.
NPG.11.02.01 The hospital assesses and manages the patient's risks for falls. **NPG.11.02.01, EP 1** The hospital implements fall risk reduction interventions based on the patient population, setting, and individual patient's assessed risks.	**Interview** ☐ Ask staff about the assessment process for determining if a patient is at risk for falls. • Describe the types of interventions the organization has available for staff to use with patients that are at risk for falls.

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	☐ If possible, interview a patient or patients that have been identified as at risk for falls. Ask if they are aware of this assessment and how staff are working with them to reduce their risk for a fall. **Document Review** **Patient Clinical Record** Review the clinical records of patients who were identified as fall risks to see if documentation reflects the interventions that are being used to mitigate the risk of falls and avoid injuries due to a fall. **Observation** Try to observe a patient or patients who have been assessed as being at risk for falls to see what risk reduction interventions are in place and how staff are working with these patients.
NPG.11.03.01 The hospital manages utility systems. **NPG.11.03.01, EP 1** The hospital develops and implements written procedures for responding to utility system disruptions. The procedures include but are not limited to shutting off a malfunctioning system and notifying staff in the affected areas. **NPG.11.03.01, EP 2** The hospital develops and implements a policy to provide emergency backup for essential medication dispensing equipment identified by the hospital, such as automatic dispensing cabinets, medication carousels, and central medication robots. Note: Examples of emergency backup can include emergency power, battery-based indoor generators, or other actions describing how dispensing and administration of medications will continue when emergency backup is needed. **NPG.11.03.01, EP 3** The hospital develops and implements a policy to provide emergency backup for essential refrigeration for medications identified by the hospital, such as designated refrigerators and freezers. Note: Examples of emergency backup can include emergency power, battery-based indoor generators, or other actions describing how refrigeration of medications will continue when emergency backup is needed.	**Interview** ☐ Facilities staff about utility systems and the procedures that are followed if there be a disruption in operations. ☐ Ask facilities staff about the emergency back-up systems that are in place in case of a malfunctioning utility system. **Document Review** ☐ Confirm that there are written procedures for responding to utility system disruptions. ☐ Confirm that the organization has policies for providing utility system emergency backup to essential medication dispensing equipment and essential medication refrigeration and freezer units.

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NPG.11.04.01 The critical access hospital safely prepares and stores food and nutrition products. **NPG.11.04.01, EP 1:** The critical access hospital prepares and stores food and nutrition products (including those brought in by patients or their families) using proper sanitation.	**Interview** ☐ Ask leaders and staff to describe the food services offered by the organization. ☐ Determine who is responsible for these services and ask them to describe the safety measures in place for food preparation and storage. ☐ Ask staff on units about how the monitor any food and nutrition products brought in by patients or their families. **Observation** Visit areas where food is prepared and stored and determine who oversees and maintains these areas and monitors them for safety.
NPG.12.04.01 The hospital verifies that staff complete all requirements for employment and practice within their scope of practice. **NPG.12.04.01, EP 1:** The hospital obtains a criminal background check on the applicant as required by law and regulation or hospital policy. Criminal background checks are documented. **NPG.12.04.01, EP 2:** Staff comply with applicable health screening as required by law and regulation or hospital policy. Health screening compliance is documented. **NPG.12.04.01, EP 3:** Staff who provide patient care, treatment, and services practice within the scope of their license, certification, or registration, in accordance with law and regulation.	**Interview** Ask clinical leaders how they monitor staff to determine that they are providing patient care, treatment and services within their scope of practice. **Document Review** **Personnel Files** ☐ Verify criminal background checks are obtained on applicants per law and regulation or hospital policy. ☐ Verify through review of a sample of employee health files any documentation that staff has undergone required health screenings. **Observation** Observe clinical staff throughout the organization providing care, treatment and services to patients.
NPG.12.05.01 The hospital provides education and training and evaluates staff competence. **NPG.12.05.01, EP 1:** The hospital orients staff on the following: - Relevant hospitalwide and unit-specific policies and procedures - Their specific job duties, including those related to infection prevention and control and assessing and managing pain - Sensitivity to cultural diversity based on their job duties and responsibilities	**Interview** ☐ Ask staff responsible for the human resources functions in the organization to describe the orientation process for new staff to the organization, job responsibilities, and/or clinical responsibilities. Ask about the topics that are included in the curriculum for all staff and all clinical staff.

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- Patient rights, including ethical aspects of care, treatment, or services and the process used to address ethical issues based on their job duties and responsibilities. Completion of this orientation is documented. **NPG.12.05.01, EP 2:** The hospital evaluates staff performance once every three years, or more frequently as required by hospital policy or in accordance with law and regulation. Staff are evaluated based on performance expectations that reflect their job responsibilities. This evaluation is documented.	☐ Ask human resources staff what they know about department and job-level orientation processes and content. ☐ Ask human resources staff about the conduct of staff performance evaluations. Is there a common process used throughout the organization? Anything unique to clinical staff? What is the frequency of such evaluations? **Document Review** **General** ☐ Review staff orientation curriculum to determine what hospital policies and procedures are covered; make a note to validate with staff encountered during individual patient tracers. **Personnel Files** ☐ Review personnel files for documentation of staff member orientation completion and any performance evaluations. Check that each are based on job responsibilities.
NPG.12.06.01 The hospital evaluates staffing during performance improvement activities. **NPG.12.06.01, EP 1:** When the hospital identifies undesirable patterns, trends, or variations in its performance related to the safety or quality of care (for example, as identified in the analysis of data or a single undesirable event), it includes the adequacy of staffing, including nurse staffing, in its analysis of possible causes. Note 1: Adequacy of staffing includes the number, skill mix, and competency of all staff. In their analysis, hospitals may also wish to examine issues such as processes related to workflow; competency assessment; credentialing; supervision of staff; and orientation, training, and education. Note 2: Hospitals may find value in using the staffing effectiveness indicators (which include National Quality Forum Nursing Sensitive Measures) to help identify potential staffing issues. **NPG.12.06.01, EP 2:** When analysis reveals a problem with the adequacy of staffing, the leaders responsible for the hospitalwide patient safety program (as	**Interview** ☐ Ask leaders and staff responsible for organization quality and performance improvement: • When staffing adequacy is considered or evaluated in association with a quality or safety issue that is in need of correction or improvement. • How are organization leaders responsible for the organization-wide patient safety program informed of analyses that reveal staffing adequacy problems and actions taken to resolve the problems. • How frequently are the leaders of the organizationwide safety program presented with the results of staffing adequacy analyses and actions taken to resolve problems. • If any information is shared with governance about staffing adequacy analyses? **Document Review**

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addressed at NPG.02.03.01, EP 1) are informed, in a manner determined by the safety program, of the results of this analysis and actions taken to resolve the identified problem(s). **NPG.12.06.01, EP 3:** At least once a year, the leaders responsible for the hospitalwide patient safety program review a written report on the results of any analyses related to the adequacy of staffing and any actions taken to resolve identified problems. **NPG.12.06.01, EP 4:** At least once a year, the leaders provide governance with written reports that include results of the analyses related to the adequacy of staffing.	Review any written reports related to staffing adequacy analyses that are provided to safety program leaders and governance.
NPG.13.01.01 The hospital defines and verifies qualifications and education requirements for imaging services staff. **NPG.13.01.01, EP 1**: Technologists who perform diagnostic computed tomography (CT) exams have advanced-level certification by the American Registry of Radiologic Technologists (ARRT) or the Nuclear Medicine Technology Certification Board (NMTCB) in computed tomography or have one of the following qualifications: - State licensure that permits them to perform diagnostic CT exams and documented training on the provision of diagnostic CT exams - Registration and certification in radiography by ARRT and documented training on the provision of diagnostic CT exams - Certification in nuclear medicine technology by ARRT or NMTCB and documented training on the provision of diagnostic CT exams Note 1: This element of performance does not apply to CT exams performed for therapeutic radiation treatment planning or delivery or for calculating attenuation coefficients for nuclear medicine studies. Note 2: This element of performance does not apply to dental cone beam CT radiographic imaging studies	**Document Review** **Personnel and Credentials Files** ☐ Review the personnel and credentials files and job descriptions of specific staff and other credentialed practitioners. For example, the director of dietary services, pharmacist responsible for pharmacy services, radiology and nuclear medicine, and therapy staff. ☐ Verify that the medical staff determines the qualifications of the radiology staff and approves the nuclear services director's specifications for qualifications of the nuclear medical staff. ☐ Review the personnel and credentials files of the medical physicist(s) supporting CT and fluoroscopy services ☐ Review personnel files of technologists responsible for performing diagnostic CT exams. Verify whether they have obtained any certification(s) or licensure that would indicate they are qualified to perform diagnostic CT exams ☐ Check for documentation indicating that CT technologists have received training in the provision of diagnostic CT exams.

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performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. **NPG.13.01.01, EP 2:** The hospital verifies and documents that diagnostic medical physicists who support computed tomography (CT) services have board certification in diagnostic radiologic physics or radiologic physics by the American Board of Radiology, or in diagnostic imaging physics by the American Board of Medical Physics, or in diagnostic radiological physics by the Canadian College of Physicists in Medicine, or meet all of the following requirements: - A graduate degree in physics, medical physics, biophysics, radiologic physics, medical health physics, or a closely related science or engineering discipline from an accredited college or university - College coursework in the biological sciences with at least one course in biology or radiation biology and one course in anatomy, physiology, or a similar topic related to the practice of medical physics - Documented experience in a clinical CT environment conducting at least 10 CT performance evaluations under the direct supervision of a board-certified medical physicist Note: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. **NPG.13.01.01, EP 3:** The hospital verifies and documents that individuals who perform diagnostic computed tomography (CT) examinations participate in ongoing education that includes annual training on the following: - Radiation dose optimization techniques and tools for pediatric and adult patients addressed in the Image Gently® and Image Wisely® campaigns - Safe procedures for operation of the types of CT equipment they will use Note 1: Information on the Image Gently and Image Wisely initiatives can be found online at https://www.imagegently.org and https://www.imagewisely.org, respectively.	

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Note 2: This element of performance does not apply to CT systems used for therapeutic radiation treatment planning or delivery or for calculating attenuation coefficients for nuclear medicine studies. Note 3: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. **NPG.13.01.01, EP 4:** The hospital verifies and documents that technologists who perform magnetic resonance imaging (MRI) examinations participate in ongoing education, including annual training on safe MRI practices in the MRI environment that addresses the following: - Patient screening criteria that address ferromagnetic items, electrically conductive items, medical implants and devices, and risk for nephrogenic systemic fibrosis (NSF) - Proper patient and equipment positioning activities to avoid thermal injuries - Equipment and supplies that have been determined to be acceptable for use in the MRI environment (MR safe or MR conditional) - MRI safety response procedures for patients who require urgent or emergent medical care - MRI system emergency shutdown procedures, such as MRI system quench and cryogen safety procedures - Patient hearing protection - Management of patients with claustrophobia, anxiety, or emotional distress Note: Terminology for defining the safety of items in the magnetic resonance environment is provided in ASTM F2503 Standard Practice for Marking Medical Devices and Other Items for Safety in the Magnetic Resonance Environment (http://www.astm.org).	
NPG.13.02.01 The hospital's imaging services have a designated leader and follow current safe imaging practices. **NPG.13.02.01, EP 1:** The hospital designates an individual to serve as the radiation safety officer who is responsible for making certain that radiologic services are provided in accordance with law, regulation, and hospital policy. This individual has the necessary authority and leadership support to do the following:	**Interview** ☐ Identify who the organization has identified to serve as the radiation safety officer. Ask this individual about their responsibilities and the authority and leadership support they receive to make certain radiologic services are provided in accordance with law, regulation, and hospital policy.

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- Monitor and verify compliance with established radiation safety practices (including oversight of dosimetry monitoring) - Provide recommendations for improved radiation safety - Intervene as needed to stop unsafe practices - Implement corrective action **NPG.13.02.01, EP 2:** The hospital provides radiology services that meet safety standards approved by nationally recognized professional organizations. At a minimum, diagnostic radiology services are maintained and available at all times the hospital provides services, including emergency services. Note: If the hospital also provides other radiology services, such as therapeutic radiology, the requirements of this element of performance also apply to those services. **NPG.13.02.01, EP 3:** The hospital establishes or adopts diagnostic computed tomography (CT) imaging protocols based on current standards of practice, which address key criteria including the following: - Clinical indication - Contrast administration - Age (to indicate whether the patient is pediatric or an adult) - Patient size and body habitus - Expected radiation dose index range Note: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. **NPG.13.02.01, EP 4:** Diagnostic computed tomography (CT) imaging protocols are reviewed and kept current with input from an interpreting physician, medical physicist, and lead imaging technologist to make certain that they adhere to current standards of practice and account for changes in CT imaging equipment. These reviews are conducted at time frames identified by the hospital. (For rehabilitation and psychiatric distinct part units in hospitals, refer to MS.17.01.03, EP 5 for supervision of radiologic services) Note: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.	☐ Ask about the availability of diagnostic radiology services and the availability of therapeutic radiology services if provided by the organization. ☐ Ask radiology services leaders and staff about imaging services protocols and what these are based on, as well as who is involved in the review and update. **Document Review** Confirm the organization is following diagnostic CT imaging protocols and that they are current with standards of practice.
NPG.13.03.01 The hospital manages imaging safety risks.	**Interview**

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NPG.13.03.01, EP 1: The hospital manages magnetic resonance imaging (MRI) safety risks associated with the following: - Patients who may experience claustrophobia, anxiety, or emotional distress - Patients who may require urgent or emergent medical care - Patients with medical implants, devices, or imbedded metallic foreign objects (such as shrapnel) - Ferromagnetic objects entering the MRI environment - Acoustic noise **NPG.13.03.01, EP 2:** The hospital manages magnetic resonance imaging (MRI) safety risks by doing the following: - Restricting access of everyone not trained in MRI safety or screened by staff trained in MRI safety from the scanner room and the area that immediately precedes the entrance to the MRI scanner room. - Making sure that these restricted areas are controlled by and under the direct supervision of staff trained in MRI safety. - Posting signage at the entrance to the MRI scanner room that conveys that potentially dangerous magnetic fields are present in the room. Signage should also indicate that the magnet is always on except in cases where the MRI system, by its design, can have its magnetic field routinely turned on and off by the operator. **NPG.13.03.01, EP 3:** For diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist does the following: - Measures the radiation dose (in the form of volume computed tomography dose index [CTDIvol]) produced by each diagnostic CT imaging system for the following four CT protocols: adult brain, adult abdomen, pediatric brain, and pediatric abdomen. If one or more of these protocols is not used by the hospital, other commonly used CT protocols may be substituted. - Verifies that the radiation dose (in the form of CTDIvol) produced and measured for each protocol tested is within 20 percent of the CTDIvol displayed on the CT console. The dates, results, and verifications of these measurements are documented. Note 1: This element of performance is only applicable for systems capable of calculating and displaying radiation doses.	☐ Ask radiology leaders and staff about the safety program they have in place related to imaging services. ☐ Ask for details related to managing MRI safety risks ☐ If provided, ask about dosimetry monitoring for staff who are performing these services and who is providing this monitoring. ☐ When diagnostic CT services are provided ask if the organization is engaging a diagnostic medical physicist to perform the services that are noted in EPs 3-5. **Observation** ☐ Visit radiology services as part of tracer activity to look for evidence that imaging safety risks are being managed. ☐ Review reports and records that demonstrate the organization is engaging the services of a diagnostic medical physicist or MRI scientist to perform the services noted in EPs 3-5.

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Note 2: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. Note 3: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. (For more information, refer to HR.11.01.03, EP 1; HR.11.02.01, EP 2; NPG.12.04.01, EP 3) **NPG.13.03.01, EP 4:** For diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist conducts a performance evaluation of all CT imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes the use of phantoms to assess the following imaging metrics: - Image uniformity - Scout prescription accuracy - Alignment light accuracy - Table travel accuracy - Radiation beam width - High-contrast resolution - Low-contrast detectability - Geometric or distance accuracy - CT number accuracy and uniformity - Artifact evaluation Note 1: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. Note 2: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. (For more information, refer to HR.11.01.03, EP 1; HR.11.02.01, EP 2; NPG.12.04.01, EP 3) **NPG.13.03.01, EP 5:** At least annually, a diagnostic medical physicist or magnetic resonance imaging (MRI) scientist conducts a performance evaluation of all MRI imaging equipment. The evaluation results, along with	

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recommendations for correcting any problems identified, are documented. The evaluation includes the use of phantoms to assess the following imaging metrics: - Image uniformity for all radiofrequency (RF) coils used clinically - Signal-to-noise ratio (SNR) for all coils used clinically - Slice thickness accuracy - Slice position accuracy - Alignment light accuracy - High-contrast resolution - Low-contrast resolution (or contrast-to-noise ratio) - Geometric or distance accuracy - Magnetic field homogeneity - Artifact evaluation Note: Medical physicists or MRI scientists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the medical physicist or MRI scientist. (For more information, refer to HR.11.01.03, EP 1; HR.11.02.01, EP 2; NPG.12.04.01, EP 3)	
NPG.13.04.01 The hospital monitors quality improvement projects related to imaging safety. **NPG.13.04.01, EP 1:** The hospital collects data on the following: - Patient thermal injuries that occur during magnetic resonance imaging (MRI) exams - Incidents where ferromagnetic object unintentionally entered the MRI scanner room - Injuries resulting from the presence of ferromagnetic objects in the MRI scanner room **NPG.13.04.01, EP 2:** The hospital reviews and analyzes incidents where the radiation dose index (computed tomography dose index [CTDIvol], dose length product [DLP], or size-specific dose estimate [SSDE]) from diagnostic CT examinations exceeded expected dose index ranges identified in imaging protocols. These incidents are then compared to external benchmarks.	**Interview** ☐ Ask imaging services leaders and staff about the data being collected to monitor safety of imaging services. ☐ Ask about the frequency of analysis and reporting of the imaging safety data. ☐ Who is monitoring these data and determining if there is any action needed to correct or improve performance. ☐ Who is responsible for reviewing and analyzing incidents related to CT and MRI incidents.

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Note 1: While the CTDIvol, DLP, and SSDE are useful indicators for monitoring radiation dose indices from the CT machine, they do not represent the patient's radiation dose. Note 2: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.	
NPG.14.01.01 The hospital safely manages pharmaceutical services. **NPG.14.01.01, EP 1** When an on-site pharmacy is not open 24 hours a day, 7 days a week, the following occurs: - A health care professional, who the hospital determines is qualified, reviews the medication order in the pharmacist's absence - A pharmacist conducts a retrospective review of all medication orders during this period as soon as a pharmacist is available or the pharmacy opens **NPG.14.01.01, EP 2** When automatic dispensing cabinets (ADCs) are used, the hospital develops and implements a policy that describes the types of medication overrides that will be reviewed for appropriateness and the frequency of the reviews. A 100% review of overrides is not required.	**Interview** ☐ Ask organization leaders and staff who reviews medication orders in the pharmacist's absence. ☐ Ask the pharmacist about their process for reviewing orders that are received while the pharmacy is closed. ☐ Ask the pharmacist and other clinical leaders about the policy and procedures for automatic dispensing cabinet medication overrides.
NPG.14.02.01 The hospital selects and procures medications. **NPG.14.02.01, EP 1** The hospital standardizes and limits the number of drug concentrations available to meet patient care needs. **NPG.14.02.01, EP 2** The hospital follows a process to communicate medication shortages and outages to staff who participate in medication management. **NPG.14.02.01, EP 3** The hospital follows written medication substitution protocols to be used in the event of a medication shortage or outage and communicates the medication substitution protocols for shortages or outages to all affected staff.	**Interview** ☐ Discuss with leaders and staff: • ~~The safeguards the organization has in place to reduce the risk of errors and minimize patient or staff harm related to high alert or hazardous medication(s) and look alike and sound alike medications.~~ • Interventions/solutions the organization/unit has in place to prevent medication errors (standardizing processes). • Process to communicate medication shortages and outages to staff who participate in medication management, and the substitution protocols that will be followed

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
	• Medication substitution protocols that are followed in the event of a medication shortage or outage. ~~Document Review~~ ~~□ Review organization lists and processes for managing high alert and hazardous medication(s) and look-alike and sound-alike medications~~ ~~□ For hazardous drugs, review organization requirements for drug precaution labeling and appropriate personal protective equipment and observe handling by nursing staff if possible.~~
NPG.14.03.01 The hospital labels all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings. Note: Medication containers include syringes, medicine cups, and basins. **NPG.14.03.01, EP 1** In perioperative and other procedural settings both on and off the sterile field, the hospital labels medications and solutions that are not immediately administered. This applies even if there is only one medication being used. Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process. **NPG.14.03.01, EP 2** In perioperative and other procedural settings both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to another container. **NPG.14.03.01, EP 3** In perioperative and other procedural settings both on and off the sterile field, medication or solution labels include the following: - Medication or solution name - Strength - Amount of medication or solution containing medication (if not apparent from the container) - Diluent name and volume (if not apparent from the container)	Interview □ Discuss with staff in procedural areas what procedures are followed for medication safety specific to labeling of medications and containers. Document Review □ Review any policy or procedures, data collection, PI activities for hospital performance and evaluation. Data collection may also be found with hospital internal reporting systems. Observation □ In perioperative and other procedural settings observe actions of staff for medication preparation both on and off the sterile field.

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
- Expiration date and time Note: The date and time are not necessary for short procedures, as defined by the hospital. **NPG.14.03.01, EP 4** The hospital verifies all medication or solution labels both verbally and visually. Verification is done by two individuals qualified to participate in the procedure whenever the person preparing the medication or solution is not the person who will be administering it. **NPG.14.03.01, EP 5** The hospital labels each medication or solution as soon as it is prepared, unless it is immediately administered. Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.	
NPG.14.04.01 The hospital reduces the likelihood of patient harm associated with the use of anticoagulant therapy. Note: This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for preventing venous thromboembolism (for example, related to procedures or hospitalization). **NPG.14.04.01, EP 1** The hospital uses approved protocols and evidence-based practice guidelines for reversal of anticoagulation and management of bleeding events related to each anticoagulant medication. **NPG.14.04.01, EP 2** The hospital uses approved protocols and evidence-based practice guidelines for perioperative management of all patients on oral anticoagulants. Note: Perioperative management may address the use of bridging medications, timing for stopping an anticoagulant, and timing and dosing for restarting an anticoagulant. **NPG.14.04.01, EP 3** The hospital uses only oral unit-dose products, prefilled syringes, or premixed infusion bags when these types of products are available. Note: For pediatric patients, prefilled syringe products should be used only if specifically designed for children.	**Interview** ☐ Interview staff about monitoring patients on anticoagulant therapy. **Document Review** ☐ Review hospital approved protocols and evidence based practice guidelines for reversal of anticoagulation management and bleeding events. ☐ Review performance improvement data and discuss any ongoing activities for anticoagulation therapy. ☐ Review medical records of patients on anticoagulant therapy, including those in perioperative areas and management of the pediatric patient.
NPG.14.05.01 The hospital maintains and communicates accurate patient medication information.	**Interview** ☐ Interview the staff who compares the medication information the patient brought to the hospital with the medications ordered:

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
NPG.14.05.01, EP 1 The hospital obtains information on the medications the patient is currently taking when they are admitted to the hospital or are seen in an outpatient setting. This information is documented in a list or other format that is useful to those who manage medications. Note 1: Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications. Note 2: It is often difficult to obtain complete information on current medications from a patient. A good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the EP. **NPG.14.05.01, EP 2** Define the types of medication information (for example, name, dose, route, frequency, purpose) to be collected in non-24-hour settings. Note: Examples of non-24-hour settings include the emergency department, primary care, outpatient radiology, ambulatory surgery, and diagnostic settings. **NPG.14.05.01, EP 3** Compare the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve discrepancies. Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the hospital, does the comparison. **NPG.14.05.01 EP 4** Provide the patient (or family, caregiver, or support person as needed) with written information on the medications the patient should be taking when they are discharged from the hospital or at the end of an outpatient encounter (for example, name, dose, route, frequency, purpose). **NPG.14.05.01, EP 5** Explain the importance of managing medication information to the patient when they are discharged from the hospital or at the end of an outpatient encounter. Note: Examples include instructing the patient to give a list to their primary care provider; to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added; and to carry medication information at all times in the event of emergency situations. (For information on patient education on medications, refer to Standards MM.16.01.01, PC.12.02.01, and PC.14.01.01.)	• How are discrepancies, omissions, duplication, unclear information resolved? • Is this person qualified to do this comparison? Review staff/credential file as appropriate. ☐ Interview patient and family about discharge medications. Determine from review of hospital policy if the patient was provided with any required information upon discharge. **Document Review** ☐ Review patient medical records for • medication reconciliation in both inpatient and outpatient settings and determine if the documentation is congruent in accordance with defined policy and procedures. • Be sure to determine if the documentation follows the hospital defined types of medication information. For example, name, dose, route, frequency etc. **Observation** ☐ Observe staff discharge process on patient care units. This may also be observed in outpatient areas. Ensure compliance through review of hospital policy and procedures.

Medical Staff-Related Standards Compliance Evaluation Guides

The material presented in this section is representative of what surveyors use when they are evaluating compliance with the medical staff-related standards in the **Hospital** and **Critical Access Hospital** accreditation program**.** Organizations may find these tools useful for continuous compliance and survey readiness efforts.

1. **Medical Staff Bylaws Review Guide**
2. **Medical Staff and Related Standards Compliance Evaluation Guide**
3. **Professional Graduate Medical Education Program Standard Compliance Evaluation Guide**
4. **Credentials File Review Tool**

Medical Staff Bylaws Review Guide	
Notes	**Requirement**
	MS.14.01.01, EP1 The organized medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following: ð Statement of the duties and privileges of each category of medical staff (for example, active, courtesy) ð Description of the organization of the medical staff, including those members who are eligible to vote ð Description of the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body ð Criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges, including the process for reprivileging physicians and other licensed practitioners ð Process for credentialing and recredentialing physicians and other licensed practitioners ð List of all the officer positions for the medical staff ð Process by which the organized medical staff selects and/or elects and removes the medical staff officers ð Process for adopting and amending the medical staff bylaws, medical staff rules and regulations, and policies ð The qualifications and roles and responsibilities of the department chair, when applicable Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the hospital are also subject to the requirements in 42 CFR 482.12(a)(8) and (a)(9), and 42 CFR 482.22(a)(3) and (a)(4). CoPs: §482.22(c)(1), §482.22(c)(2), §482.22(c)(3), §482.22(c)(4), §482.22(c)(6)
	MS.14.01.01, EP 2

	The medical staff bylaws include the qualifications for appointment and reappointment to the medical staff. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff is composed of doctors of medicine or osteopathy. In accordance with state law, including scope of practice laws, the medical staff may also include other categories of physicians, as listed at 42 CFR 482.12(c)(1), and other licensed practitioners who the governing body determines are eligible for appointment. Note 2: Gender, race, creed, and national origin are not used in making decisions regarding the granting or denying of medical staff membership. CoPs: §482.22(a)
	MS.14.01.01, EP 3 The medical staff bylaws include requirements for the following: ð Medical history and physical examination for each patient as described in PC.11.02.01, EP 2 ð Updated patient examinations as described in PC.11.02.01, EP 3 ð Assessments in lieu of medical history and physical examinations for patients as described in PC.11.02.01, EP 4 Note: The medical history and physical examination are completed and documented by a physician (as defined in section 1861(r) of the Social Security Act), an oral and maxillofacial surgeon, or other qualified licensed practitioner in accordance with state law and hospital policy. CoPs: §482.22(c)(5)(i), §482.22(c)(5)(ii), §482.22(c)(5)(iii)
	MS.14.01.01, EP 6 (HAP) The medical staff bylaws include the following requirements regarding the medical executive committee: ð The function, size, and composition, as determined by the organized medical staff and approved by the governing body; ð The authority delegated to the medical executive committee by the organized medical staff to act on the medical staff's behalf and how such authority is delegated or removed. (For more information on the role of the medical executive committee, refer to Standard MS.14.02.01.) ð The process, as determined by the organized medical staff and approved by the governing body, for selecting and/or electing and removing the medical executive committee members.

	Note: The medical executive committee includes physicians and may include other licensed practitioners.
	MS.14.01.01, EP 7 (HAP) The medical staff bylaws include the following requirements regarding the suspension or termination of a physician's or other licensed practitioner's medical staff membership or privileges: - Indications and process for automatic suspension of a physician's or other licensed practitioner's medical staff membership or clinical privileges - Indications and process for summary suspension of a physician's or other licensed practitioner's medical staff membership or clinical privileges - Indications and process for recommending termination or suspension of medical staff membership, and/or termination, suspension, or reduction of clinical privileges
	MS.14.01.01, EP 8 (HAP) The medical staff bylaws include requirements for the composition of the fair hearing committee.
	MS.14.01.01, EP 9 The medical staff bylaws include the following requirements: • Description of those members of the medical staff who are eligible to vote • Process for credentialing and recredentialing physicians and other licensed practitioners • Process for fair hearings and appeals, which at a minimum, includes the process for scheduling and conducting hearings and appeals
	MS.14.03.01, EP 4 **CAH:** If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals, and the system chooses to establish a unified and integrated medical staff, the unified and integrated medical staff bylaws, rules, and requirements include the following: - Process for self-governance, appointment, credentialing, privileging, and oversight, as well as its peer review policies and due process rights guarantees - Description of the process by which medical staff members at each separately accredited hospital (that is, all medical staff members who hold privileges to practice at that specific hospital) are advised of their right to opt out of the unified and integrated medical staff structure after a majority vote by the members to maintain a separate and distinct medical staff for their respective critical access hospital

	CoPs: §482.22(b)(4)(ii), §485.631(e)(2)
	MS.15.01.01, EP 1 (HAP) The structure and function of the medical staff executive committee conforms to the medical staff bylaws.
	MS.15.01.01, EP 4 (HAP) The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on all of the following, at a minimum: ð Organized medical staff's structure ð Process used to review credentials and delineate privileges ð Executive committee's review of and actions on reports of medical staff committees, departments, and other assigned activity groups
	MS.17.01.03, EP 4 The medical staff examines the credentials of all candidates eligible for medical staff membership and makes recommendations to the governing body on the appointment of these candidates, in accordance with state law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations. A candidate who has been recommended by the medical staff and who has been appointed by the governing body is subject to all medical staff bylaws, rules, and regulations. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: A candidate who has been recommended by the medical staff and who has been appointed by the governing body is also subject to 42 CFR 482.22(a). CoPs: §482.22(a)(2)
	MS.17.02.01, EP 5 Completed applications for privileges are acted on within the time period specified in the medical staff bylaws, rules, and regulations, or in policies and procedures.
	MS.17.04.01, EP 1

	Temporary privileges are granted to meet an important patient care need for a time period defined in the medical staff bylaws.
	MS.18.04.01, EP 2 (HAP) The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has a mechanism to schedule a hearing of such requests.
	MS.18.04.01, EP 3 (HAP) The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has identified the procedures for the hearing to follow.
	MS.18.04.01, EP 5 (HAP) The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that, with the governing body, provides a mechanism to appeal adverse decisions as provided in the medical staff bylaws.
Other Medical Staff and Related Standards	
	NPG.03.02.03, EP 2 The hospital identifies the individual(s) responsible for granting disaster privileges to volunteer physicians and other licensed practitioners and has a process for granting these privileges. This is documented in the medical staff bylaws, rules and regulations, or policies and procedures.

Medical Staff and Related Standards Compliance Evaluation Guide

1- Credentialing Process Discussion			
YES	**NO**	If no issues found in document review, begin the meeting with the discussion of the credentialing process.	**Notes**
☐	☐	Ask to discuss the credentialing process – application, processing, role of department chair, cred comm, medical executive committee, governing body. Basic steps must be in bylaws ***(See also: MS Bylaws Checklist for relevant EPs)*** Privileges are granted for a period not to **exceed 3 years**. Physician or other licensed practitioner is notified in writing of the decision regarding appointment, reappointment, privileges. MS.15.01.01, EP 4; MS.17.01.03, EP 4; MS.18.02.03, EP 1	
☐	☐	Discuss how primary source verification (PSV) is performed for licensure, training, competence. Training and competence PSV in writing for privileges requested. Licensure at initial, renewal, and request for new privileges. (PSV for competency and training only on initial appt unless new/additional privileges requested.) MS.17.01.03, EP 3	
☐	☐	Evidence of physician and other licensed practitioner ID verification (Hospital or government-issued picture ID) DEA Registration, when required by MS, hospital, or state. MS.17.01.03, EP 2; LD.13.01.01, EP 1 (Scored only if DEA has expired)	
☐	☐	Are peer recommendations considered; how are "peers" defined and, if yes, did written peer recommendations include information regarding the medical/clinical knowledge, clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism of the physician or other licensed practitioner? MS.18.01.01, EP 1 - 4	
☐	☐	When are the National Practitioner Data Bank (NPDB) queries performed: Must be at least at initial/re-appointment and whenever new privileges are requested. Is there a statement regarding practitioner's health and ability to perform the requested procedures? MS.17.02.01, EP 3, EP 4	
☐	☐	Is there a process for evaluation of identified red flags regarding voluntary or involuntary licensure reductions/termination, reduced/revoked privileges, MS membership terminations, etc. at the same or previous organizations? This should be a credible process that involves MS leaders. MS.17.03.01, EP 3	
☐	☐	Is there an expedited credentialing process? If so, are at least 2 voting board members on the approving committee? Are there established criteria for ineligibility, and do they include an incomplete application and adverse MEC recommendation? MS.17.03.01, EP 1, EP 2	

☐	☐	How are criteria for granting privileges determined and approved *(does the governing body approve?)* Do the criteria include licensure, training, evidence of current competency, peer recommendations, and information from other organizations, when applicable? MS.17.02.01, EP 1	
☐	☐	Temporary privileges: Time periods must be defined in bylaws. ***Must be no more than 120 Days***. (See also box 3 below - file review) MS.17.04.01, EP 1	
☐	☐	**Telemedicine:** How are these credentialed? They should all be granted privileges by the originating site but may do so in the usual way **-OR-** By contractual arrangement to accept the credentialing information from a Joint Commission accredited or CMS certified organization **-OR-** Joint Commission accredited or CMS certified accept the privilege decision of distant site if all of these are met by the distant site and the privileges to be exercised are granted: • List of privileges at distant site is provided • FPPE, OPPE information is shared • Physician or other licensed practitioner is licensed in the originating site's state MS.20.01.01, EP 1	
☐	☐	CME: Requires that the MS sets priorities for CME topics ☐ Requires CME resources are related to the scope of services of the organization ☐ State CME should be related to outcomes of PI activities ☐ Requires documentation of CME; and ☐ Requires CME to be considered in the credentialing process MS.19.01.01, EP 1 - 4	
2- FPPE/OPPE			
YES	**NO**	FPPE for all initial or new privileges (MS.18.02.01)	
☐	☐	EP 2 Implemented for all practitioners in all clinical sites and privilege specific (includes physicians, PAs, APRNs, CRNAs, dietitians granted privileges to write orders, pharmacists with prescriptive authority, telemedicine practitioners, etc., exercised in all settings- inpatient or outpatient-on-site or off-site within the scope of the organization's survey; is a focused direct evaluation of the requested/exercised privileges) EP 1 The process including criteria is approved by the MS (evaluation should be qualitative and not just quantitative). EP 3 The process is clearly defined *(i.e., written policy required: criteria for conducting performance monitoring, method for establishing a monitoring plan specific to the requested privilege, method for determining the duration of performance monitoring, circumstances under which monitoring by an external source is required).*	
☐	☐	FPPE for Cause (MS.18.02.01) EP 4 Triggers should be defined clearly *(i.e., in policy).* EP 3 Decisions to initiate FPPE for cause should be based upon objective measures of current performance reflective of quality and/or safety concerns.	

		EP 5 Criteria are developed for type of monitoring to be conducted. EP 6 Measures/actions to address performance issues are defined. EP 7 These measures/actions are consistently implemented.	
☐	☐	OPPE: MS.18.02.03 EP 1 There is a clearly defined process: For example, a written policy, bylaw, or rules and regulations. The organization determines the frequency of the data collection and review, but this may not exceed 12 months. Process includes all physicians and other licensed practitioners in all clinical sites and includes methodology of data collection and who/how the data is reviewed and acted upon. EP 2 The process requires that the data to be collected is approved by the individual departments and the MS (MEC) or just the MEC if there are no departments: • Aggregate (quantitative) or trended quality metrics are encouraged - e.g., SSI rates, complications. BUT: • Qualitative or chart review data may be used. • The data must be RELEVANT to the specialty or privileges granted. • Review of data that occurs only when triggered by an incident is NOT acceptable. • When there are situations in which there is no other way to collect data or assets, then peer recommendations may be used (*low or no volume physicians or other licensed practitioners).* • Data must be from the organization except for low volume physicians or other licensed practitioners who have available data from other accredited or CMS certified organizations. However, any data obtained must be supplemental and cannot be used in lieu of a process to attempt to capture 'local' performance data. • Use of quantitative (raw) data may be used; however, it cannot be the only type of data used to evaluate performance EP 3 The data collection, review, and analysis must be used to inform the credentialing process, i.e., it must be used in the process of determining whether to continue, reduce, or otherwise modify a physician's or other licensed practitioner's privileges. This review process should be consistent and documented. This review process should be ongoing, i.e., reports reviewed when they are produced, not just at the time of the 3-year reappointment.	
Other items to review/confirm related to the medical staff.			
YES ☐	**NO** ☐	Does the medical staff (MEC) approve the dietary manual for the hospital? Frequency: MS approval should be a part of the usual periodic review of the policy and whenever the manual is substantively amended. PC.12.01.09, EP 2	
☐	☐	The medical staff approval by the radiology, nuclear medicine medical director or MEC are acceptable options to approve the qualification of the radiology and nuclear medicine technical staff. Frequency: MS approval should occur initially and be a part of the usual periodic review of job descriptions and qualifications or whenever there is a substantive amendment or change in these qualifications. MS.16.01.01, EP 11 MS.16.01.01, EP 12	

☐	☐	Is there a process for education of licensed practitioners in antibiotic stewardship? Is there a process for education of licensed practitioners in pain management and safe use of opioid medication? *(These standards require evidence of process, but do not have to be documented in individual credentialing files.)* MM.18.01.01, EP 7 NPG.06.01.01, EP 3	
☐	☐	Disaster Privileges This may be addressed in document review of the disaster privileges policy which must comply with all EPs Note: Bylaws document review should confirm that the individuals who may grant disaster privileges are specified in the bylaws, rules and regulations, or policy and procedures. NPG.03.02.03	

Professional Graduate Medical Education Program Standard Compliance Evaluation Guide

Response (if "no" score standard and EP)		Standard, EP, and Compliance Criteria	Notes
YES	**NO**	**MS.16.02.01 All EPs (1-9)**	
☐	☐	MS.16.02.01, EP 1 *This EP has a documentation requirement* Does the organized medical staff have a document that defines a process for supervision by a physician with appropriate clinical privileges of each program participant while carrying out patient care responsibilities? Note: This information should reside in the rules and regulations or a medical staff approved document.	
☐ If "yes" continue to next item for EP 2	☐ If "no" consider also scoring EP 3	MS.16.02.01, EP 2 *This EP has a documentation requirement* Does the organization have documentation of written descriptions of the roles, responsibilities, and patient care activities of the participants of graduate education programs? Note: GME trainees have, at various levels of their training, specific functions and skills they may exercise either independently or with supervision. GME programs must develop criteria to determine the competence and level of independence for each trainee as they advance in the program. See EP 3.	
☐	☐	Does the organization provide this information to the organized medical staff and hospital staff? Note: For the resident specific roles and responsibilities to be of use, they must be available to hospital staff in the work centers. The method for making this information available is up to the organization.	
☐	☐	MS.16.02.01, EP 3 The descriptions from EP 2 must include identification of mechanisms by which the supervisor(s) and graduate education program director make decisions about each participant's progressive involvement and independence in specific patient care activities.	

☐	☐	MS.16.02.01, EP 4 *This EP has a documentation requirement*. The organized medical staff rules and regulations and policies delineate participants in professional education programs who may write patient care orders, the circumstances under which they may do so, and what entries, if any, must be countersigned by a supervising physician.	
☐	☐	MS.16.02.01, EP 5 Can the organization demonstrate a mechanism for effective communication between the committee(s) responsible for professional graduate education (which may or may not reside within the organization being surveyed) and the organized medical staff and the governing body of the organization being surveyed? Note: A GME program may reside within the hospital being surveyed and usually has a professional graduate medical education committee (GMEC), or the hospital being surveyed may be an affiliated hospital with a training program residing in another hospital. Affiliated hospitals often have only a coordinator and not a full GMEC, in which case the hospital should demonstrate a method for effective communication with the hospital owning the training program. See EP 6 Note: GMEC minutes or medical staff minutes often have evidence of compliance with this EP. The entire medical staff is rarely briefed, but specific members on the MEC often are.	
☐	☐	MS.16.02.01, EP 6 Can the hospital demonstrate a mechanism for effective communication (whether training occurs at the organization that is responsible for the GME program or in a participating local or community organization or hospital)? If the hospital surveyed has a professional GMEC, how does it communicate to the medical staff and governing body information about: • Safety and quality of patient care, treatment and services by the training program • Related educational and supervisory needs of the training program If the hospital surveyed is a community or local participating hospital or organization hospital, does the person(s) responsible for overseeing the	

		participants from the program communicate to the organized medical staff and its governing body about: • Patient care, treatment, and services provided by the training program • Related educational and supervisory needs of its participants in the GME programs. Note: EP 6 is broad and reflects the overall management of the GME program. The GMEC minutes often have evidence of compliance with this EP. See also EP 8 for information specific to the governing body.	
☐	☐	MS.16.02.01, EP 7 Can the hospital demonstrate a mechanism for an appropriate person from the community or local hospital or organization to communicate information to the GMEC about the quality of care, treatment, and services and educational needs of the participants? Note: Sometimes GME trainees participate with providers who don't report directly to a GMEC (such as private or community clinics, community based private physicians etc.) and there must be a way for these providers to communicate with the GMEC.	
☐	☐	MS.16.02.01, EP 8 If the hospital sponsors a GME program and has a GMEC, can the hospital demonstrate it specifically informed the governing board about the quality of care, treatment, and services and educational needs? Note: While this EP is like EP 6, it is specific to elements the sponsoring hospital governing board must be informed of. Compliance is often demonstrated in the board or GMEC minutes.	
☐	☐	MS.16.02.01, EP 9 Can the hospital demonstrate how the medical staff demonstrates compliance with residency review committee citations? Note: Graduate medical education programs accredited by the Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), or the American Dental Association's Commission on Dental Accreditation are expected to be in compliance with the above requirements; the hospital should be able to	

		demonstrate compliance with any postgraduate education review committee citations related to this standard. Note: AOA programs may now be accredited under the ACGME.	

Credentials File Review Tool

Practitioner info				PSV Documents						Peer Recommendations					FPPE	OPPE	Administration	
Practitioner	Specialty	Application Type	Valid Picture ID (file copy not required)	Current License	Relevant Training	Current Competence	NPDB Review	Health Status	DEA Current? (if required by medical	Medical/Clinical Knowledge	Technical/Clinical Skills	Interpersonal Skills	Communication Skills	Professionalism	Was FPPE process used for new applicant or new privileges?	Was OPPE data used for recredentialing decision?	Timeliness of decision and < 2 yr term	Board approval and letter to applicant

Other Medical Staff Standards to Review	Yes	No
Confirm qualifications of key department leaders—name, license and board certification:		
Respiratory		
Radiology		
Nuclear Medicine		
Emergency Department		
Psychiatry (Inpatient)		
Anesthesia		
(Refer to the Medical Staff chapter for relevant standards and EPs.)		

OPTIONAL Primary Care Medical Home (PCMH) Certification Evaluation Guide (Hospital and Critical Access Hospital)

Program Information:

Primary care medical home certification is optional and can be obtained initially through an extension survey (focused only on PCMH-specific requirements) or as part of your triennial accreditation survey. Once certification is obtained, re-certification will always occur at the time of the triennial survey.

If an extension survey is chosen as the route for initially obtaining PCMH certification, then only the unique PCMH accreditation requirements are evaluated during the certification survey.

When PCMH certification is obtained as part of the accreditation survey, all hospital standards as well as the unique PCMH accreditation requirements are evaluated. Surveyors will integrate the evaluation of PCMH requirements into the hospital survey as appropriate to your organization.

Organization Participants

Staff involved in patient care, support staff, and clinic management staff at each PCMH location seeking certification.

Logistical Needs

Hospitals can choose which sites they want to be PCMH certified. During the surveyor planning session, your hospital will need to provide the surveyor with information related to the services provided at those ambulatory care clinics that have been selected for primary care medical home certification, the locations or distance of the clinic from the hospital site, and the individuals who are serving in the role of the primary care clinician at each site. This information will help the surveyor determine which sites will be visited.

Documents for Surveyor Review

- Performance improvement data related to:
    - Disease management outcomes
    - Patient access to care
    - Patient experience and satisfaction related to access to care, treatment, or services, and communication
    - Patient perception of the comprehensiveness, coordination, and continuity of care, treatment, or services
    - Patient perception of the continuity of care

Scope of PCMH Survey

The survey will focus on evaluating the organization's provision of patient-centered care, comprehensive care, coordinated care, and superb access to care. Additionally, the survey will include an evaluation of the organization's system-based approach to quality, that is, the commitment to quality and quality improvement through ongoing engagement in activities such as:

- Using evidence-based medicine and clinical decision support tools,
- Guiding shared decision making with patients and families,
- Engaging in performance measurement and improvement,
- Measuring and responding to patient experiences and patient satisfaction, and
- Practicing population health management.

The site visit to PCMH locations will include evaluation of hospital accreditation standards as well as unique PCMH standards.

Individual tracer activity for unique PCMH requirements will focus on areas such as:

- Information provided to patients related to access to care, treatment and services, as well as primary care clinician information (for example, information related to selection of primary care clinician, how to access clinic staff, make appointments, and obtain specialty care)
- Tracking and follow-up on referrals and test results
- Interdisciplinary team collaboration and communication
- Involvement of patients in establishing treatment goals
- How patients are assessed for health literacy, where this is information documented in the medical record and how do they ensure it is available to all care team members
- The development of self-management goals, when are they developed, and where are they documented in the medical record?
- 24/7 access to prescription renewal requests, test results, clinical advice for urgent health care needs, and appointment availability
- Competence of primary care clinicians and staff
- PI activities related to PCMH

The following standards and EPs directly relate to the **operational characteristics** of the Primary Care Medical Home Model.

Patient-Centered Care	LD.12.01.01, EP 5; NPG.02.03.01, EP 10; NPG.07.01.01, EP 1, EP 2, EP 3; NPG.07.02.01, EP 1, EP 2; NPG.07.04.01, EP 1; PC.11.02.07, EP 1; PC.11.03.01, EP 1, EP 2; PC.12.01.01, EP 5; PC.12.02.01, EP 1, EP 3, EP 4, EP 5, EP 6, EP 7, EP 8; PC.12.03.05, EP 7, EP 9; RC.11.01.01, EP 9; RC.12.01.01, EP 1; RI.11.01.01, EP 1, EP 2, EP 3, EP 4, EP 5, EP 6; RI.11.02.01, EP 1; RI.12.01.01, EP 1, EP 5, EP 7, EP 8, EP 9; RI.12.02.01, EP 1; RI.12.02.03, EP 1, EP 2, EP 3, EP 4, EP 5, EP 6; RI.14.01.01, EP 2
Comprehensive care	MS.16.01.01, EP 13; MS.16.01.03, EP 5; PC.12.03.03, EP 1, EP 2, EP 3; PC.12.03.05, EP 1, EP 2, EP 4, EP 6, EP 10;
Coordinated care	MS.16.01.01, EP 3; NPG.12.04.01, EP 3; PC.11.03.01, EP 4; PC.12.03.03, EP 4, EP 5; PC.12.03.05, EP 3, EP 5, EP 8; PC.14.01.01, EP 3, EP 4, EP 6, EP 7; PC.14.02.03, EP1; RC.11.01.01, EP 2, EP 4; RC.12.01.01, EP 2
Superb access to care	PC.12.03.01, EP 1, EP 2, EP 3
Systems-based approach to quality and safety	LD.11.01.01, EP 11; LD.12.01.01, EP 2, EP 4; MM.14.01.01, EP 4; MS.16.01.01, EP 1; MS.16.03.01, EP 5; NPG.02.03.01, EP 1, EP 2, EP 3, EP 4, EP 5, EP 6, EP 8, EP 10; NPG.13.04.01, EP 1; PC.11.03.01, EP 5; PI.12.01.01, EP 4, EP 5; PI.13.01.01, EP 1; PI.14.01.01, EP 1, EP 2; RC.11.01.01, EP 4

Please refer to the Joint Commission E-dition®, under JC Manual Documents for additional information regarding the *Primary Care Medical Home Certification Option*.