Critical Access Hospital Crosswalk

Medicare Critical Access Hospital Requirements to 2025 Joint Commission Critical Access Hospital Standards & EPs

CFR Number §412.25	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§412.25			
§412.25 Excluded hospital units: Common Requirements			
§412.25(a)		See Appendix B of the CAMCAH.	
(a) Basis for exclusion. In order to be excluded from the prospective payment systems as specified in §412.1(a)(1) and be paid under the inpatient psychiatric facility prospective payment system as specified in §412.1(a)(2) or the inpatient rehabilitation facility prospective payment system as specified in §412.1(a)(3), a psychiatric or rehabilitation unit must meet the following requirements.			
§412.25(a)(1)			
(1) Be part of an institution that—			
§412.25(a)(1)(i)		See Appendix B of the CAMCAH.	
(i) Has in effect an agreement under part 489 of this chapter to participate as a hospital;			
§412.25(a)(1)(ii)		See Appendix B of the CAMCAH.	
(ii) Is not excluded in its entirety from the prospective payment systems; and			
§412.25(a)(1)(iii)		See Appendix B of the CAMCAH.	
(iii) Unless it is a unit in a critical access hospital, the hospital of which an IRF is a unit must have at least 10 staffed and maintained hospital beds that are not excluded from the inpatient prospective payment system, or at least 1 staffed and maintained hospital bed for every 10 certified inpatient rehabilitation facility beds, whichever number is greater. Otherwise, the IRF will be classified as an IRF hospital, rather than an IRF unit. In the case of an inpatient psychiatric facility unit, the hospital must have enough beds that are not excluded from the inpatient prospective payment system to permit the provision of adequate cost information, as required by §413.24(c) of this chapter.			
§412.25(a)(2) **TAG: C-0504, C-0704**		**PC.11.01.01**	**The critical access hospital accepts the patient for care, treatment, and services based on its ability to meet the patient's needs.**
(2) Have written admission criteria that are applied uniformly to both Medicare and non-Medicare patients.		**EP 1**	The critical access hospital develops and implements a written process for accepting a patient that addresses admission criteria and procedures for accepting referrals. Note: Admission criteria is applied uniformly to all patients (both Medicare and non-Medicare patients).

CFR Number §412.25(a)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§412.25(a)(3)	**TAG: C-0505, C-0705**	**RC.11.01.01**	**The critical access hospital maintains complete and accurate medical records for each individual patient.**
(3) Have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available.		**EP 8**	For rehabilitation and psychiatric distinct part units in critical access hospitals: Admission and discharge records for rehabilitation and psychiatric distinct part units are separately identified from those of the critical access hospital in which the units are located.
§412.25(a)(4)	**TAG: C-0506, C-0706**	**PC.14.02.01**	**The critical access hospital coordinates the patient's care, treatment, and services based on the patient's needs.**
(4) Have policies specifying that necessary clinical information is transferred to the unit when a patient of the hospital is transferred to the unit.		**EP 1**	The critical access hospital develops and implements a process to receive or share patient information when the patient is referred to internal providers of care, treatment, and services. Note: For rehabilitation distinct part units in critical access hospitals: The process includes how it will transmit necessary clinical patient information to the distinct part unit when a critical access hospital patient is transferred to the unit.
§412.25(a)(5)	**TAG: C-0507, C-0707**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
(5) Meet applicable State licensure laws.		**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.
§412.25(a)(6)	**TAG: C-0508, C-0708**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(6) Have utilization review standards applicable for the type of care offered in the unit.		**EP 11**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has utilization review standards appropriate to the services offered in the unit(s).
§412.25(a)(7)	**TAG: C-0509, C-0709**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
(7) Have beds physically separate from (that is, not commingled with) the hospital's other beds.		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital provides no more than 10 beds in a distinct part unit. The beds are physically separate from the critical access hospital's other beds. Note 1: Beds in the rehabilitation and psychiatric distinct part units are excluded from the 25 inpatient-bed count limits specified in 42 CFR 485.620(a). Note 2: The average annual 96-hour length of stay requirement specified under 42 CFR 485.620(b) does not apply to the 10 beds in the distinct part units specified in 42 CFR 485.647(b)(1). Admissions and days of inpatient care in the distinct part units are not taken into account in determining the critical access hospital's compliance with the limits on the number of beds and length of stay in 42 CFR 485.620.
§412.25(a)(8)	**TAG: C-0510, C-0710**	See Appendix B of the CAMCAH.	
(8) Be serviced by the same fiscal intermediary as the hospital.			
§412.25(a)(9)	**TAG: C-0511, C-0711**	See Appendix B of the CAMCAH.	
(9) Be treated as a separate cost center for cost finding and apportionment purposes.			
§412.25(a)(10)	**TAG: C-0512, C-0712**	See Appendix B of the CAMCAH.	
(10) Use an accounting system that properly allocates costs.			
§412.25(a)(11)	**TAG: C-0513, C-0713**	See Appendix B of the CAMCAH.	
(11) Maintain adequate statistical data to support the basis of allocation.			

CFR Number §412.25(a)(12)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§412.25(a)(12)	**TAG: C-0514, C-0714**	See Appendix B of the CAMCAH.	
(12) Report its costs in the hospital's cost report covering the same fiscal period and using the same method of apportionment as the hospital.			
§412.25(a)(13)	**TAG: C-0515, C-0715**	**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(13) 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.		**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.
§412.25(b)	**TAG: C-0516, C-0716**	See Appendix B of the CAMCAH.	
(b) Changes in the size of excluded units. Except in the special cases noted at the end of this paragraph, changes in the number of beds or square footage considered to be part of an excluded unit under this section are allowed one time during a cost reporting period if the hospital notifies its Medicare contractor and the CMS RO in writing of the planned change at least 30 days before the date of the change. The hospital must maintain the information needed to accurately determine costs that are attributable to the excluded unit. A change in bed size or a change in square footage may occur at any time during a cost reporting period and must remain in effect for the rest of that cost reporting period. Changes in bed size or square footage may be made at any time if these changes are made necessary by relocation of a unit to permit construction or renovation necessary for compliance with changes in Federal, State, or local law affecting the physical facility or because of catastrophic events such as fires, floods, earthquakes, or tornadoes.			
§412.25(c)		See Appendix B of the CAMCAH.	
(c) Changes in the status of hospital units. For purposes of exclusions from the prospective payment systems under this section, the status of each hospital unit (excluded or not excluded) is determined as specified in paragraphs (c)(1) and (c)(2) of this section.			
§412.25(c)(1)	**TAG: C-0519, C-0719**	See Appendix B of the CAMCAH.	
(1) The status of a hospital unit may be changed from not excluded to excluded only at the start of the cost reporting period. If a unit is added to a hospital after the start of a cost reporting period, it cannot be excluded from the prospective payment systems before the start of a hospital's next cost reporting period.			

CFR Number §412.25(c)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§412.25(c)(2)	**TAG: C-0520, C-0720**	See Appendix B of the CAMCAH.	
(2) The status of a hospital unit may be changed from excluded to not excluded at any time during a cost reporting period, but only if the hospital notifies the fiscal intermediary and the CMS Regional Office in writing of the change at least 30 days before the date of the change, and maintains the information needed to accurately determine costs that are or are not attributable to the excluded unit. A change in the status of a unit from excluded to not excluded that is made during a cost reporting period must remain in effect for the rest of that cost reporting period.			
§412.25(d)	**TAG: C-0521, C-0721**	See Appendix B of the CAMCAH.	
(d) Number of excluded units. Each hospital may have only one unit of each type (psychiatric or rehabilitation) excluded from the prospective payment systems.			
§412.25(e)		Critical access hospitals are not permitted to have satellite facilities per 485.610(e). See Appendix B of the CAMCAH.	
(e) Satellite facilities.			
§412.25(e)(1)	**TAG: C-0522, C-0722**	Critical access hospitals are not permitted to have satellite facilities per 485.610(e). See Appendix B of the CAMCAH.	
(1) For purposes of paragraphs (e)(2) through (e)(5) of this section, a satellite facility is a part of a hospital unit that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.			
§412.25(e)(2)	**TAG: C-0523, C-0723**	Critical access hospitals are not permitted to have satellite facilities per 485.610(e). See Appendix B of the CAMCAH.	
(2) Except as provided in paragraphs (e)(3) and (e)(6) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the acute care hospital inpatient prospective payment systems for any period:			
§412.25(e)(2)(i)	**TAG: C-0523, C-0723**	Critical access hospitals are not permitted to have satellite facilities per 485.610(e). See Appendix B of the CAMCAH.	
(i) In the case of a unit excluded from the prospective payment systems for the most recent cost reporting period beginning before October 1, 1997, the unit's number of State-licensed and Medicare-certified beds, including those at the satellite facility, does not exceed the unit's number of State-licensed and Medicare-certified beds on the last day of the unit's last cost reporting period beginning before October 1, 1997.			
§412.25(e)(2)(ii)	**TAG: C-0524, C-0724**	Critical access hospitals are not permitted to have satellite facilities per 485.610(e). See Appendix B of the CAMCAH.	
(ii) The satellite facility independently complies with—			
§412.25(e)(2)(ii)(A)	**TAG: C-0524, C-0724**	Critical access hospitals are not permitted to have satellite facilities per 485.610(e). See Appendix B of the CAMCAH.	
(A) For a rehabilitation unit, the requirements under §412.29; or			
§412.25(e)(2)(ii)(B)	**TAG: C-0524, C-0724**	Critical access hospitals are not permitted to have satellite facilities per 485.610(e). See Appendix B of the CAMCAH.	
(B) For a psychiatric unit, the requirements under §412.27(a).			
§412.25(e)(2)(iii)	**TAG: C-0525, C-0725**	Critical access hospitals are not permitted to have satellite facilities per 485.610(e). See Appendix B of the CAMCAH.	
(iii) The satellite facility meets all of the following requirements:			

CFR Number §412.25(e)(2)(iii)(A)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§412.25(e)(2)(iii)(A)	**TAG: C-0525, C-0725**	Critical access hospitals are not permitted to have satellite facilities per 485.610(e). See Appendix B of the CAMCAH.	
(A) Effective for cost reporting periods beginning on or after October 1, 2002, it is not under the control of the governing body or chief executive officer of the hospital in which it is located, and it furnishes inpatient care through the use of medical personnel who are not under the control of the medical staff or chief medical officer of the hospital in which it is located.			
§412.25(e)(2)(iii)(B)	**TAG: C-0526, C-0726**	Critical access hospitals are not permitted to have satellite facilities per 485.610(e). See Appendix B of the CAMCAH.	
(B) It maintains admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available.			
§412.25(e)(2)(iii)(C)	**TAG: C-0527, C-0727**	Critical access hospitals are not permitted to have satellite facilities per 485.610(e). See Appendix B of the CAMCAH.	
(C) It has beds that are physically separate from (that is, not commingled with) the beds of the hospital in which it is located.			
§412.25(e)(2)(iii)(D)	**TAG: C-0528, C-0728**	Critical access hospitals are not permitted to have satellite facilities per 485.610(e). See Appendix B of the CAMCAH.	
(D) It is serviced by the same fiscal intermediary as the hospital unit of which it is a part.			
§412.25(e)(2)(iii)(E)	**TAG: C-0529, C-0729**	Critical access hospitals are not permitted to have satellite facilities per 485.610(e). See Appendix B of the CAMCAH.	
(E) It is treated as a separate cost center of the hospital unit of which it is a part.			
§412.25(e)(2)(iii)(F)	**TAG: C-0530, C-0730**	Critical access hospitals are not permitted to have satellite facilities per 485.610(e). See Appendix B of the CAMCAH.	
(F) For cost reporting and apportionment purposes, it uses an accounting system that properly allocates costs and maintains adequate statistical data to support the basis of allocation.			
§412.25(e)(2)(iii)(G)	**TAG: C-0531, C-0731**	Critical access hospitals are not permitted to have satellite facilities per 485.610(e). See Appendix B of the CAMCAH.	
(G) It reports its costs on the cost report of the hospital of which it is a part, covering the same fiscal period and using the same method of apportionment as the hospital of which it is a part.			
§412.25(e)(2)(iv)	**TAG: C-0731**		
(iv) Effective for cost reporting periods beginning on or after October 1, 2019, the requirements of paragraph (e)(2)(iii)(A) of this section do not apply to a satellite facility of a unit that is part of a hospital excluded from the prospective payment systems specified in §412.1(a)(1) that does not furnish services in a building also used by another hospital that is not excluded from the prospective payment systems specified in §412.1(a)(1), or in one or more entire buildings located on the same campus as buildings used by another hospital that is not excluded from the prospective payment systems specified in §412.1(a)(1).			

CFR Number §412.25(e)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§412.25(e)(3)	**TAG: C-0532, C-0732**	Critical access hospitals are not permitted to have satellite facilities per 485.610(e). See Appendix B of the CAMCAH.	
(3) Except as specified in paragraphs (e)(4) and (e)(5) of this section, the provisions of paragraph (e)(2) of this section do not apply to any unit structured as a satellite facility on September 30, 1999, and excluded from the prospective payment systems on that date, to the extent the unit continues operating under the same terms and conditions, including the number of beds and square footage considered to be part of the unit at the satellite facility on September 30, 1999.			
§412.25(e)(4)	**TAG: C-0533, C-0733**	Critical access hospitals are not permitted to have satellite facilities per 485.610(e). See Appendix B of the CAMCAH.	
(4) In applying the provisions of paragraph (e)(3) of this section, any unit structured as a satellite facility on September 30, 1999, may increase or decrease the square footage of the satellite facility or may decrease the number of beds in the satellite facility considered to be part of the satellite facility at any time, if these changes are made by the relocation of a facility—			
§412.25(e)(4)(i)	**TAG: C-0533, C-0733**	Critical access hospitals are not permitted to have satellite facilities per 485.610(e). See Appendix B of the CAMCAH.	
(i) To permit construction or renovation necessary for compliance with changes in Federal, State, or local law affecting the physical facility; or			
§412.25(e)(4)(ii)	**TAG: C-0533, C-0733**	Critical access hospitals are not permitted to have satellite facilities per 485.610(e). See Appendix B of the CAMCAH.	
(ii) Because of catastrophic events such as fires, floods, earthquakes, or tornadoes.			
§412.25(e)(5)	**TAG: C-0534, C-0734**	Critical access hospitals are not permitted to have satellite facilities per 485.610(e). See Appendix B of the CAMCAH.	
(5) For cost reporting periods beginning on or after October 1, 2006, in applying the provisions of paragraph (e)(3) of this section—			
§412.25(e)(5)(i)	**TAG: C-0534, C-0734**	Critical access hospitals are not permitted to have satellite facilities per 485.610(e). See Appendix B of the CAMCAH.	
(i) Any unit structured as a satellite facility on September 30, 1999, may increase the square footage of the unit only at the beginning of a cost reporting period or decrease the square footage or number of beds considered to be part of the satellite facility subject to the provisions of paragraph (b)(2) of this section, without affecting the provisions of paragraph (e)(3) of this section; and			
§412.25(e)(5)(ii)	**TAG: C-0534, C-0734**	Critical access hospitals are not permitted to have satellite facilities per 485.610(e). See Appendix B of the CAMCAH.	
(ii) If the unit structured as a satellite facility decreases its number of beds below the number of beds considered to be part of the satellite facility on September 30, 1999, subject to the provisions of paragraph (b)(2) of this section, it may subsequently increase the number of beds at the beginning or a cost reporting period as long as the resulting total number of beds considered to be part of the satellite facility does not exceed the number of beds at the satellite facility on September 30, 1999.			
§412.25(e)(6)	**TAG: C-0534, C-0734**	Critical access hospitals are not permitted to have satellite facilities per 485.610(e). See Appendix B of the CAMCAH.	
(6) The provisions of paragraph (e)(2)(i) of this section do not apply to any inpatient rehabilitation facility that is subject to the inpatient rehabilitation facility prospective payment system under subpart P of this part, effective for cost reporting periods beginning on or after October 1, 2003.			

CFR Number §412.25(f)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§412.25(f)	**TAG: C-0535, C-0735**	See Appendix B of the CAMCAH.	
(f) Changes in classification of hospital units. For purposes of exclusions from the prospective payment system under this section, the classification of a hospital unit is effective for the unit's entire cost reporting period. Any change in the classification of a hospital unit is made only at the start of a cost reporting period.			
§412.25(g)	**TAG: C-0535**	See Appendix B of the CAMCAH.	
(g) CAH units not meeting applicable requirements. If a psychiatric or rehabilitation unit of a CAH does not meet the requirements of §485.647 with respect to a cost reporting period, no payment may be made to the CAH for services furnished in that unit for that period. Payment to the CAH for services in the unit may resume only after the start of the first cost reporting period beginning after the unit has demonstrated to CMS that the unit meets the requirements of §485.647.			
§412.27			
§412.27 Excluded psychiatric units: Additional requirements. In order to be excluded from the prospective payment system as specified in §412.1(a)(1), and paid under the prospective payment system as specified in §412.1(a)(2), a psychiatric unit must meet the following requirements:			
§412.27(a)	**TAG: C-0547**	**PC.11.01.01**	**The critical access hospital accepts the patient for care, treatment, and services based on its ability to meet the patient's needs.**
(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 Fourth Edition, Text Revision of the American Psychiatric Association's Diagnostic and Statistical Manual, or in Chapter Five (''Mental Disorders'') of the International Classification of Diseases, Ninth Revision, Clinical Modification.		**EP 3**	For psychiatric distinct part units in critical access hospitals: Patients with a psychiatric principal diagnosis (listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR) or in Chapter 5 of the International Classification of Diseases, 9th Revision (ICD-9-CM)) are admitted only when the intensity of the active treatment can be provided only in an inpatient hospital setting.
§412.27(b)	**TAG: C-0548**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(b) Furnish, through the use of qualified personnel, psychological services, social work services, psychiatric nursing, and therapeutic activities.		**EP 18**	For psychiatric distinct part units in critical access hospitals: The critical access hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities provided by qualified staff to meet the needs of its patients. Note 1: The therapeutic activities program is appropriate to the needs and interests of patients and is directed toward restoring and maintaining optimal levels of physical and psychosocial functioning. Note 2: The psychological services are provided in accordance with accepted standards of practice, service objectives, and established policies and procedures.

CFR Number §412.27(c)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§412.27(c) **TAG: C-0549**		**RC.11.01.01**	**The critical access hospital maintains complete and accurate medical records for each individual patient.**
(c) Maintain medical records that permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the unit, and that meet the following requirements:		**EP 6**	For psychiatric distinct part units in critical access hospitals: The medical record reflects the degree and intensity of treatment and contains the following information: • History of findings and treatment provided for the psychiatric condition for which the patient is hospitalized • Identification data, including the patient's legal status • Provisional or admitting diagnosis for the patient at the time of admission that includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses • Reasons for admission, as stated by the patient and/or others significantly involved • Social service records, including reports of interviews with patients, family members, and others; an assessment of home plans, family attitudes, and community resource contacts; and a social history • When indicated, record of a complete neurological examination, recorded at the time of the admission physical examination • Documentation of treatment received, including all active therapeutic efforts • Discharge summary of the patient's hospitalization that includes a recapitulation of the patient's hospitalization in the unit, recommendations from appropriate services concerning follow-up or aftercare, and a brief summary of the patient's condition on discharge
§412.27(c)(1) **TAG: C-0549**		**RC.11.01.01**	**The critical access hospital maintains complete and accurate medical records for each individual patient.**
(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.		**EP 6**	For psychiatric distinct part units in critical access hospitals: The medical record reflects the degree and intensity of treatment and contains the following information: • History of findings and treatment provided for the psychiatric condition for which the patient is hospitalized • Identification data, including the patient's legal status • Provisional or admitting diagnosis for the patient at the time of admission that includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses • Reasons for admission, as stated by the patient and/or others significantly involved • Social service records, including reports of interviews with patients, family members, and others; an assessment of home plans, family attitudes, and community resource contacts; and a social history • When indicated, record of a complete neurological examination, recorded at the time of the admission physical examination • Documentation of treatment received, including all active therapeutic efforts • Discharge summary of the patient's hospitalization that includes a recapitulation of the patient's hospitalization in the unit, recommendations from appropriate services concerning follow-up or aftercare, and a brief summary of the patient's condition on discharge

CFR Number §412.27(c)(1)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§412.27(c)(1)(i) **TAG: C-0550**		**RC.11.01.01**	**The critical access hospital maintains complete and accurate medical records for each individual patient.**
(i) The identification data must include the inpatient's legal status.		**EP 6**	For psychiatric distinct part units in critical access hospitals: The medical record reflects the degree and intensity of treatment and contains the following information: • History of findings and treatment provided for the psychiatric condition for which the patient is hospitalized • Identification data, including the patient's legal status • Provisional or admitting diagnosis for the patient at the time of admission that includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses • Reasons for admission, as stated by the patient and/or others significantly involved • Social service records, including reports of interviews with patients, family members, and others; an assessment of home plans, family attitudes, and community resource contacts; and a social history • When indicated, record of a complete neurological examination, recorded at the time of the admission physical examination • Documentation of treatment received, including all active therapeutic efforts • Discharge summary of the patient's hospitalization that includes a recapitulation of the patient's hospitalization in the unit, recommendations from appropriate services concerning follow-up or aftercare, and a brief summary of the patient's condition on discharge
§412.27(c)(1)(ii) **TAG: C-0551**		**RC.11.01.01**	**The critical access hospital maintains complete and accurate medical records for each individual patient.**
(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.		**EP 6**	For psychiatric distinct part units in critical access hospitals: The medical record reflects the degree and intensity of treatment and contains the following information: • History of findings and treatment provided for the psychiatric condition for which the patient is hospitalized • Identification data, including the patient's legal status • Provisional or admitting diagnosis for the patient at the time of admission that includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses • Reasons for admission, as stated by the patient and/or others significantly involved • Social service records, including reports of interviews with patients, family members, and others; an assessment of home plans, family attitudes, and community resource contacts; and a social history • When indicated, record of a complete neurological examination, recorded at the time of the admission physical examination • Documentation of treatment received, including all active therapeutic efforts • Discharge summary of the patient's hospitalization that includes a recapitulation of the patient's hospitalization in the unit, recommendations from appropriate services concerning follow-up or aftercare, and a brief summary of the patient's condition on discharge

CFR Number §412.27(c)(1)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§412.27(c)(1)(iii) **TAG: C-0552**		**RC.11.01.01**	**The critical access hospital maintains complete and accurate medical records for each individual patient.**
(iii) The reasons for admission must be clearly documented as stated by the inpatient or others significantly involved, or both.		**EP 6**	For psychiatric distinct part units in critical access hospitals: The medical record reflects the degree and intensity of treatment and contains the following information: • History of findings and treatment provided for the psychiatric condition for which the patient is hospitalized • Identification data, including the patient's legal status • Provisional or admitting diagnosis for the patient at the time of admission that includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses • Reasons for admission, as stated by the patient and/or others significantly involved • Social service records, including reports of interviews with patients, family members, and others; an assessment of home plans, family attitudes, and community resource contacts; and a social history • When indicated, record of a complete neurological examination, recorded at the time of the admission physical examination • Documentation of treatment received, including all active therapeutic efforts • Discharge summary of the patient's hospitalization that includes a recapitulation of the patient's hospitalization in the unit, recommendations from appropriate services concerning follow-up or aftercare, and a brief summary of the patient's condition on discharge
§412.27(c)(1)(iv) **TAG: C-0553**		**RC.11.01.01**	**The critical access hospital maintains complete and accurate medical records for each individual patient.**
(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.		**EP 6**	For psychiatric distinct part units in critical access hospitals: The medical record reflects the degree and intensity of treatment and contains the following information: • History of findings and treatment provided for the psychiatric condition for which the patient is hospitalized • Identification data, including the patient's legal status • Provisional or admitting diagnosis for the patient at the time of admission that includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses • Reasons for admission, as stated by the patient and/or others significantly involved • Social service records, including reports of interviews with patients, family members, and others; an assessment of home plans, family attitudes, and community resource contacts; and a social history • When indicated, record of a complete neurological examination, recorded at the time of the admission physical examination • Documentation of treatment received, including all active therapeutic efforts • Discharge summary of the patient's hospitalization that includes a recapitulation of the patient's hospitalization in the unit, recommendations from appropriate services concerning follow-up or aftercare, and a brief summary of the patient's condition on discharge
§412.27(c)(1)(v) **TAG: C-0554**		**PC.11.02.03**	**For psychiatric distinct part units in critical access hospitals: The critical access hospital assesses the needs of patients who receive treatment for emotional and behavioral disorders.**
(v) When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.		**EP 1**	For psychiatric distinct part units in critical access hospitals: Patients who receive treatment for emotional and behavioral disorders receive an assessment that includes a history of mental, emotional, behavioral, and substance use problems, their co-occurrence, and their treatment.

CFR Number §412.27(c)(1)(v)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		RC.11.01.01	**The critical access hospital maintains complete and accurate medical records for each individual patient.**
		EP 6	For psychiatric distinct part units in critical access hospitals: The medical record reflects the degree and intensity of treatment and contains the following information: • History of findings and treatment provided for the psychiatric condition for which the patient is hospitalized • Identification data, including the patient's legal status • Provisional or admitting diagnosis for the patient at the time of admission that includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses • Reasons for admission, as stated by the patient and/or others significantly involved • Social service records, including reports of interviews with patients, family members, and others; an assessment of home plans, family attitudes, and community resource contacts; and a social history • When indicated, record of a complete neurological examination, recorded at the time of the admission physical examination • Documentation of treatment received, including all active therapeutic efforts • Discharge summary of the patient's hospitalization that includes a recapitulation of the patient's hospitalization in the unit, recommendations from appropriate services concerning follow-up or aftercare, and a brief summary of the patient's condition on discharge
§412.27(c)(2) TAG: C-0555 (2) Psychiatric evaluation. Each inpatient must receive a psychiatric evaluation that must—			
§412.27(c)(2)(i) TAG: C-0555 (i) Be completed within 60 hours of admission;		**PC.11.02.03**	**For psychiatric distinct part units in critical access hospitals: The critical access hospital assesses the needs of patients who receive treatment for emotional and behavioral disorders.**
		EP 2	For psychiatric distinct part units in critical access hospitals: Each patient receives a psychiatric evaluation completed within 60 hours of admission. The psychiatric evaluation includes the following: • Medical history • Record of mental status • Description of the onset of illness and the circumstances leading to admission • Description of attitudes and behavior • Estimation of intellectual functioning, memory functioning, and orientation • Inventory of the patient's assets in descriptive, not interpretative, fashion
§412.27(c)(2)(ii) TAG: C-0556 (ii) Include a medical history;		**PC.11.02.03**	**For psychiatric distinct part units in critical access hospitals: The critical access hospital assesses the needs of patients who receive treatment for emotional and behavioral disorders.**
		EP 2	For psychiatric distinct part units in critical access hospitals: Each patient receives a psychiatric evaluation completed within 60 hours of admission. The psychiatric evaluation includes the following: • Medical history • Record of mental status • Description of the onset of illness and the circumstances leading to admission • Description of attitudes and behavior • Estimation of intellectual functioning, memory functioning, and orientation • Inventory of the patient's assets in descriptive, not interpretative, fashion

CFR Number §412.27(c)(2)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§412.27(c)(2)(iii) **TAG: C-0557**		**PC.11.02.03**	**For psychiatric distinct part units in critical access hospitals: The critical access hospital assesses the needs of patients who receive treatment for emotional and behavioral disorders.**
(iii) Contain a record of mental status;		**EP 2**	For psychiatric distinct part units in critical access hospitals: Each patient receives a psychiatric evaluation completed within 60 hours of admission. The psychiatric evaluation includes the following: • Medical history • Record of mental status • Description of the onset of illness and the circumstances leading to admission • Description of attitudes and behavior • Estimation of intellectual functioning, memory functioning, and orientation • Inventory of the patient's assets in descriptive, not interpretative, fashion
§412.27(c)(2)(iv) **TAG: C-0558**		**PC.11.02.03**	**For psychiatric distinct part units in critical access hospitals: The critical access hospital assesses the needs of patients who receive treatment for emotional and behavioral disorders.**
(iv) Note the onset of illness and the circumstances leading to admission;		**EP 2**	For psychiatric distinct part units in critical access hospitals: Each patient receives a psychiatric evaluation completed within 60 hours of admission. The psychiatric evaluation includes the following: • Medical history • Record of mental status • Description of the onset of illness and the circumstances leading to admission • Description of attitudes and behavior • Estimation of intellectual functioning, memory functioning, and orientation • Inventory of the patient's assets in descriptive, not interpretative, fashion
§412.27(c)(2)(v) **TAG: C-0559**		**PC.11.02.03**	**For psychiatric distinct part units in critical access hospitals: The critical access hospital assesses the needs of patients who receive treatment for emotional and behavioral disorders.**
(v) Describe attitudes and behavior;		**EP 2**	For psychiatric distinct part units in critical access hospitals: Each patient receives a psychiatric evaluation completed within 60 hours of admission. The psychiatric evaluation includes the following: • Medical history • Record of mental status • Description of the onset of illness and the circumstances leading to admission • Description of attitudes and behavior • Estimation of intellectual functioning, memory functioning, and orientation • Inventory of the patient's assets in descriptive, not interpretative, fashion
§412.27(c)(2)(vi) **TAG: C-0560**		**PC.11.02.03**	**For psychiatric distinct part units in critical access hospitals: The critical access hospital assesses the needs of patients who receive treatment for emotional and behavioral disorders.**
(vi) Estimate intellectual functioning, memory functioning, and orientation; and		**EP 2**	For psychiatric distinct part units in critical access hospitals: Each patient receives a psychiatric evaluation completed within 60 hours of admission. The psychiatric evaluation includes the following: • Medical history • Record of mental status • Description of the onset of illness and the circumstances leading to admission • Description of attitudes and behavior • Estimation of intellectual functioning, memory functioning, and orientation • Inventory of the patient's assets in descriptive, not interpretative, fashion

CFR Number §412.27(c)(2)(vii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§412.27(c)(2)(vii)	**TAG: C-0561**	**PC.11.02.03**	**For psychiatric distinct part units in critical access hospitals: The critical access hospital assesses the needs of patients who receive treatment for emotional and behavioral disorders.**
(vii) Include an inventory of the inpatient's assets in descriptive, not interpretative fashion.		**EP 2**	For psychiatric distinct part units in critical access hospitals: Each patient receives a psychiatric evaluation completed within 60 hours of admission. The psychiatric evaluation includes the following: • Medical history • Record of mental status • Description of the onset of illness and the circumstances leading to admission • Description of attitudes and behavior • Estimation of intellectual functioning, memory functioning, and orientation • Inventory of the patient's assets in descriptive, not interpretative, fashion
§412.27(c)(3)	**TAG: C-0562**		
(3) Treatment plan.			
§412.27(c)(3)(i)	**TAG: C-0562, C-0563, C-0564, C-0565, C-0566**	**PC.11.03.01**	**The critical access hospital plans the patient's care.**
(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		**EP 3**	For psychiatric distinct part units in critical access hospitals: Each patient has an individual comprehensive treatment plan that is based on an inventory of the patient's strengths and disabilities. The written plan includes the following: • Substantiated diagnosis • Short-term and long-term goals • Specific treatment modalities utilized • Responsibilities of each member of the treatment team • Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out
§412.27(c)(3)(ii)	**TAG: C-0567**	**RC.11.01.01**	**The critical access hospital maintains complete and accurate medical records for each individual patient.**
(ii) The treatment received by the inpatient must be documented in such a way as to assure that all active therapeutic efforts are included.		**EP 6**	For psychiatric distinct part units in critical access hospitals: The medical record reflects the degree and intensity of treatment and contains the following information: • History of findings and treatment provided for the psychiatric condition for which the patient is hospitalized • Identification data, including the patient's legal status • Provisional or admitting diagnosis for the patient at the time of admission that includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses • Reasons for admission, as stated by the patient and/or others significantly involved • Social service records, including reports of interviews with patients, family members, and others; an assessment of home plans, family attitudes, and community resource contacts; and a social history • When indicated, record of a complete neurological examination, recorded at the time of the admission physical examination • Documentation of treatment received, including all active therapeutic efforts • Discharge summary of the patient's hospitalization that includes a recapitulation of the patient's hospitalization in the unit, recommendations from appropriate services concerning follow-up or aftercare, and a brief summary of the patient's condition on discharge

CFR Number §412.27(c)(4)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§412.27(c)(4)	**TAG: C-0568, C-0569, C-0571, C-0570, C-0572, C-0573**	**RC.12.01.01**	**The medical record contains information that reflects the patient's care, treatment, and services.**
(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.		**EP 4**	For psychiatric distinct part units in critical access hospitals: Progress notes are recorded at least weekly for the first two months of a patient's stay and at least monthly thereafter by the following individuals involved in the active treatment of the patient: • Physician(s), psychologist(s), or other licensed practitioner(s) responsible for the care of the inpatient • Nurse • Social worker • Others involved in active treatment modalities The progress notes include revisions to the treatment plan and assessments of the patient's progress in accordance with the original or revised treatment plan.
§412.27(c)(5)	**TAG: C-0575, C-0574, C-0576**	**RC.11.01.01**	**The critical access hospital maintains complete and accurate medical records for each individual patient.**
(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.		**EP 6**	For psychiatric distinct part units in critical access hospitals: The medical record reflects the degree and intensity of treatment and contains the following information: • History of findings and treatment provided for the psychiatric condition for which the patient is hospitalized • Identification data, including the patient's legal status • Provisional or admitting diagnosis for the patient at the time of admission that includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses • Reasons for admission, as stated by the patient and/or others significantly involved • Social service records, including reports of interviews with patients, family members, and others; an assessment of home plans, family attitudes, and community resource contacts; and a social history • When indicated, record of a complete neurological examination, recorded at the time of the admission physical examination • Documentation of treatment received, including all active therapeutic efforts • Discharge summary of the patient's hospitalization that includes a recapitulation of the patient's hospitalization in the unit, recommendations from appropriate services concerning follow-up or aftercare, and a brief summary of the patient's condition on discharge
§412.27(d)	**TAG: C-0577**	**NPG.12.03.01**	**For psychiatric distinct part units in critical access hospitals: The critical access hospital develops and implements staffing plans according to law and regulation.**
(d) Meet special staff requirements in that the unit must have adequate numbers of qualified professional and supportive staff to evaluate inpatients, formulate written, individualized, comprehensive treatment plans, provide active treatment measures and engage in discharge planning, as follows:		**EP 4**	For psychiatric distinct part units in critical access hospitals: There is an adequate number of qualified professional, technical, and consultative staff (including but not limited to doctors of medicine and/or osteopathy, registered nurses, licensed practical nurses, and mental health workers) to do the following: • Evaluate patients • Formulate written individualized, comprehensive treatment plans • Provide active treatment measures • Engage in discharge planning • Provide the nursing care necessary under each patient's active treatment program • Maintain progress notes on each patient • Provide essential psychiatric services
§412.27(d)(1)	**TAG: C-0578**		
(1) Personnel. The unit must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to—			

CFR Number §412.27(d)(1)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§412.27(d)(1)(i) **TAG: C-0578**		**NPG.12.03.01**	**For psychiatric distinct part units in critical access hospitals: The critical access hospital develops and implements staffing plans according to law and regulation.**
(i) Evaluate inpatients;		**EP 4**	For psychiatric distinct part units in critical access hospitals: There is an adequate number of qualified professional, technical, and consultative staff (including but not limited to doctors of medicine and/or osteopathy, registered nurses, licensed practical nurses, and mental health workers) to do the following: • Evaluate patients • Formulate written individualized, comprehensive treatment plans • Provide active treatment measures • Engage in discharge planning • Provide the nursing care necessary under each patient's active treatment program • Maintain progress notes on each patient • Provide essential psychiatric services
§412.27(d)(1)(ii) **TAG: C-0578**		**NPG.12.03.01**	**For psychiatric distinct part units in critical access hospitals: The critical access hospital develops and implements staffing plans according to law and regulation.**
(ii) Formulate written, individualized, comprehensive treatment plans;		**EP 4**	For psychiatric distinct part units in critical access hospitals: There is an adequate number of qualified professional, technical, and consultative staff (including but not limited to doctors of medicine and/or osteopathy, registered nurses, licensed practical nurses, and mental health workers) to do the following: • Evaluate patients • Formulate written individualized, comprehensive treatment plans • Provide active treatment measures • Engage in discharge planning • Provide the nursing care necessary under each patient's active treatment program • Maintain progress notes on each patient • Provide essential psychiatric services
§412.27(d)(1)(iii) **TAG: C-0578**		**NPG.12.03.01**	**For psychiatric distinct part units in critical access hospitals: The critical access hospital develops and implements staffing plans according to law and regulation.**
(iii) Provide active treatment measures; and		**EP 4**	For psychiatric distinct part units in critical access hospitals: There is an adequate number of qualified professional, technical, and consultative staff (including but not limited to doctors of medicine and/or osteopathy, registered nurses, licensed practical nurses, and mental health workers) to do the following: • Evaluate patients • Formulate written individualized, comprehensive treatment plans • Provide active treatment measures • Engage in discharge planning • Provide the nursing care necessary under each patient's active treatment program • Maintain progress notes on each patient • Provide essential psychiatric services
§412.27(d)(1)(iv) **TAG: C-0578**		**NPG.12.03.01**	**For psychiatric distinct part units in critical access hospitals: The critical access hospital develops and implements staffing plans according to law and regulation.**
(iv) Engage in discharge planning.		**EP 4**	For psychiatric distinct part units in critical access hospitals: There is an adequate number of qualified professional, technical, and consultative staff (including but not limited to doctors of medicine and/or osteopathy, registered nurses, licensed practical nurses, and mental health workers) to do the following: • Evaluate patients • Formulate written individualized, comprehensive treatment plans • Provide active treatment measures • Engage in discharge planning • Provide the nursing care necessary under each patient's active treatment program • Maintain progress notes on each patient • Provide essential psychiatric services

CFR Number §412.27(d)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§412.27(d)(2)	**TAG: C-0579, C-0580**	**MS.17.01.03**	**The critical access hospital collects information regarding each physician's or other licensed practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.**
(2) Director of inpatient psychiatric services: Medical staff. Inpatient psychiatric services must be under the supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program. The number and qualifications of doctors of medicine and osteopathy must be adequate to provide essential psychiatric services.		**EP 6**	For psychiatric distinct part units in critical access hospitals: Inpatient psychiatric services are under the direction and supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program and who meets the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.
§412.27(d)(2)(i)	**TAG: C-0581**	**MS.17.01.03**	**The critical access hospital collects information regarding each physician's or other licensed practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.**
(i) The clinical director, service chief, or equivalent must meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.		**EP 6**	For psychiatric distinct part units in critical access hospitals: Inpatient psychiatric services are under the direction and supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program and who meets the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.
§412.27(d)(2)(ii)	**TAG: C-0582**	**MS.16.01.01**	**The organized medical staff oversees the quality of patient care, treatment, and services provided by physicians and other licensed practitioners privileged through the medical staff process.**
(ii) The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.		**EP 8**	For psychiatric distinct part units in critical access hospitals: The clinical director, service chief, or equivalent for inpatient psychiatric services monitors and evaluates the medical staff's treatment and services for quality and appropriateness.
		MS.17.01.03	**The critical access hospital collects information regarding each physician's or other licensed practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.**
		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, 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.
§412.27(d)(3)	**TAG: C-0583, C-0584**	**NPG.12.02.01**	**The nurse executive directs the implementation of a nurse staffing plan(s).**
(3) Nursing services. The unit must have a qualified director of psychiatric nursing services. In addition to the director of nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under each inpatient's active treatment program and to maintain progress notes on each inpatient.		**EP 6**	For psychiatric distinct part units in critical access hospitals: The director of psychiatric nursing is a registered nurse who has a master's degree in psychiatric or mental health nursing, or its equivalent, from a school of nursing accredited by the National League for Nursing or is qualified by education and experience in the care of the mentally ill. The director of psychiatric nursing demonstrates competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care provided.

CFR Number §412.27(d)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		NPG.12.03.01	**For psychiatric distinct part units in critical access hospitals: The critical access hospital develops and implements staffing plans according to law and regulation.**
		EP 4	For psychiatric distinct part units in critical access hospitals: There is an adequate number of qualified professional, technical, and consultative staff (including but not limited to doctors of medicine and/or osteopathy, registered nurses, licensed practical nurses, and mental health workers) to do the following: • Evaluate patients • Formulate written individualized, comprehensive treatment plans • Provide active treatment measures • Engage in discharge planning • Provide the nursing care necessary under each patient's active treatment program • Maintain progress notes on each patient • Provide essential psychiatric services
§412.27(d)(3)(i)	**TAG: C-0585, C-0586**	**NPG.12.02.01**	**The nurse executive directs the implementation of a nurse staffing plan(s).**
(i) The director of psychiatric nursing services must be a registered nurse who has a master's degree in psychiatric or mental health nursing, or its equivalent, from a school of nursing accredited by the National League for Nursing, or be qualified by education and experience in the care of the mentally ill. The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished.		**EP 6**	For psychiatric distinct part units in critical access hospitals: The director of psychiatric nursing is a registered nurse who has a master's degree in psychiatric or mental health nursing, or its equivalent, from a school of nursing accredited by the National League for Nursing or is qualified by education and experience in the care of the mentally ill. The director of psychiatric nursing demonstrates competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care provided.
§412.27(d)(3)(ii)	**TAG: C-0587, C-0588**	**NPG.12.03.01**	**For psychiatric distinct part units in critical access hospitals: The critical access hospital develops and implements staffing plans according to law and regulation.**
(ii) The staffing pattern must ensure the availability of a registered nurse 24 hours each day. There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each inpatient's active treatment program.		**EP 2**	For psychiatric distinct part units in critical access hospitals: The critical access hospital makes certain a registered professional nurse is available 24 hours a day.
		EP 4	For psychiatric distinct part units in critical access hospitals: There is an adequate number of qualified professional, technical, and consultative staff (including but not limited to doctors of medicine and/or osteopathy, registered nurses, licensed practical nurses, and mental health workers) to do the following: • Evaluate patients • Formulate written individualized, comprehensive treatment plans • Provide active treatment measures • Engage in discharge planning • Provide the nursing care necessary under each patient's active treatment program • Maintain progress notes on each patient • Provide essential psychiatric services
§412.27(d)(4)	**TAG: C-0589, C-0590**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(4) Psychological services. The unit must provide or have available psychological services to meet the needs of the inpatients. The services must be furnished in accordance with acceptable standards of practice, service objectives, and established policies and procedures.		**EP 18**	For psychiatric distinct part units in critical access hospitals: The critical access hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities provided by qualified staff to meet the needs of its patients. Note 1: The therapeutic activities program is appropriate to the needs and interests of patients and is directed toward restoring and maintaining optimal levels of physical and psychosocial functioning. Note 2: The psychological services are provided in accordance with accepted standards of practice, service objectives, and established policies and procedures.

CFR Number §412.27(d)(5)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§412.27(d)(5)	**TAG: C-0591, C-0592, C-0593**	**NPG.12.03.01**	**For psychiatric distinct part units in critical access hospitals: The critical access hospital develops and implements staffing plans according to law and regulation.**
(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.		**EP 6**	For psychiatric distinct part units in critical access hospitals: The critical access hospital has a director of social services who monitors and evaluates the quality and appropriateness of social services provided. Social services staff responsibilities include but are not limited to the following: • Participating in discharge planning • Arranging for follow-up care • Developing mechanisms for the exchange of appropriate information with sources outside the critical access hospital Note: Social services are provided in accordance with accepted standards of practice and established policies and procedures.
§412.27(d)(6)	**TAG: C-0594**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(6) Therapeutic activities. The unit must provide a therapeutic activities program.		**EP 18**	For psychiatric distinct part units in critical access hospitals: The critical access hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities provided by qualified staff to meet the needs of its patients. Note 1: The therapeutic activities program is appropriate to the needs and interests of patients and is directed toward restoring and maintaining optimal levels of physical and psychosocial functioning. Note 2: The psychological services are provided in accordance with accepted standards of practice, service objectives, and established policies and procedures.
§412.27(d)(6)(i)	**TAG: C-0595**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(i) The program must be appropriate to the needs and interests of inpatients and be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.		**EP 18**	For psychiatric distinct part units in critical access hospitals: The critical access hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities provided by qualified staff to meet the needs of its patients. Note 1: The therapeutic activities program is appropriate to the needs and interests of patients and is directed toward restoring and maintaining optimal levels of physical and psychosocial functioning. Note 2: The psychological services are provided in accordance with accepted standards of practice, service objectives, and established policies and procedures.
§412.27(d)(6)(ii)	**TAG: C-0596**	**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(ii) The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each inpatient's active treatment program.		**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.

CFR Number §412.27(d)(6)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		NPG.12.03.01	**For psychiatric distinct part units in critical access hospitals: The critical access hospital develops and implements staffing plans according to law and regulation.**
		EP 3	For psychiatric distinct part units in critical access hospitals: The number of qualified therapists, support personnel, and consultants is adequate to provide therapeutic activities consistent with each patient's active treatment program.
§412.29	**TAG: C-0747**	See Appendix B of the CAMCAH.	
§412.29 Classification criteria for payment under the inpatient rehabilitation facility prospective payment system. To be excluded from the prospective payment systems described in §412.1(a)(1) and to be paid under the prospective payment system specified in §412.1(a)(3), an inpatient rehabilitation hospital or an inpatient rehabilitation unit of a hospital (otherwise referred to as an IRF) must meet the following requirements:			
§412.29(a)	**TAG: C-0747**	See Appendix B of the CAMCAH.	
(a) Have (or be part of a hospital that has) a provider agreement under part 489 of this chapter to participate as a hospital.			
§412.29(b)	**TAG: C-0748**	See Appendix B of the CAMCAH.	
(b) Except in the case of a “new” IRF or “new” IRF beds, as defined in paragraph (c) of this section, an IRF must show that, during its most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the Medicare contractor), it served an inpatient population that meets the following criteria:			
§412.29(b)(1)	**TAG: C-0748**	See Appendix B of the CAMCAH.	
(1) For cost reporting periods beginning on or after July 1, 2004, and before July 1, 2005, the IRF served an inpatient population of whom at least 50 percent, and for cost reporting periods beginning on or after July 1, 2005, the IRF served an inpatient population of whom at least 60 percent required intensive rehabilitation services for treatment of one or more of the conditions specified at paragraph (b)(2) of this section. A patient with a comorbidity, as defined at §412.602 of this part, may be included in the inpatient population that counts toward the required applicable percentage if—			
§412.29(b)(1)(i)	**TAG: C-0748**	See Appendix B of the CAMCAH.	
(i) The patient is admitted for inpatient rehabilitation for a condition that is not one of the conditions specified in paragraph (b)(2) of this section;			
§412.29(b)(1)(ii)	**TAG: C-0748**	See Appendix B of the CAMCAH.	
(ii) The patient has a comorbidity that falls in one of the conditions specified in paragraph (b)(2) of this section; and			
§412.29(b)(1)(iii)	**TAG: C-0748**	See Appendix B of the CAMCAH.	
(iii) The comorbidity has caused significant decline in functional ability in the individual that, even in the absence of the admitting condition, the individual would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities paid under subpart P of this part and that cannot be appropriately performed in another care setting covered under this title.			

CFR Number §412.29(b)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§412.29(b)(2) **TAG: C-0748**		See Appendix B of the CAMCAH.	
(2) List of conditions.			
§412.29(b)(2)(i) **TAG: C-0748**		See Appendix B of the CAMCAH.	
(i) Stroke.			
§412.29(b)(2)(ii) **TAG: C-0748**		See Appendix B of the CAMCAH.	
(ii) Spinal cord injury.			
§412.29(b)(2)(iii) **TAG: C-0748**		See Appendix B of the CAMCAH.	
(iii) Congenital deformity.			
§412.29(b)(2)(iv) **TAG: C-0748**		See Appendix B of the CAMCAH.	
(iv) Amputation.			
§412.29(b)(2)(v) **TAG: C-0748**		See Appendix B of the CAMCAH.	
(v) Major multiple trauma.			
§412.29(b)(2)(vi) **TAG: C-0748**		See Appendix B of the CAMCAH.	
(vi) Fracture of femur (hip fracture).			
§412.29(b)(2)(vii) **TAG: C-0748**		See Appendix B of the CAMCAH.	
(vii) Brain injury.			
§412.29(b)(2)(viii) **TAG: C-0748**		See Appendix B of the CAMCAH.	
(viii) Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease.			
§412.29(b)(2)(ix) **TAG: C-0748**		See Appendix B of the CAMCAH.	
(ix) Burns.			
§412.29(b)(2)(x) **TAG: C-0748**		See Appendix B of the CAMCAH.	
(x) Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.			

CFR Number §412.29(b)(2)(xi)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§412.29(b)(2)(xi)	**TAG: C-0748**	See Appendix B of the CAMCAH.	
(xi) Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.			
§412.29(b)(2)(xii)	**TAG: C-0748**	See Appendix B of the CAMCAH.	
(xii) Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission but have the potential to improve with more intensive rehabilitation. (A joint replaced by a prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)			
§412.29(b)(2)(xiii)	**TAG: C-0748**	See Appendix B of the CAMCAH.	
(xiii) Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay and also meet one or more of the following specific criteria:			
§412.29(b)(2)(xiii)(A)	**TAG: C-0748**	See Appendix B of the CAMCAH.	
(A) The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission.			
§412.29(b)(2)(xiii)(B)	**TAG: C-0748**	See Appendix B of the CAMCAH.	
(B) The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF.			
§412.29(b)(2)(xiii)(C)	**TAG: C-0748**	See Appendix B of the CAMCAH.	
(C) The patient is age 85 or older at the time of admission to the IRF.			
§412.29(c)	**TAG: C-0749**	See Appendix B of the CAMCAH.	
(c) In the case of new IRFs (as defined in paragraph (c)(1) of this section) or new IRF beds (as defined in paragraph (c)(2)of this section), the IRF must provide a written certification that the inpatient population it intends to serve meets the requirements of paragraph (b) of this section. This written certification will apply until the end of the IRF's first full 12-month cost reporting period or, in the case of new IRF beds, until the end of the cost reporting period during which the new beds are added to the IRF.			

CFR Number §412.29(c)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§412.29(c)(1)	**TAG: C-0750**	See Appendix B of the CAMCAH.	
(1) New IRFs. An IRF hospital or IRF unit is considered new if it has not been paid under the IRF PPS in subpart P of this part for at least 5 calendar years. A new IRF will be considered new from the point that it first participates in Medicare as an IRF until the end of its first full 12-month cost reporting period.			
§412.29(c)(2)	**TAG: C-0750**	See Appendix B of the CAMCAH.	
(2) New IRF beds. Any IRF beds that are added to an existing IRF must meet all applicable State Certificate of Need and State licensure laws. New IRF beds may be added one time at any point during a cost reporting period and will be considered new for the rest of that cost reporting period. A full 12-month cost reporting period must elapse between the delicensing or decertification of IRF beds in an IRF hospital or IRF unit and the addition of new IRF beds to that IRF hospital or IRF unit. Before an IRF can add new beds, it must receive written approval from the appropriate CMS RO, so that the CMS RO can verify that a full 12-month cost reporting period has elapsed since the IRF has had beds delicensed or decertified. New IRF beds are included in the compliance review calculations under paragraph (b) of this section from the time that they are added to the IRF.			
§412.29(c)(3)	**TAG: C-0751**	See Appendix B of the CAMCAH.	
(3) Change of ownership or leasing. An IRF hospital or IRF unit that undergoes a change of ownership or leasing, as defined in §489.18 of this chapter, retains its excluded status and will continue to be paid under the prospective payment system specified in §412.1(a)(3) before and after the change of ownership or leasing if the new owner(s) of the IRF accept assignment of the previous owners' Medicare provider agreement and the IRF continues to meet all of the requirements for payment under the IRF prospective payment system. If the new owner(s) do not accept assignment of the previous owners' Medicare provider agreement, the IRF is considered to be voluntarily terminated and the new owner(s) may re-apply to participate in the Medicare program. If the IRF does not continue to meet all of the requirements for payment under the IRF prospective payment system, then the IRF loses its excluded status and is paid according to the prospective payment systems described in §412.1(a)(1).			
§412.29(c)(4)	**TAG: C-0751**	See Appendix B of the CAMCAH.	
(4) Mergers. If an IRF hospital (or a hospital with an IRF unit) merges with another hospital and the owner(s) of the merged hospital accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit retains its excluded status and will continue to be paid under the prospective payment system specified in §412.1(a)(3) before and after the merger, as long as the IRF hospital or IRF unit continues to meet all of the requirements for payment under the IRF prospective payment system. If the owner(s) of the merged hospital do not accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit is considered voluntarily terminated and the owner(s) of the merged hospital may reapply to the Medicare program to operate a new IRF.			

CFR Number §412.29(d)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§412.29(d)	**TAG: C-0752**	**PC.11.01.01**	**The critical access hospital accepts the patient for care, treatment, and services based on its ability to meet the patient's needs.**
(d) 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.		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has 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. Note: This procedure makes certain 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 inpatient rehabilitation facility.
§412.29(e)	**TAG: C-0753, C-0754**	**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(e) 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.		**EP 5**	For rehabilitation distinct part units in critical access hospitals: The critical access hospital develops and implements a process to make certain that patients receive close medical supervision, as evidenced by at least three 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 and to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. Note: Beginning with the second week, as defined in 42 CFR 412.622, after admission to the inpatient rehabilitation unit, a non-physician practitioner who is determined by the inpatient rehabilitation unit to have specialized training and experience in inpatient rehabilitation may conduct one of the three required face-to-face patient visits per week, provided that such duties are within the nonphysician practitioner's scope of practice under applicable state law.
§412.29(f)	**TAG: C-0755**	**PC.12.01.01**	**The critical access hospital provides care, treatment, and services as ordered or prescribed and in accordance with law and regulation.**
(f) Furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech-language pathology, social services, psychological services (including neuropsychological services), and orthotic and prosthetic services.		**EP 4**	If the critical access hospital provides rehabilitation, physical therapy, occupational therapy, speech-language pathology, or audiology services, the services are organized and provided in accordance with national accepted standards of practice. Note: For rehabilitation distinct part units in critical access hospitals: The critical access hospital provides rehabilitation nursing, physical therapy, and occupational therapy, and, as needed, speech-language pathology, social services, psychological services (including neuropsychological services), and orthotic and prosthetic services by qualified staff in accordance with national accepted standards of practice.
§412.29(g)	**TAG: C-0756**		
(g) Have a director of rehabilitation who—			
§412.29(g)(1)	**TAG: C-0756**	**MS.17.01.03**	**The critical access hospital collects information regarding each physician's or other licensed practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.**
(1) Provides services to the IRF hospital and its inpatients on a full-time basis or, in the case of a rehabilitation unit, at least 20 hours per week;		**EP 7**	For rehabilitation distinct part units in critical access hospitals: The critical access hospital has a director of the rehabilitation unit who fulfills all of the following requirements: • Provides services to the unit and to its inpatients for at least 20 hours per week • Is a doctor of medicine or osteopathy • Is licensed under state law to practice medicine or surgery • Has had, after completing a one-year hospital internship, at least two years of training or experience in the medical management of inpatients requiring rehabilitation services

CFR Number §412.29(g)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§412.29(g)(2)	**TAG: C-0756**	**MS.17.01.03**	**The critical access hospital collects information regarding each physician's or other licensed practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.**
(2) Is a doctor of medicine or osteopathy;		**EP 7**	For rehabilitation distinct part units in critical access hospitals: The critical access hospital has a director of the rehabilitation unit who fulfills all of the following requirements: • Provides services to the unit and to its inpatients for at least 20 hours per week • Is a doctor of medicine or osteopathy • Is licensed under state law to practice medicine or surgery • Has had, after completing a one-year hospital internship, at least two years of training or experience in the medical management of inpatients requiring rehabilitation services
§412.29(g)(3)	**TAG: C-0756**	**MS.17.01.03**	**The critical access hospital collects information regarding each physician's or other licensed practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.**
(3) Is licensed under State law to practice medicine or surgery; and		**EP 7**	For rehabilitation distinct part units in critical access hospitals: The critical access hospital has a director of the rehabilitation unit who fulfills all of the following requirements: • Provides services to the unit and to its inpatients for at least 20 hours per week • Is a doctor of medicine or osteopathy • Is licensed under state law to practice medicine or surgery • Has had, after completing a one-year hospital internship, at least two years of training or experience in the medical management of inpatients requiring rehabilitation services
§412.29(g)(4)	**TAG: C-0756**	**MS.17.01.03**	**The critical access hospital collects information regarding each physician's or other licensed practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.**
(4) Has had, after completing a one-year hospital internship, at least 2 years of training or experience in the medical-management of inpatients requiring rehabilitation services.		**EP 7**	For rehabilitation distinct part units in critical access hospitals: The critical access hospital has a director of the rehabilitation unit who fulfills all of the following requirements: • Provides services to the unit and to its inpatients for at least 20 hours per week • Is a doctor of medicine or osteopathy • Is licensed under state law to practice medicine or surgery • Has had, after completing a one-year hospital internship, at least two years of training or experience in the medical management of inpatients requiring rehabilitation services
§412.29(h)	**TAG: C-0757**	**PC.11.03.01**	**The critical access hospital plans the patient's care.**
(h) 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.		**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 professional staff who provide services to the patient.
§412.29(i)	**TAG: C-0758**	**PC.12.01.03**	**The critical access hospital provides interdisciplinary, collaborative care, treatment, and services.**
(i) Use a coordinated interdisciplinary team approach in the rehabilitation of each inpatient, as documented by the periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment and discharge plans, and that team conferences are held at least once per week to determine the appropriateness of treatment.		**EP 1**	The critical access hospital provides care, treatment, and services to the patient in an interdisciplinary, collaborative manner. Note: For rehabilitation distinct part units in critical access hospitals: The critical access hospital uses a coordinated interdisciplinary team approach in the rehabilitation of each inpatient, as documented by the periodic clinical entries made in the patient's medical record to note the patient's status related to goal attainment and discharge plans, and team conferences that are held at least once per week to determine the appropriateness of treatment.

CFR Number §412.29(j)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§412.29(j)	**TAG: C-0758**	See Appendix B of the CAMCAH.	
(j) Retroactive adjustments. If a new IRF (or new beds that are added to an existing IRF) are excluded from the prospective payment systems specified in §412.1(a)(1) and paid under the prospective payment system specified in §412.1(a)(3) for a cost reporting period under paragraph (c) of this section, but the inpatient population actually treated during that period does not meet the requirements of paragraph (b) of this section, we adjust payments to the IRF retroactively in accordance with the provisions in §412.130.			
§485.601	**TAG: C-0800**	Statutory basis and scope for designating hospitals as critical access hospitals.	
§485.601 Basis and scope.			
§485.601(a)	**TAG: C-0800**	Statutory basis and scope for designating hospitals as critical access hospitals.	
(a) Statutory basis. This subpart is based on section 1820 of the Act which sets forth the conditions for designating certain hospitals as CAHs.			
§485.601(b)	**TAG: C-0800**	Statutory basis and scope for designating hospitals as critical access hospitals.	
(b) Scope. This subpart sets forth the conditions that a hospital must meet to be designated as a CAH.			
§485.603	**TAG: C-0802**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
§485.603 Rural health network. A rural health network is an organization that meets the following specifications:		**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.
		The glossary includes this Medicare definition.	
§485.603(a)	**TAG: C-0802**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
(a) It includes—		**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.
		The glossary includes this Medicare definition.	
§485.603(a)(1)	**TAG: C-0802**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
(1) At least one hospital that the State has designated or plans to designate as a CAH; and		**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.
		The glossary includes this Medicare definition.	
§485.603(a)(2)	**TAG: C-0802**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
(2) At least one hospital that furnishes acute care services.		**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.
		The glossary includes this Medicare definition.	
§485.603(b)	**TAG: C-0802**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
(b) The members of the organization have entered into agreements regarding—		**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.
		The glossary includes this Medicare definition.	

CFR Number §485.603(b)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.603(b)(1)	**TAG: C-0802**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
(1) Patient referral and transfer;		**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.
		The glossary includes this Medicare definition.	
§485.603(b)(2)	**TAG: C-0802**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
(2) The development and use of communications systems, including, where feasible, telemetry systems and systems for electronic sharing of patient data; and		**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.
		The glossary includes this Medicare definition.	
§485.603(b)(3)	**TAG: C-0802**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
(3) The provision of emergency and nonemergency transportation among members.		**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.
		The glossary includes this Medicare definition.	
§485.603(c)	**TAG: C-0802**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
(c) Each CAH has an agreement with respect to credentialing and quality assurance with at least—		**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.
		The glossary includes this Medicare definition.	
§485.603(c)(1)	**TAG: C-0802**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
(1) One hospital that is a member of the network when applicable;		**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.
		The glossary includes this Medicare definition.	
§485.603(c)(2)	**TAG: C-0802**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
(2) One QIO or equivalent entity; or		**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.
		The glossary includes this Medicare definition.	
§485.603(c)(3)	**TAG: C-0802**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
(3) One other appropriate and qualified entity identified in the State rural health care plan.		**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.
		The glossary includes this Medicare definition.	
§485.604	**TAG: C-0804**	**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
§485.604 Personnel qualifications. Staff that furnish services in a CAH must meet the applicable requirements of this section.		**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.

CFR Number §485.604(a)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.604(a) **TAG: C-0804**		**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(a) Clinical nurse specialist. A clinical nurse specialist must be a person who—		**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(a)(1) **TAG: C-0804**		**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(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		**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(a)(2) **TAG: C-0804**		**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(2) Holds a master's or doctoral level degree in a defined clinical area of nursing from an accredited educational institution.		**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(b) **TAG: C-0804**		**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(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:		**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(b)(1) **TAG: C-0804**		**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(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.		**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(b)(2) **TAG: C-0804**		**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(2) Has successfully completed a 1 academic year program that—		**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.

CFR Number §485.604(b)(2)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.604(b)(2)(i)	**TAG: C-0804**	**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(i) Prepares registered nurses to perform an expanded role in the delivery of primary care;		**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(b)(2)(ii)	**TAG: C-0804**	**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(ii) Includes at least 4 months (in the aggregate) of classroom instruction and a component of supervised clinical practice; and		**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(b)(2)(iii)	**TAG: C-0804**	**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(iii) Awards a degree, diploma, or certificate to persons who successfully complete the program.		**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(b)(3)	**TAG: C-0804**	**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(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 the delivery of primary care for a total of 12 months during the 18-month period immediately preceding June 25, 1993.		**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(c)	**TAG: C-0804**	**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(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:		**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(c)(1)	**TAG: C-0804**	**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(1) Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians.		**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.

CFR Number §485.604(c)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.604(c)(2) **TAG: C-0804**		**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(2) Has satisfactorily completed a program for preparing physician assistants that—		**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(c)(2)(i) **TAG: C-0804**		**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(i) Was at least one academic year in length;		**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(c)(2)(ii) **TAG: C-0804**		**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(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		**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(c)(2)(iii) **TAG: C-0804**		**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(iii) Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation.		**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(c)(3) **TAG: C-0804**		**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(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.		**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.
§485.606 **TAG: C-0808**		This is the responsibility of the State and CMS.	
§485.606 Designation and certification of CAHs.			
§485.606(a) **TAG: C-0808**		This is the responsibility of the State and CMS.	
(a) Criteria for State designation.			
§485.606(a)(1) **TAG: C-0808**		This is the responsibility of the State and CMS.	
(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.			

CFR Number §485.606(a)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.606(a)(2)	**TAG: C-0808**	This is the responsibility of the State and CMS.	
(2) The State must not deny any hospital that is otherwise eligible for designation as a CAH under this paragraph (a) solely because the hospital has entered into an agreement under which the hospital may provide post hospital SNF care as described in § 482.58 of this chapter.			
§485.606(b)	**TAG: C-0808**	This is the responsibility of the State and CMS.	
(b) Criteria for CMS certification. CMS certifies a facility as a CAH if—			
§485.606(b)(1)	**TAG: C-0808**	This is the responsibility of the State and CMS.	
(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.			
§485.606(b)(2)	**TAG: C-0808**	This is the responsibility of the State and CMS.	
(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.			
§485.608	**TAG: C-0810**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
§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.		**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(a)	**TAG: C-0812**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
§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.		**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(b)	**TAG: C-0814**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
§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.		**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(c)	**TAG: C-0816**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
§485.608(c) Standard: Licensure of CAH The CAH is licensed in accordance with applicable Federal, State and local laws and regulations.		**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.

CFR Number §485.608(d)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.608(d)	**TAG: C-0818**	**HR.11.01.03**	**The critical access hospital determines how staff function within the organization.**
§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.		**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	**The critical access hospital collects information regarding each physician's or other licensed practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.**
		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	**The decision to grant or deny a privilege(s) and/or to renew an existing privilege(s) is an objective, evidence-based process.**
		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.
§485.610	**TAG: C-0822**	This CoP is determined by CMS at the time the hospital applies for CAH designation.	
§485.610 Condition of Participation: Status and Location			
§485.610(a)	**TAG: C-0824**	This CoP is determined by CMS at the time the hospital applies for CAH designation.	
§485.610(a) Standard: Status The facility is--			
§485.610(a)(1)	**TAG: C-0824**	This CoP is determined by CMS at the time the hospital applies for CAH designation.	
(1) A currently participating hospital that meets all conditions of participation set forth in this subpart;			
§485.610(a)(2)	**TAG: C-0824**	This CoP is determined by CMS at the time the hospital applies for CAH designation.	
(2) A recently closed facility, provided that the facility--			
§485.610(a)(2)(i)	**TAG: C-0824**	This CoP is determined by CMS at the time the hospital applies for CAH designation.	
(i) Was a hospital that ceased operations on or after the date that is 10 years before November 29, 1999; and			
§485.610(a)(2)(ii)	**TAG: C-0824**	This CoP is determined by CMS at the time the hospital applies for CAH designation.	
(ii) Meets the criteria for designation under this subpart as of the effective date of its designation; or			
§485.610(a)(3)	**TAG: C-0824**	This CoP is determined by CMS at the time the hospital applies for CAH designation.	
(3) A health clinic or a health center (as defined by the State) that--			
§485.610(a)(3)(i)	**TAG: C-0824**	This CoP is determined by CMS at the time the hospital applies for CAH designation.	
(i) Is licensed by the State as a health clinic or a health center;			

CFR Number §485.610(a)(3)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.610(a)(3)(ii) **TAG: C-0824**		This CoP is determined by CMS at the time the hospital applies for CAH designation.	
(ii) Was a hospital that was downsized to a health clinic or a health center; and			
§485.610(a)(3)(iii) **TAG: C-0824**		This CoP is determined by CMS at the time the hospital applies for CAH designation.	
(iii) As of the effective date of its designation, meets the criteria for designation set forth in this subpart.			
§485.610(b) **TAG: C-0826**		This CoP is determined by CMS at the time the hospital applies for CAH designation.	
§485.610(b) Standard: Location in a rural area or treatment as rural. The CAH meets the requirements of either paragraph (b)(1) or (b)(2) of this section or the requirements of paragraph (b)(3), (b)(4), or (b)(5) of this section.			
§485.610(b)(1) **TAG: C-0826**		This CoP is determined by CMS at the time the hospital applies for CAH designation.	
(1) The CAH meets the following requirements:			
§485.610(b)(1)(i) **TAG: C-0826**		This CoP is determined by CMS at the time the hospital applies for CAH designation.	
(i) The CAH is located outside any area that is a Metropolitan Statistical Area, as defined by the Office of Management and Budget, or that has been recognized as urban under §412.64(b), excluding paragraph (b)(3) of this chapter;			
§485.610(b)(1)(ii) **TAG: C-0826**		This CoP is determined by CMS at the time the hospital applies for CAH designation.	
(ii) The CAH has not been classified as an urban hospital for purposes of the standardized payment amount by CMS or the Medicare Geographic Classification Review Board under §412.230(e) of this chapter, and is not among a group of hospitals that have been redesignated to an adjacent urban area under §412.232 of this chapter.			
§485.610(b)(2) **TAG: C-0826**		This CoP is determined by CMS at the time the hospital applies for CAH designation.	
(2) The CAH is located within a Metropolitan Statistical Area, as defined by the Office of Management and Budget, but is being treated as being located in a rural area in accordance with §412.103 of this chapter.			
§485.610(b)(3) **TAG: C-0826**		This CoP is determined by CMS at the time the hospital applies for CAH designation.	
(3) Effective for October 1, 2004 through September 30, 2006, the CAH does not meet the location requirements in either paragraph (b)(1) or (b)(2) of this section and is located in a county that, in FY 2004, was not part of a Metropolitan Statistical Area as defined by the Office of Management and Budget, but as of FY 2005 was included as part of such a Metropolitan Statistical Area as a result of the most recent census data and implementation of the new Metropolitan Statistical Area definitions announced by the Office of Management and Budget on June 3, 2003			

CFR Number §485.610(b)(4)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.610(b)(4)	**TAG: C-0826**	This CoP is determined by CMS at the time the hospital applies for CAH designation.	
(4) Effective for October 1, 2009 through September 30, 2011, the CAH does not meet the location requirements in either paragraph (b)(1) or (b)(2) of this section and is located in a county that, in FY 2009, was not part of a Metropolitan Statistical Area as defined by the Office of Management and Budget, but, as of FY 2010, was included as part of such a Metropolitan Statistical Area as a result of the most recent census data and implementation of the new Metropolitan Statistical Area definitions announced by the Office of Management and Budget on November 20, 2008.			
§485.610(b)(5)	**TAG: C-0826**	This CoP is determined by CMS at the time the hospital applies for CAH designation.	
(5) Effective on or after October 1, 2014, for a period of 2 years beginning with the effective date of the most recent Office of Management and Budget (OMB) standards for delineating statistical areas adopted by CMS, the CAH no longer meets the location requirements in either paragraph (b)(1) or (b)(2) of this section and is located in a county that, prior to the most recent OMB standards for delineating statistical areas adopted by CMS and the most recent Census Bureau data, was located in a rural area as defined by OMB, but under the most recent OMB standards for delineating statistical areas adopted by CMS and the most recent Census Bureau data, is located in an urban area.			
§485.610(c)	**TAG: C-0830**		
§485.610(c) Standard: Location Relative to Other Facilities or Necessary Provider Certification			
§485.610(c)(1)	**TAG: C-0830**	This CoP is determined by CMS at the time the hospital applies for CAH designation.	
(1) The CAH is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital or another CAH, or before January 1, 2006, the CAH is certified by the State as being a necessary provider of health care services to residents in the area. A CAH that is designated as a necessary provider on or before December 31, 2005, will maintain its necessary provider designation after January 1, 2006.			
§485.610(c)(2)	**TAG: C-0830**		
(2) Primary roads of travel for determining the driving distance of a CAH and its proximity to other providers is defined as:			
§485.610(c)(2)(i)	**TAG: C-0830**	This CoP is determined by CMS at the time the hospital applies for CAH designation.	
(i) A numbered Federal highway, including interstates, intra-states, expressways, or any other numbered federal highway with 2 or more lanes each way; or			
§485.610(c)(2)(ii)	**TAG: C-0830**	This CoP is determined by CMS at the time the hospital applies for CAH designation.	
(ii) A numbered State highway with 2 or more lanes each way.			

CFR Number §485.610(d)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.610(d)	**TAG: C-0832**	This CoP is determined by CMS at the time the hospital applies for CAH designation.	
§485.610(d) Standard: Relocation of CAHs With a Necessary Provider Designation A CAH that has a necessary provider designation from the State that was in effect prior to January 1, 2006, and relocates its facility after January 1, 2006, can continue to meet the location requirement of paragraph (c) of this section based on the necessary provider designation only if the relocated facility meets the requirements as specified in paragraph (d)(1) of this section.			
§485.610(d)(1)	**TAG: C-0832**	This CoP is determined by CMS at the time the hospital applies for CAH designation.	
(1) If a necessary provider CAH relocates its facility and begins providing services in a new location, the CAH can continue to meet the location requirement of paragraph (c) of this section based on the necessary provider designation only if the CAH in its new location--			
§485.610(d)(1)(i)	**TAG: C-0832**	This CoP is determined by CMS at the time the hospital applies for CAH designation.	
(i) Serves at least 75 percent of the same service area that it served prior to its relocation;			
§485.610(d)(1)(ii)	**TAG: C-0832**	This CoP is determined by CMS at the time the hospital applies for CAH designation.	
(ii) Provides at least 75 percent of the same services that it provided prior to the relocation; and			
§485.610(d)(1)(iii)	**TAG: C-0832**	This CoP is determined by CMS at the time the hospital applies for CAH designation.	
(iii) Is staffed by 75 percent of the same staff (including medical staff, contracted staff, and employees) that were on staff at the original location.			
§485.610(d)(2)	**TAG: C-0832**	This CoP is determined by CMS at the time the hospital applies for CAH designation.	
(2) If a CAH that has been designated as a necessary provider by the State begins providing services at another location after January 1, 2006, and does not meet the requirements in paragraph (d)(1) of this section, the action will be considered a cessation of business as described in §489.52(b)(3).			
§485.610(e)	**TAG: C-0834**	See Appendix A of the CAMCAH.	
§485.610(e) Standard: Off-campus and co-location requirements for CAHs A CAH may continue to meet the location requirements of paragraph (c) of this section only if the CAH meets the following:			
§485.610(e)(1)	**TAG: C-0834**	See Appendix A of the CAMCAH.	
(1) If a CAH with a necessary provider designation is co-located (that is, it shares a campus, as defined in §413.65(a)(2) of this chapter, with another hospital or CAH), the necessary provider CAH can continue to meet the location requirement of paragraph (c) of this section only if the co-location arrangement was in effect before January 1, 2008, and the type and scope of services offered by the facility co-located with the necessary provider CAH do not change. A change of ownership of any of the facilities with a co-location arrangement that was in effect before January 1, 2008, will not be considered to be a new co-location arrangement.			

CFR Number §485.610(e)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.610(e)(2)	**TAG: C-0836**	See Appendix A of the CAMCAH.	
(2) If a CAH or a necessary provider CAH operates an off-campus provider-based location, excluding an RHC as defined in §405.2401(b) of this chapter, but including a department or remote location, as defined in §413.65(a)(2) of this chapter, or an off-campus distinct part psychiatric or rehabilitation unit, as defined in §485.647, that was created or acquired by the CAH on or after January 1, 2008, the CAH can continue to meet the location requirement of paragraph (c) of this section only if the off-campus provider-based location or off-campus distinct part unit is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital or another CAH.			
§485.610(e)(3)	**TAG: C-0836, C-0834**	See Appendix A of the CAMCAH.	
(3) If either a CAH or a CAH that has been designated as a necessary provider by the State does not meet the requirements in paragraph (e)(1) of this section, by co-locating with another hospital or CAH on or after January 1, 2008, or creates or acquires an off-campus provider-based location or off-campus distinct part unit on or after January 1, 2008, that does not meet the requirements in paragraph (e)(2) of this section, the CAH's provider agreement will be subject to termination in accordance with the provisions of §489.53(a)(3) of this subchapter, unless the CAH terminates the off-campus arrangement or the co-location arrangement, or both.			
§485.612	**TAG: C-0840**	This CoP is determined by CMS at the time the hospital applies for CAH designation.	
§485.612 Condition of Participation: Compliance With CAH Requirements at the Time of Application Except for recently closed facilities as described in §485.610(a)(2), or health clinics or health centers as described in §485.610(a)(3), the facility is a hospital that has a provider agreement to participate in the Medicare program as a hospital at the time the hospital applies for designation as a CAH.			
§485.614		**RI.11.01.01**	**The critical access hospital respects, protects, and promotes patient rights.**
§ 485.614 Condition of participation: Patient's rights. A CAH must protect and promote each patient's rights.		**EP 1**	The critical access hospital develops and implements written policies to protect and promote patient rights.
§485.614(a)			
(a) Standard: Notice of rights.			
§485.614(a)(1)		**RI.11.01.01**	**The critical access hospital respects, protects, and promotes patient rights.**
(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.		**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.

CFR Number §485.614(a)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.614(a)(2)		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(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:		**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 • 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	**The patient and their family have the right to have grievances reviewed by the critical access hospital.**
		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.
		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)(i)		**RI.11.02.01**	**The critical access hospital respects the patient's right to receive information in a manner the patient understands.**
(i) The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital.		**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	**The patient and their family have the right to have grievances reviewed by the critical access hospital.**
		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)		**RI.14.01.01**	**The patient and their family have the right to have grievances reviewed by the critical access hospital.**
(ii) The grievance process must specify time frames for review of the grievance and the provision of a response.		**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.

CFR Number §485.614(a)(2)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.614(a)(2)(iii)		**RI.14.01.01**	**The patient and their family have the right to have grievances reviewed by the critical access hospital.**
(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.		**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(b)			
(b) Standard: Exercise of rights			
§485.614(b)(1)		**PC.11.03.01**	**The critical access hospital plans the patient's care.**
(1) The patient has the right to participate in the development and implementation of their plan of care.		**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)(2)		**RI.12.01.01**	**The critical access hospital respects the patient's right to participate in decisions about their care, treatment, and services. Note: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.**
(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 provision of treatment or services deemed medically unnecessary or inappropriate.		**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 or services deemed medically unnecessary or inappropriate.
§485.614(b)(3)		**RI.12.01.01**	**The critical access hospital respects the patient's right to participate in decisions about their care, treatment, and services. Note: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.**
(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).		**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)(4)		**RI.12.01.01**	**The critical access hospital respects the patient's right to participate in decisions about their care, treatment, and services. Note: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.**
(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.		**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 service 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(c)			
(c) Standard: Privacy and safety.			

CFR Number §485.614(c)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.614(c)(1)		**RI.11.01.01**	**The critical access hospital respects, protects, and promotes patient rights.**
(1) The patient has the right to personal privacy.		**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)(2)		**PE.01.01.01**	**The critical access hospital has a safe and adequate physical environment.**
(2) The patient has the right to receive care in a safe setting.		**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)(3)		**RI.13.01.01**	**The patient has the right to be free from harassment, neglect, exploitation, and verbal, mental, physical, and sexual abuse.**
(3) The patient has the right to be free from all forms of abuse or harassment.		**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(d)			
(d) Standard: Confidentiality of patient records.			
§485.614(d)(1)		**IM.12.01.01**	**The critical access hospital protects the privacy and confidentiality of health information.**
(1) The patient has the right to the confidentiality of their clinical records.		**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.
§485.614(d)(2)		**RI.11.01.01**	**The critical access hospital respects, protects, and promotes patient rights.**
(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.		**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 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).

CFR Number §485.614(e)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.614(e)		**PC.13.02.01**	**The critical access hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others. Note: See Glossary for the definitions of restraint and seclusion.**
(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.		**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	**The patient has the right to be free from harassment, neglect, exploitation, and verbal, mental, physical, and sexual abuse.**
		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)(1)			
(1) Definitions.			
§485.614(e)(1)(i)			
(i) A restraint is—			
§485.614(e)(1)(i)(A)		**PC.13.02.01**	**The critical access hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others. Note: See Glossary for the definitions of restraint and seclusion.**
(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		**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)(B)		**PC.13.02.01**	**The critical access hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others. Note: See Glossary for the definitions of restraint and seclusion.**
(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.		**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).

CFR Number §485.614(e)(1)(i)(C)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.614(e)(1)(i)(C)		**PC.13.02.01**	**The critical access hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others. Note: See Glossary for the definitions of restraint and seclusion.**
(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).		**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)(ii)		**PC.13.02.01**	**The critical access hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others. Note: See Glossary for the definitions of restraint and seclusion.**
(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.		**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)(2)		**PC.13.02.01**	**The critical access hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others. Note: See Glossary for the definitions of restraint and seclusion.**
(2) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.		**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.
§485.614(e)(3)		**PC.13.02.01**	**The critical access hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others. Note: See Glossary for the definitions of restraint and seclusion.**
(3) The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.		**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.
§485.614(e)(4)		**PC.13.02.09**	**The critical access hospital has written policies and procedures that guide the use of restraint or seclusion.**
(4) The CAH must have written policies and procedures regarding the use of restraint and seclusion that are consistent with current standards of practice.		**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

CFR Number §485.614(f)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.614(f)		**PC.13.02.03**	**The critical access hospital uses restraint or seclusion safely.**
(f) Standard: Restraint or seclusion: Staff training requirements. The patient has the right to safe implementation of restraint or seclusion by trained staff.		**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)(1)		**PC.13.02.17**	**The critical access hospital trains staff to safely implement the use of restraint or seclusion.**
(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.		**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)(2)		**PC.13.02.17**	**The critical access hospital trains staff to safely implement the use of restraint or seclusion.**
(2) The training must include alternatives to the use of restraint/seclusion.		**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(g)		**PC.13.02.19**	**The critical access hospital reports deaths associated with the use of restraint or seclusion.**
(g) Standard: Death reporting requirements. Hospitals must report deaths associated with the use of seclusion or restraint.		**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 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.
§485.614(g)(1)		**PC.13.02.19**	**The critical access hospital reports deaths associated with the use of restraint or seclusion.**
(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:		**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)(1)(i)		**PC.13.02.19**	**The critical access hospital reports deaths associated with the use of restraint or seclusion.**
(i) Each death that occurs while a patient is in restraint or seclusion.		**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 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.

CFR Number §485.614(g)(1)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.614(g)(1)(ii)		**PC.13.02.19**	**The critical access hospital reports deaths associated with the use of restraint or seclusion.**
(ii) Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.		**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 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.
§485.614(g)(1)(iii)		**PC.13.02.19**	**The critical access hospital reports deaths associated with the use of restraint or seclusion.**
(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.		**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 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.
§485.614(g)(2)			
(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)		**PC.13.02.19**	**The critical access hospital reports deaths associated with the use of restraint or seclusion.**
(i) Any death that occurs while a patient is in such restraints.		**EP 3**	When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, nonrigid, 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 patient's care, 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.

CFR Number §485.614(g)(2)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.614(g)(2)(ii)		**PC.13.02.19**	**The critical access hospital reports deaths associated with the use of restraint or seclusion.**
(ii) Any death that occurs within 24 hours after a patient has been removed from such restraints.		**EP 3**	When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, nonrigid, 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 patient's care, 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)(3)			
(3) The staff must document in the patient's medical record the date and time the death was:			
§485.614(g)(3)(i)		**PC.13.02.19**	**The critical access hospital reports deaths associated with the use of restraint or seclusion.**
(i) Reported to CMS for deaths described in paragraph (g)(1) of this section; or		**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)(ii)		**PC.13.02.19**	**The critical access hospital reports deaths associated with the use of restraint or seclusion.**
(ii) Recorded in the internal log or other systems for deaths described in paragraph (g)(2) of this section.		**EP 3**	When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, nonrigid, 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 patient's care, 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)			
(4) For deaths described in paragraph (g)(2) of this section, entries into the internal log or other system must be documented as follows:			

CFR Number §485.614(g)(4)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.614(g)(4)(i)		**PC.13.02.19**	**The critical access hospital reports deaths associated with the use of restraint or seclusion.**
(i) Each entry must be made not later than seven days after the date of death of the patient.		**EP 3**	When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, nonrigid, 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 patient's care, 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)(ii)		**PC.13.02.19**	**The critical access hospital reports deaths associated with the use of restraint or seclusion.**
(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).		**EP 3**	When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, nonrigid, 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 patient's care, 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)(iii)		**PC.13.02.19**	**The critical access hospital reports deaths associated with the use of restraint or seclusion.**
(iii) The information must be made available in either written or electronic form to CMS immediately upon request.		**EP 3**	When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, nonrigid, 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 patient's care, 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(h)		**RI.11.01.01**	**The critical access hospital respects, protects, and promotes patient rights.**
(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:		**EP 7**	The critical access hospital develops and implements policies and procedures for patient visitation rights. Visitation rights include the right to receive 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 consent for visitors 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 appropriate) of the patient's visitation rights, including any clinical restriction or limitation on such rights.

CFR Number §485.614(h)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.614(h)(1)		**RI.11.01.01**	**The critical access hospital respects, protects, and promotes patient rights.**
(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.		**EP 7**	The critical access hospital develops and implements policies and procedures for patient visitation rights. Visitation rights include the right to receive 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 consent for visitors 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 appropriate) of the patient's visitation rights, including any clinical restriction or limitation on such rights.
§485.614(h)(2)		**RI.11.01.01**	**The critical access hospital respects, protects, and promotes patient rights.**
(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.		**EP 7**	The critical access hospital develops and implements policies and procedures for patient visitation rights. Visitation rights include the right to receive 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 consent for visitors 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 appropriate) of the patient's visitation rights, including any clinical restriction or limitation on such rights.
§485.614(h)(3)		**RI.11.01.01**	**The critical access hospital respects, protects, and promotes patient rights.**
(3) Not restrict, limit , or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.		**EP 4**	The critical access hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, 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.
§485.614(h)(4)		**RI.11.01.01**	**The critical access hospital respects, protects, and promotes patient rights.**
(4) Ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences.		**EP 4**	The critical access hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, 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.
§485.616 TAG: C-0860			
§485.616 Condition of Participation: Agreements			
§485.616(a) TAG: C-0862			
§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:			

CFR Number §485.616(a)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.616(a)(1)	**TAG: C-0864**	**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
(1) Patient referral and transfer;		**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 • 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
§485.616(a)(2)	**TAG: C-0866**	**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
(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		**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 • 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
§485.616(a)(3)	**TAG: C-0868**	**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
(3) The provision of emergency and non-emergency transportation between the facility and the hospital.		**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 • 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
§485.616(b)	**TAG: C-0870**		
§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--			
§485.616(b)(1)	**TAG: C-0870**	**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
(1) One hospital that is a member of the network;		**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)(2)	**TAG: C-0870**	**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
(2) One QIO or equivalent entity; or		**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

CFR Number §485.616(b)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.616(b)(3) **TAG: C-0870**		**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
(3) One other appropriate and qualified entity identified in the State rural health care plan.		**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(c) **TAG: C-0872**			
(c) Standard: Agreements for credentialing and privileging of telemedicine physicians and practitioners.			
§485.616(c)(1) **TAG: C-0872**		**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
(1) 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 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:		**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 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 for appointment to the medical staff 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
§485.616(c)(1)(i) **TAG: C-0872**		**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
(i) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff.		**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 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 for appointment to the medical staff 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

CFR Number §485.616(c)(1)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.616(c)(1)(ii) TAG: C-0872		**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
(ii) Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff.		**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 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 for appointment to the medical staff 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
§485.616(c)(1)(iii) TAG: C-0872		**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
(iii) Assure that the medical staff has bylaws.		**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 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 for appointment to the medical staff 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

CFR Number §485.616(c)(1)(iv)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.616(c)(1)(iv) **TAG: C-0872**		**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
(iv) Approve medical staff bylaws and other medical staff rules and regulations.		**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 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 for appointment to the medical staff 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
§485.616(c)(1)(v) **TAG: C-0872**		**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
(v) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients.		**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 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 for appointment to the medical staff 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

CFR Number §485.616(c)(1)(vi)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.616(c)(1)(vi) TAG: C-0872		**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
(vi) Ensure the criteria for selection are individual character, competence, training, experience, and judgment.		**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 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 for appointment to the medical staff 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
§485.616(c)(1)(vii) TAG: C-0872		**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
(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.		**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 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 for appointment to the medical staff 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

CFR Number §485.616(c)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.616(c)(2) TAG: C-0872		**MS.20.01.01**	**Physicians or other licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.**
(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 must ensure, through its written agreement with the distant-site hospital, that the following provisions are met:		**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 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 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). (See also MS.14.01.01, EP 2)

CFR Number §485.616(c)(2)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.616(c)(2)(i) TAG: C-0872		**MS.20.01.01**	**Physicians or other licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.**
(i) The distant-site hospital providing telemedicine services is a Medicare-participating hospital.		**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 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 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). (See also MS.14.01.01, EP 2)

CFR Number §485.616(c)(2)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.616(c)(2)(ii) TAG: C-0872		**MS.20.01.01**	**Physicians or other licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.**
(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 at the distant-site hospital;		**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 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 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). (See also MS.14.01.01, EP 2)

CFR Number §485.616(c)(2)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.616(c)(2)(iii) TAG: C-0872		**MS.20.01.01**	**Physicians or other licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.**
(iii) The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the CAH is located; and		**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 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 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). (See also MS.14.01.01, EP 2)

CFR Number §485.616(c)(2)(iv)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.616(c)(2)(iv) TAG: C-0872		**MS.20.01.01**	**Physicians or other licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.**
(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.		**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 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 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). (See also MS.14.01.01, EP 2)
§485.616(c)(3) TAG: C-0874		**LD.11.01.03**	**The critical access hospital identifies the responsibilities of its leaders.**
(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.		**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

CFR Number §485.616(c)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		LD.13.03.03	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
		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 all applicable Medicare Conditions of Participation for the contracted services, 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 element of performance.

CFR Number §485.616(c)(4)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.616(c)(4) TAG: C-0874		**MS.20.01.01**	**Physicians or other licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.**
(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:		**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 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 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). (See also MS.14.01.01, EP 2)

CFR Number §485.616(c)(4)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.616(c)(4)(i) **TAG: C-0874**		**MS.20.01.01**	**Physicians or other licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.**
(i) The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at paragraphs (c)(1)(i) through (c)(1)(vii) of this section.		**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 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 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). (See also MS.14.01.01, EP 2)

CFR Number §485.616(c)(4)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.616(c)(4)(ii) TAG: C-0874		**MS.20.01.01**	**Physicians or other licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.**
(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.		**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 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 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). (See also MS.14.01.01, EP 2)

CFR Number §485.616(c)(4)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.616(c)(4)(iii) TAG: C-0874		**MS.20.01.01**	**Physicians or other licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.**
(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.		**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 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 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). (See also MS.14.01.01, EP 2)

CFR Number §485.616(c)(4)(iv)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.616(c)(4)(iv) **TAG: C-0874**		**MS.20.01.01**	**Physicians or other licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.**
(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 telemedicine entity such information for use in the 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.		**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 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 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). (See also MS.14.01.01, EP 2)
§485.618 **TAG: C-0880**		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§485.618 Condition of Participation: Emergency Services The CAH provides emergency care necessary to meet the needs of its inpatients and outpatients.		**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) **TAG: C-0882**		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§485.618(a) Standard: Availability Emergency services are available on a 24-hours a day basis.		**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.

CFR Number §485.618(b)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.618(b) **TAG: C-0884**		**PC.12.01.07**	**The critical access hospital recognizes and responds to changes in a patient's condition. Note: Critical access 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.**
§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:		**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)(1) **TAG: C-0886**		**PC.12.01.07**	**The critical access hospital recognizes and responds to changes in a patient's condition. Note: Critical access 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.**
(1) Drugs and biologicals commonly used in life-saving procedures, including analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids, antiarrythmics, cardiac glycosides, antihypertensives, diuretics, and electrolytes and replacement solutions.		**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)(2) **TAG: C-0888**		**PC.12.01.07**	**The critical access hospital recognizes and responds to changes in a patient's condition. Note: Critical access 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.**
(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.		**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(c) **TAG: C-0890**			
§485.618(c) Standard: Blood and Blood Products The facility provides, either directly or under arrangements, the following--			

CFR Number §485.618(c)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.618(c)(1)	**TAG: C-0890**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(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.		**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)(2)	**TAG: C-0892**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(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. 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.		**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 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.
§485.618(d)	**TAG: C-0894**		
§485.618(d) Standard: Personnel			
§485.618(d)(1)	**TAG: C-0894**	**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(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:		**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 the 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 minutes is the only feasible method for 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.

CFR Number §485.618(d)(1)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.618(d)(1)(i) **TAG: C-0894** (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		**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
		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 the 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 minutes is the only feasible method for 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.
§485.618(d)(1)(ii) **TAG: C-0894** (ii) Within 60 minutes, on a 24-hour a day basis, if all of the following requirements are met:			
§485.618(d)(1)(ii)(A) **TAG: C-0894** (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 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.		**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
		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 the 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 minutes is the only feasible method for 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.

CFR Number §485.618(d)(1)(ii)(B)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.618(d)(1)(ii)(B) **TAG: C-0894**		**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(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.		**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 the 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 minutes is the only feasible method for 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.
§485.618(d)(1)(ii)(C) **TAG: C-0894**		**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(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.		**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 the 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 minutes is the only feasible method for 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.
§485.618(d)(2) **TAG: C-0894**			
(2) A registered nurse with training and experience in emergency care can be utilized to conduct specific medical screening examinations only if--			
§485.618(d)(2)(i) **TAG: C-0894**		**HR.11.01.01**	**The critical access hospital has the necessary staff to support the care, treatment, and services it provides.**
(i) The registered nurse is on site and immediately available at the CAH when a patient requests medical care; and		**EP 2**	A registered nurse with training and experience in emergency care is allowed 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.

CFR Number §485.618(d)(2)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.618(d)(2)(ii) **TAG: C-0894**		**HR.11.01.01**	**The critical access hospital has the necessary staff to support the care, treatment, and services it provides.**
(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.		**EP 2**	A registered nurse with training and experience in emergency care is allowed 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.
§485.618(d)(3) **TAG: C-0894**			
(3) A registered nurse satisfies the personnel requirement specified in paragraph (d)(1) of this section for a temporary period if--			
§485.618(d)(3)(i) **TAG: C-0894**		**NPG.12.02.01**	**The nurse executive directs the implementation of a nurse staffing plan(s).**
(i) The CAH has no greater than 10 beds;		**EP 8**	A registered nurse satisfies the personnel availability 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 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 attests 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 the 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 registered nurses on a temporary basis or its withdrawal of this request can be submitted to CMS at any time and is effective upon submission.

CFR Number §485.618(d)(3)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.618(d)(3)(ii)	**TAG: C-0894**	**NPG.12.02.01**	**The nurse executive directs the implementation of a nurse staffing plan(s).**
(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;		**EP 8**	A registered nurse satisfies the personnel availability 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 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 attests 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 the 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 registered nurses on a temporary basis or its withdrawal of this request can be submitted to CMS at any time and is effective upon submission.
§485.618(d)(3)(iii)	**TAG: C-0894**	**NPG.12.02.01**	**The nurse executive directs the implementation of a nurse staffing plan(s).**
(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 healthcare 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;		**EP 8**	A registered nurse satisfies the personnel availability 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 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 attests 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 the 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 registered nurses on a temporary basis or its withdrawal of this request can be submitted to CMS at any time and is effective upon submission.

CFR Number §485.618(d)(3)(iv)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.618(d)(3)(iv) TAG: C-0894		**NPG.12.02.01**	**The nurse executive directs the implementation of a nurse staffing plan(s).**
(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 adequate coverage as specified in this paragraph (d).		**EP 8**	A registered nurse satisfies the personnel availability 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 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 attests 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 the 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 registered nurses on a temporary basis or its withdrawal of this request can be submitted to CMS at any time and is effective upon submission.
§485.618(d)(4) TAG: C-0894		**NPG.12.02.01**	**The nurse executive directs the implementation of a nurse staffing plan(s).**
(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.		**EP 8**	A registered nurse satisfies the personnel availability 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 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 attests 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 the 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 registered nurses on a temporary basis or its withdrawal of this request can be submitted to CMS at any time and is effective upon submission.
§485.618(e)		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§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.		**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.

CFR Number §485.618(e)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.618(e)(1)		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(1) 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 postdelivery care.		**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)(2)		**HR.11.03.01**	**The critical access hospital provides orientation, education, and training to their staff.**
(2) Staff training. Applicable staff, as identified by the CAH, must be trained annually on the protocols and provisions implemented pursuant to this section.		**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). 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.
§485.618(e)(2)(i)		**HR.11.03.01**	**The critical access hospital provides orientation, education, and training to their staff.**
(i) The governing body must identify and document which staff must complete such training.		**EP 3**	The governing body identifies and documents which staff must complete the annual emergency services readiness training.
§485.618(e)(2)(ii)		**HR.11.03.01**	**The critical access hospital provides orientation, education, and training to their staff.**
(ii) The CAH must document in the staff personnel records that the training was successfully completed.		**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). 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.
§485.618(e)(2)(iii)		**HR.11.03.01**	**The critical access hospital provides orientation, education, and training to their staff.**
(iii) The CAH must be able to demonstrate staff knowledge on such training.		**EP 4**	The critical access hospital is able to demonstrate staff knowledge of emergency services readiness protocols and provisions training.
§485.618(e)(2)(iv)		**HR.11.03.01**	**The critical access hospital provides orientation, education, and training to their staff.**
(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.		**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.
§485.618(f) TAG: C-0898		**LD.13.01.09**	**The critical access hospital has policies and procedures that guide and support patient care, treatment, and services.**
§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 the CAH or other appropriate locations for treatment.		**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 24 hours 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.
§485.620 TAG: C-0900			
§485.620 Condition of Participation: Number of Beds and Length of Stay			

CFR Number §485.620(a)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.620(a)	**TAG: C-0902**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
§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.		**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(b)	**TAG: C-0904**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
§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.		**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.
§485.623	**TAG: C-0910**		
§485.623 Condition of Participation: Physical Plant and Environment			
§485.623(a)	**TAG: C-0912**	**PE.01.01.01**	**The critical access hospital has a safe and adequate physical environment.**
§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.		**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.
		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 needs of the community served. Note: The extent and complexity of facilities is determined by the services offered.
§485.623(b)	**TAG: C-0914**		
§485.623(b) Standard: Maintenance The CAH has housekeeping and preventive maintenance programs to ensure that--			
§485.623(b)(1)	**TAG: C-0914**	**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(1) All essential mechanical, electrical, and patient-care equipment is maintained in safe operating condition;		**EP 2**	The critical access hospital maintains essential mechanical, electrical, and patient care equipment in safe operating condition.
		PE.04.01.05	**The critical access hospital has a water management program that addresses Legionella and other waterborne pathogens. Note: The water management program is in accordance with law and regulation.**
		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.

CFR Number §485.623(b)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		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 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, EP 2)
		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.
		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."
§485.623(b)(2) TAG: C-0920		**PE.02.01.01**	**The critical access hospital manages risks related to hazardous materials and waste.**
(2) There is proper routine storage and prompt disposal of trash;		**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)(3) TAG: C-0922		**MM.13.01.01**	**The critical access hospital safely stores medications.**
(3) Drugs and biologicals are appropriately stored;		**EP 2**	The critical access hospital stores all medications and biologicals, including controlled (scheduled) 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.

CFR Number §485.623(b)(4)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.623(b)(4) **TAG: C-0924**		**PE.01.01.01**	**The critical access hospital has a safe and adequate physical environment.**
(4) The premises are clean and orderly; and		**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)(5) **TAG: C-0926**		**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(5) There is proper ventilation, lighting, and temperature control in all pharmaceutical, patient care, and food preparation areas.		**EP 3**	The critical access hospital has proper ventilation, lighting, and temperature control in all pharmaceutical, patient care, and food preparation areas.
§485.623(c) **TAG: C-0930**			
§485.623(c) Standard: Life Safety From Fire			
§485.623(c)(1) **TAG: C-0930**			
(1) Except as otherwise provided in this section –			
§485.623(c)(1)(i) **TAG: C-0930**		**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(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.)		**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 standard(s) referenced for the activity; and results of the activity.
§485.623(c)(1)(ii) **TAG: C-0930**		**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(ii) Notwithstanding paragraph (c)(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.		**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.

CFR Number §485.623(c)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.623(c)(2)	**TAG: C-0942**	**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(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.		**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 standard(s) referenced for the activity; and results of the activity.
§485.623(c)(3)	**TAG: C-0932**	**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(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.		**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 standard(s) referenced for the activity; and results of the activity.
§485.623(c)(4)	**TAG: C-0934**	**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(4) The CAH maintains written evidence of regular inspection and approval by State or local fire control agencies.		**EP 5**	The critical access hospital maintains written evidence of regular inspection and approval by state or local fire control agencies.
§485.623(c)(5)	**TAG: C-0936**	**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(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.		**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.

CFR Number §485.623(c)(6)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.623(c)(6) **TAG: C-0938**			
(6) When a sprinkler system is shut down for more than 10 hours, the CAH must:			
§485.623(c)(6)(i) **TAG: C-0938**		**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(i) Evacuate the building or portion of the building affected by the system outage until the system is back in service, or		**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 the critical access hospital establishes a fire watch until the system is back in service.
§485.623(c)(6)(ii) **TAG: C-0938**		**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(ii) Establish a fire watch until the system is back in service.		**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 the critical access hospital establishes a fire watch until the system is back in service.
§485.623(c)(7) **TAG: C-0940**		**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(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.		**EP 9**	Buildings have an outside window or outside door in every sleeping room. 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)(i) **TAG: C-0940**		**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(i) The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours.		**EP 9**	Buildings have an outside window or outside door in every sleeping room. 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)(ii) **TAG: C-0940**		**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(ii) Special nursing care areas of new occupancies shall not exceed 60 inches.		**EP 9**	Buildings have an outside window or outside door in every sleeping room. 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(d) **TAG: C-0944**		**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
§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).		**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.

CFR Number §485.623(d)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.623(d)(1) **TAG: C-0944**		**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to a CAH.		**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.
§485.623(d)(2) **TAG: C-0944**		**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(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.		**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.
§485.623(e)			
§485.623(e) 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_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.			
§485.623(e)(1)			
(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.			
§485.623(e)(1)(i)		**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(i) NFPA 99, Standards for Health Care Facilities Code of the National Fire Protection Association 99, 2012 edition, issued August 11, 2011.		**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.

CFR Number §485.623(e)(1)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.623(e)(1)(ii)		**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(ii) TIA 12–2 to NFPA 99, issued August 11, 2011.		**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.
§485.623(e)(1)(iii)		**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(iii) TIA 12–3 to NFPA 99, issued August 9, 2012.		**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.
§485.623(e)(1)(iv)		**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(iv) TIA 12–4 to NFPA 99, issued March 7, 2013.		**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.
§485.623(e)(1)(v)		**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(v) TIA 12–5 to NFPA 99, issued August 1, 2013.		**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.

CFR Number §485.623(e)(1)(vi)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.623(e)(1)(vi)		**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(vi) TIA 12–6 to NFPA 99, issued March 3, 2014.		**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.
§485.623(e)(1)(vii)		**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011;		**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 standard(s) referenced for the activity; and results of the activity.
§485.623(e)(1)(viii)		**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(viii) TIA 12–1 to NFPA 101, issued August 11, 2011.		**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 standard(s) referenced for the activity; and results of the activity.

CFR Number §485.623(e)(1)(ix)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.623(e)(1)(ix)		**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(ix) TIA 12–2 to NFPA 101, issued October 30, 2012.		**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 standard(s) referenced for the activity; and results of the activity.
§485.623(e)(1)(x)		**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(x) TIA 12–3 to NFPA 101, issued October 22, 2013.		**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 standard(s) referenced for the activity; and results of the activity.

CFR Number §485.623(e)(1)(xi)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.623(e)(1)(xi)		**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(xi) TIA 12–4 to NFPA 101, issued October 22, 2013.		**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 standard(s) referenced for the activity; and results of the activity.
§485.625 TAG: E-0001		**EM.09.01.01**	**The critical access hospital has a comprehensive emergency management program that utilizes an all-hazards approach.**
§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, utilizing an all-hazards approach. The emergency preparedness plan must include, but not be limited to, the following elements:		**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
		EP 3	The critical access hospital complies with all applicable federal, state, and local emergency preparedness laws and regulations.

CFR Number §485.625(a)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(a)	**TAG: E-0004**	**EM.12.01.01**	**The critical access hospital develops an emergency operations plan based on an all-hazards approach. Note: The critical access hospital considers its prioritized hazards identified as part of its hazards vulnerability analysis when developing an emergency operations plan.**
(a) Emergency plan. The CAH 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:		**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 • 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	**The critical access hospital evaluates its emergency management program, emergency operations plan, and continuity of operations plans.**
		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
§485.625(a)(1)	**TAG: E-0006**	**EM.11.01.01**	**The critical access hospital conducts a hazard vulnerability analysis utilizing an all-hazards approach.**
(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.		**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 threats, or the patient population and services offered are unique to this facility.
		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)

CFR Number §485.625(a)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(a)(2) **TAG: E-0006**		**EM.11.01.01**	**The critical access hospital conducts a hazard vulnerability analysis utilizing an all-hazards approach.**
(2) Include strategies for addressing emergency events identified by the risk assessment.		**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.
		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.
§485.625(a)(3) **TAG: E-0007**		**EM.12.01.01**	**The critical access hospital develops an emergency operations plan based on an all-hazards approach. Note: The critical access hospital considers its prioritized hazards identified as part of its hazards vulnerability analysis when developing an emergency operations plan.**
(3) Address patient population, including, but not limited to, persons at-risk; the type of services the CAH has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.		**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.13.01.01	**The critical access hospital has a continuity of operations plan. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a continuity of operations plan.**
		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.
		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.
		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.
		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.

CFR Number §485.625(a)(4)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(a)(4)	**TAG: E-0009**	**EM.12.01.01**	**The critical access hospital develops an emergency operations plan based on an all-hazards approach. Note: The critical access hospital considers its prioritized hazards identified as part of its hazards vulnerability analysis when developing an emergency operations plan.**
(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.		**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(b)	**TAG: E-0013**	**EM.12.01.01**	**The critical access hospital develops an emergency operations plan based on an all-hazards approach. Note: The critical access hospital considers its prioritized hazards identified as part of its hazards vulnerability analysis when developing an emergency operations plan.**
(b) Policies and procedures. The CAH 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. At a minimum, the policies and procedures must address the following:		**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 • 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	**The critical access hospital evaluates its emergency management program, emergency operations plan, and continuity of operations plans.**
		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
§485.625(b)(1)	**TAG: E-0015**		
(1) The provision of subsistence needs for staff and patients, whether they evacuate or shelter in place, include, but are not limited to--			

CFR Number §485.625(b)(1)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(b)(1)(i) **TAG: E-0015**		**EM.12.01.01**	**The critical access hospital develops an emergency operations plan based on an all-hazards approach. Note: The critical access hospital considers its prioritized hazards identified as part of its hazards vulnerability analysis when developing an emergency operations plan.**
(i) Food, water, medical, and pharmaceutical supplies;		**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, 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
§485.625(b)(1)(ii) **TAG: E-0015**			
(ii) Alternate sources of energy to maintain:			
§485.625(b)(1)(ii)(A) **TAG: E-0015**		**EM.12.02.11**	**The critical access hospital has a plan for managing essential or critical utilities during an emergency or disaster incident. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for utilities management.**
(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions;		**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.
§485.625(b)(1)(ii)(B) **TAG: E-0015**		**EM.12.02.11**	**The critical access hospital has a plan for managing essential or critical utilities during an emergency or disaster incident. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for utilities management.**
(B) Emergency lighting;		**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.

CFR Number §485.625(b)(1)(ii)(C)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(b)(1)(ii)(C) **TAG: E-0015**		**EM.12.02.11**	**The critical access hospital has a plan for managing essential or critical utilities during an emergency or disaster incident. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for utilities management.**
(C) Fire detection, extinguishing, and alarm systems; and		**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.
§485.625(b)(1)(ii)(D) **TAG: E-0015**		**EM.12.02.11**	**The critical access hospital has a plan for managing essential or critical utilities during an emergency or disaster incident. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for utilities management.**
(D) Sewage and waste disposal.		**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.
§485.625(b)(2) **TAG: E-0018**		**EM.12.02.07**	**The critical access hospital has a plan for safety and security measures to take during an emergency or disaster incident. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for safety and security.**
(2) 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.		**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)(3) **TAG: E-0020**		**EM.12.01.01**	**The critical access hospital develops an emergency operations plan based on an all-hazards approach. Note: The critical access hospital considers its prioritized hazards identified as part of its hazards vulnerability analysis when developing an emergency operations plan.**
(3) Safe evacuation from the CAH, 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.		**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.

CFR Number §485.625(b)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		EM.12.02.01	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
		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 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.
§485.625(b)(4) TAG: E-0022 (4) A means to shelter in place for patients, staff, and volunteers who remain in the facility.		**EM.12.01.01**	**The critical access hospital develops an emergency operations plan based on an all-hazards approach. Note: The critical access hospital considers its prioritized hazards identified as part of its hazards vulnerability analysis when developing an emergency operations plan.**
		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)(5) TAG: E-0023 (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.		**IM.11.01.01**	**The critical access hospital plans for continuity of its information management processes.**
		EP 1	The critical access hospital develops and implements policies and procedures regarding medical documentation and patient information during emergencies and other interruptions to information management systems, 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)(6) TAG: E-0024 (6) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency.		**EM.12.02.03**	**The critical access hospital has a staffing plan for managing all staff and volunteers during an emergency or disaster incident. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a staffing plan.**
		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 includes the following: • Methods for contacting off-duty staff • Acquisition of 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.
		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 • Integration of staffing agencies, volunteer staffing, or deployed medical assistance teams into assigned roles and responsibilities

CFR Number §485.625(b)(7)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(b)(7) **TAG: E-0025**		**EM.12.02.05**	**The critical access hospital has a plan for providing patient care and clinical support during an emergency or disaster incident. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for patient care and clinical support.**
(7) The development of arrangements with other CAHs or other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to CAH patients.		**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)(8) **TAG: E-0026**		**EM.12.01.01**	**The critical access hospital develops an emergency operations plan based on an all-hazards approach. Note: The critical access hospital considers its prioritized hazards identified as part of its hazards vulnerability analysis when developing an emergency operations plan.**
(8) The role of the CAH 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.		**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/what-we-do/emergency-response/how-can-we-help/waivers-flexibilities and https://www.cms.gov/about-cms/agency-information/emergency/downloads/consolidated_medicare_ffs_emergency_qsas.pdf.
§485.625(c) **TAG: E-0029**		**EM.09.01.01**	**The critical access hospital has a comprehensive emergency management program that utilizes an all-hazards approach.**
(c) Communication plan. The CAH 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. The communication plan must include all of the following:		**EP 3**	The critical access hospital complies with all applicable federal, state, and local emergency preparedness laws and regulations.
		EM.12.01.01	**The critical access hospital develops an emergency operations plan based on an all-hazards approach. Note: The critical access hospital considers its prioritized hazards identified as part of its hazards vulnerability analysis when developing an emergency operations plan.**
		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 • 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

CFR Number §485.625(c)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		EM.17.01.01	**The critical access hospital evaluates its emergency management program, emergency operations plan, and continuity of operations plans.**
		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
§485.625(c)(1)	**TAG: E-0030**		
(1) Names and contact information for the following:			
§485.625(c)(1)(i)	**TAG: E-0030**	**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(i) Staff.		**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) • 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.
§485.625(c)(1)(ii)	**TAG: E-0030**	**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(ii) Entities providing services under arrangement.		**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) • 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.

CFR Number §485.625(c)(1)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(c)(1)(iii) **TAG: E-0030**		**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(iii) Patients' physicians.		**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) • 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.
§485.625(c)(1)(iv) **TAG: E-0030**		**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(iv) Other CAHs and hospitals.		**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) • 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.

CFR Number §485.625(c)(1)(v)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(c)(1)(v) **TAG: E-0030**		**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(v) Volunteers.		**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) • 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.
§485.625(c)(2) **TAG: E-0031**			
(2) Contact information for the following:			
§485.625(c)(2)(i) **TAG: E-0031**		**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(i) Federal, State, tribal, regional, and local emergency preparedness staff.		**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) • 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.

CFR Number §485.625(c)(2)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(c)(2)(ii) **TAG: E-0031**		**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(ii) Other sources of assistance.		**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) • 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.
§485.625(c)(3) **TAG: E-0032**			
(3) Primary and alternate means for communicating with the following:			
§485.625(c)(3)(i) **TAG: E-0032**		**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(i) CAH's staff.		**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 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.
§485.625(c)(3)(ii) **TAG: E-0032**		**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(ii) Federal, State, tribal, regional, and local emergency management agencies.		**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 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.

CFR Number §485.625(c)(4)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(c)(4)	**TAG: E-0033**	**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(4) A method for sharing information and medical documentation for patients under the CAH's care, as necessary, with other health care providers to maintain the continuity of care.		**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 Note: Sharing and releasing of patient information is consistent with 45 CFR 164.510(b)(1)(ii) and (b)(4).
		EM.12.02.05	**The critical access hospital has a plan for providing patient care and clinical support during an emergency or disaster incident. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for patient care and clinical support.**
		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(c)(5)	**TAG: E-0033**	**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii).		**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 Note: Sharing and releasing of patient information is consistent with 45 CFR 164.510(b)(1)(ii) and (b)(4).
§485.625(c)(6)	**TAG: E-0033**	**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(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).		**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 Note: Sharing and releasing of patient information is consistent with 45 CFR 164.510(b)(1)(ii) and (b)(4).
§485.625(c)(7)	**TAG: E-0034**	**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(7) A means of providing information about the CAH's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee.		**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.

CFR Number §485.625(d)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(d) **TAG: E-0036**		**EM.15.01.01**	**The critical access hospital has an emergency management education and training program. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing education and training.**
(d) Training and testing. The CAH 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.		**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, 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	**The critical access hospital plans and conducts exercises to test its emergency operations plan and response procedures. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing emergency exercises.**
		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 • 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 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	**The critical access hospital evaluates its emergency management program, emergency operations plan, and continuity of operations plans.**
		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
§485.625(d)(1) **TAG: E-0037**			
(1) Training program. The CAH must do all of the following:			

CFR Number §485.625(d)(1)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(d)(1)(i) **TAG: E-0037**		**EM.15.01.01**	**The critical access hospital has an emergency management education and training program. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing education and training.**
(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.		**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 are 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.
		PE.03.01.01	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
		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.
§485.625(d)(1)(ii) **TAG: E-0037**		**EM.15.01.01**	**The critical access hospital has an emergency management education and training program. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing education and training.**
(ii) Provide emergency preparedness training at least every 2 years.		**EP 3**	The critical access hospital provides ongoing education and training to all staff, individuals providing services under arrangement, and volunteers that are 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-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.
§485.625(d)(1)(iii) **TAG: E-0037**		**EM.15.01.01**	**The critical access hospital has an emergency management education and training program. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing education and training.**
(iii) Maintain documentation of the training.		**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 are 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.

CFR Number §485.625(d)(1)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		EP 3	The critical access hospital provides ongoing education and training to all staff, individuals providing services under arrangement, and volunteers that are 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-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.
§485.625(d)(1)(iv) TAG: E-0037 (iv) Demonstrate staff knowledge of emergency procedures.		**EM.15.01.01**	**The critical access hospital has an emergency management education and training program.** **Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing education and training.**
		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 are 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.
		EP 3	The critical access hospital provides ongoing education and training to all staff, individuals providing services under arrangement, and volunteers that are 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-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.

CFR Number §485.625(d)(1)(v)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(d)(1)(v) **TAG: E-0037**		**EM.15.01.01**	**The critical access hospital has an emergency management education and training program. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing education and training.**
If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.		**EP 3**	The critical access hospital provides ongoing education and training to all staff, individuals providing services under arrangement, and volunteers that are 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-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.
§485.625(d)(2) **TAG: E-0039**		**EM.16.01.01**	**The critical access hospital plans and conducts exercises to test its emergency operations plan and response procedures. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing emergency exercises.**

(2) Testing. The CAH must conduct exercises to test the emergency plan at least twice per year. The CAH must do the following:		**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 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.

CFR Number §485.625(d)(2)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(d)(2)(i) **TAG: E-0039**		**EM.16.01.01**	**The critical access hospital plans and conducts exercises to test its emergency operations plan and response procedures. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing emergency exercises.**

(i) Participate in an annual full-scale exercise that is community-based; or		**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 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.

§485.625(d)(2)(i)(A) **TAG: E-0039**		**EM.16.01.01**	**The critical access hospital plans and conducts exercises to test its emergency operations plan and response procedures. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing emergency exercises.**

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.		**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 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.

CFR Number §485.625(d)(2)(i)(B)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(d)(2)(i)(B) **TAG: E-0039**		**EM.16.01.01**	**The critical access hospital plans and conducts exercises to test its emergency operations plan and response procedures. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing emergency exercises.**

(B) If the CAH experiences an actual natural or man-made emergency that requires activation of the emergency plan, the CAH is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.		**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 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.

§485.625(d)(2)(ii) **TAG: E-0039**			
(ii) Conduct an additional exercise that may include, but is not limited to the following:			
§485.625(d)(2)(ii)(A) **TAG: E-0039**		**EM.16.01.01**	**The critical access hospital plans and conducts exercises to test its emergency operations plan and response procedures. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing emergency exercises.**

(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or		**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 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.

CFR Number §485.625(d)(2)(ii)(B)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(d)(2)(ii)(B) **TAG: E-0039**		**EM.16.01.01**	**The critical access hospital plans and conducts exercises to test its emergency operations plan and response procedures. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing emergency exercises.**

(B) A mock disaster drill; or		**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 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.

§485.625(d)(2)(ii)(C) **TAG: E-0039**		**EM.16.01.01**	**The critical access hospital plans and conducts exercises to test its emergency operations plan and response procedures. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing emergency exercises.**

(B) A tabletop exercise or workshop that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.		**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 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.

CFR Number §485.625(d)(2)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(d)(2)(iii) **TAG: E-0039**		**EM.17.01.01**	**The critical access hospital evaluates its emergency management program, emergency operations plan, and continuity of operations plans.**
(iii) Analyze the CAH's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the CAH's emergency plan, as needed.		**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 an 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.
		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
§485.625(e) **TAG: E-0041**		**EM.12.02.11**	**The critical access hospital has a plan for managing essential or critical utilities during an emergency or disaster incident. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for utilities management.**
(e) Emergency and standby power systems. The CAH must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.		**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.
		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.
		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.

CFR Number §485.625(e)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(e)(1)	**TAG: E-0041**	**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(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.		**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 standard(s) referenced for the activity; and results of the activity.
		PE.04.01.01	**The critical access hospital addresses building safety and facility management.**
		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.
		PE.04.01.03	**The critical access hospital manages utility systems.**
		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.
§485.625(e)(2)	**TAG: E-0041**	**PE.04.01.03**	**The critical access hospital manages utility systems.**
(2) Emergency generator inspection and testing. The CAH must implement emergency power system inspection and testing requirements found in the Health Care Facilities Code, NFPA 110, and the Life Safety Code.		**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.

CFR Number §485.625(e)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(e)(3)	**TAG: E-0041**	**EM.12.02.09**	**The critical access hospital has a plan for managing resources and assets during an emergency or disaster incident. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for resources and assets.**
(3) Emergency generator fuel. CAHs 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.		**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 quickly depleted depending on the type of emergency or disaster incident.
		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	**The critical access hospital has a plan for managing essential or critical utilities during an emergency or disaster incident. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for utilities management.**
		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.
		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.
§485.625(f)	**TAG: E-0042**		
(f) Integrated healthcare systems. If a CAH 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 CAH 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:			

CFR Number §485.625(f)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(f)(1) **TAG: E-0042**		**EM.09.01.01**	**The critical access hospital has a comprehensive emergency management program that utilizes an all-hazards approach.**
(1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.		**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 • Coordinated communication plan • Training and testing program
§485.625(f)(2) **TAG: E-0042**		**EM.09.01.01**	**The critical access hospital has a comprehensive emergency management program that utilizes an all-hazards approach.**
(2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered.		**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 • Coordinated communication plan • Training and testing program

CFR Number §485.625(f)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(f)(3)	**TAG: E-0042**	**EM.09.01.01**	**The critical access hospital has a comprehensive emergency management program that utilizes an all-hazards approach.**
(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.		**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 • Coordinated communication plan • Training and testing program
§485.625(f)(4)	**TAG: E-0042**	**EM.09.01.01**	**The critical access hospital has a comprehensive emergency management program that utilizes an all-hazards approach.**
(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include—		**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 • Coordinated communication plan • Training and testing program
		EM.11.01.01	**The critical access hospital conducts a hazard vulnerability analysis utilizing an all-hazards approach.**
		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.
		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.

CFR Number §485.625(f)(4)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		EM.12.01.01	**The critical access hospital develops an emergency operations plan based on an all-hazards approach. Note: The critical access hospital considers its prioritized hazards identified as part of its hazards vulnerability analysis when developing an emergency operations plan.**
		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.
		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	**The critical access hospital has a continuity of operations plan. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a continuity of operations plan.**
		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.
		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.
		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.
		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.

CFR Number §485.625(f)(4)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(f)(4)(i) **TAG: E-0042**		**EM.09.01.01**	**The critical access hospital has a comprehensive emergency management program that utilizes an all-hazards approach.**
(i) A documented community–based risk assessment, utilizing an all-hazards approach.		**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 • Coordinated communication plan • Training and testing program
§485.625(f)(4)(ii) **TAG: E-0042**		**EM.09.01.01**	**The critical access hospital has a comprehensive emergency management program that utilizes 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.		**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 • Coordinated communication plan • Training and testing program

CFR Number §485.625(f)(5)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(f)(5) **TAG: E-0042**		**EM.09.01.01**	**The critical access hospital has a comprehensive emergency management program that utilizes 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.		**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 • Coordinated communication plan • Training and testing program
		EP 3	The critical access hospital complies with all applicable federal, state, and local emergency preparedness laws and regulations.
		EM.12.01.01	**The critical access hospital develops an emergency operations plan based on an all-hazards approach. Note: The critical access hospital considers its prioritized hazards identified as part of its hazards vulnerability analysis when developing an emergency operations plan.**
		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 • 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.15.01.01	**The critical access hospital has an emergency management education and training program. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing education and training.**
		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, 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.

CFR Number §485.625(f)(5)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		EM.16.01.01	**The critical access hospital plans and conducts exercises to test its emergency operations plan and response procedures. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing emergency exercises.**
		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 • 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 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	**The critical access hospital evaluates its emergency management program, emergency operations plan, and continuity of operations plans.**
		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
§485.625(g) **TAG: E-0041**			
(g) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.			
§485.625(g)(1) **TAG: E-0041**			
(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.			

CFR Number §485.625(g)(1)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(g)(1)(i)	**TAG: E-0041**	**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.		**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.
§485.625(g)(1)(ii)	**TAG: E-0041**	**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.		**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.
§485.625(g)(1)(iii)	**TAG: E-0041**	**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.		**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.
§485.625(g)(1)(iv)	**TAG: E-0041**	**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.		**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.

CFR Number §485.625(g)(1)(v)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(g)(1)(v) **TAG: E-0041**		**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(v) TIA 12-5 to NFPA 99, issued August 1, 2013.		**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.
§485.625(g)(1)(vi) **TAG: E-0041**		**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.		**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.
§485.625(g)(1)(vii) **TAG: E-0041**		**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.		**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 standard(s) referenced for the activity; and results of the activity.

CFR Number §485.625(g)(1)(viii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(g)(1)(viii) **TAG: E-0041**		**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.		**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 standard(s) referenced for the activity; and results of the activity.
§485.625(g)(1)(ix) **TAG: E-0041**		**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.		**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 standard(s) referenced for the activity; and results of the activity.

CFR Number §485.625(g)(1)(x)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.625(g)(1)(x) **TAG: E-0041**		**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(x) TIA 12-3 to NFPA 101, issued October 22, 2013.		**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 standard(s) referenced for the activity; and results of the activity.
§485.625(g)(1)(xi) **TAG: E-0041**		**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.		**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 standard(s) referenced for the activity; and results of the activity.
§485.625(g)(1)(xii) **TAG: E-0041**		**PE.04.01.03**	**The critical access hospital manages utility systems.**
(xii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.		**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.
§485.625(g)(2) **TAG: E-0041**			
(2) [Reserved]			
§485.627 **TAG: C-0960**			
§485.627 Condition of Participation: Organizational Structure			

CFR Number §485.627(a)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.627(a)	**TAG: C-0962**	**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
§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.		**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(b)	**TAG: C-0964**		
§485.627(b) Standard: Disclosure The CAH discloses the names and addresses of--			
§485.627(b)(1)	**TAG: C-0964**	**LD.13.02.01**	**Ethical principles guide the critical access hospital's business practices.**
(1) The person principally responsible for the operation of the CAH; and		**EP 1**	The critical access hospital discloses the names and addresses of the following: • Person principally responsible for the operation of the critical access hospital • Person responsible for medical direction of the critical access hospital
§485.627(b)(2)	**TAG: C-0966**	**LD.13.02.01**	**Ethical principles guide the critical access hospital's business practices.**
(2) The person responsible for medical direction.		**EP 1**	The critical access hospital discloses the names and addresses of the following: • Person principally responsible for the operation of the critical access hospital • Person responsible for medical direction of the critical access hospital
§485.631	**TAG: C-0970**		
§485.631 Condition of Participation: Staffing and Staff Responsibilities			
§485.631(a)	**TAG: C-0971**		
§485.631(a) Standard: Staffing			
§485.631(a)(1)	**TAG: C-0971**	**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(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.		**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.
§485.631(a)(2)	**TAG: C-0972**	**HR.11.01.03**	**The critical access hospital determines how staff function within the organization.**
(2) Any ancillary personnel are supervised by the professional staff.		**EP 2**	Professional staff supervise ancillary staff.

CFR Number §485.631(a)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.631(a)(3)	**TAG: C-0974**	**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(3) The staff is sufficient to provide the services essential to the operation of the CAH.		**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.
§485.631(a)(4)	**TAG: C-0976**	**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(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.		**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.
§485.631(a)(5)	**TAG: C-0978**	**NPG.12.02.01**	**The nurse executive directs the implementation of a nurse staffing plan(s).**
(5) A registered nurse, clinical nurse specialist, or licensed practical nurse is on duty whenever the CAH has one or more inpatients.		**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.
§485.631(b)	**TAG: C-0980**		
§485.631(b) Standard: Responsibilities of the Doctor of Medicine or Osteopathy			
§485.631(b)(1)	**TAG: C-0981**		
(1) The doctor of medicine or osteopathy--			
§485.631(b)(1)(i)	**TAG: C-0981**	**MS.16.01.03**	**The management and coordination of each patient's care, treatment, and services is the responsibility of a physician or other licensed practitioner with appropriate privileges.**
(i) Provides medical direction for the CAH'S health care activities and consultation for, and medical supervision of, the health care staff;		**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.
§485.631(b)(1)(ii)	**TAG: C-0982**	**LD.13.01.09**	**The critical access hospital has policies and procedures that guide and support patient care, treatment, and services.**
(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.		**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.
§485.631(b)(1)(iii)	**TAG: C-0984**	**MS.16.01.03**	**The management and coordination of each patient's care, treatment, and services is the responsibility of a physician or other licensed practitioner with appropriate privileges.**
(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		**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.

CFR Number §485.631(b)(1)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		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(b)(1)(iv)	**TAG: C-0986**	**MS.16.01.03**	**The management and coordination of each patient's care, treatment, and services is the responsibility of a physician or other licensed practitioner with appropriate privileges.**
(iv) Periodically reviews and signs the records of all inpatients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants.		**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.
§485.631(b)(1)(v)	**TAG: C-0986**	**MS.16.01.03**	**The management and coordination of each patient's care, treatment, and services is the responsibility of a physician or other licensed practitioner with appropriate privileges.**
(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.		**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.
§485.631(b)(2)	**TAG: C-0988**	**MS.16.01.03**	**The management and coordination of each patient's care, treatment, and services is the responsibility of a physician or other licensed practitioner with appropriate privileges.**
(2) A doctor of medicine or osteopathy is present for sufficient periods of 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.		**EP 13**	A doctor of medicine or osteopathy is present for sufficient periods of 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.
§485.631(c)	**TAG: C-0990**		
§485.631(c) Standard: Physician Assistant, Nurse Practitioner, and Clinical Nurse Specialist Responsibilities			
§485.631(c)(1)	**TAG: C-0991**		
(1) The physician assistant, the nurse practitioner, or clinical nurse specialist members of the CAH'S staff--			
§485.631(c)(1)(i)	**TAG: C-0991**	**LD.13.01.09**	**The critical access hospital has policies and procedures that guide and support patient care, treatment, and services.**
(i) Participate in the development, execution and periodic review of the written policies governing the services the CAH furnishes; and		**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.
§485.631(c)(1)(ii)	**TAG: C-0993**	**MS.16.01.03**	**The management and coordination of each patient's care, treatment, and services is the responsibility of a physician or other licensed practitioner with appropriate privileges.**
(ii) Participate with a doctor of medicine or osteopathy in a periodic review of the patients' health records.		**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)(2)	**TAG: C-0995**		
(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:			

CFR Number §485.631(c)(2)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.631(c)(2)(i) **TAG: C-0995**		**MS.16.01.03**	**The management and coordination of each patient's care, treatment, and services is the responsibility of a physician or other licensed practitioner with appropriate privileges.**
(i) Provides services in accordance with the CAH'S policies.		**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 • Maintains and transfers patient records when patients are referred
§485.631(c)(2)(ii) **TAG: C-0997**		**MS.16.01.03**	**The management and coordination of each patient's care, treatment, and services is the responsibility of a physician or other licensed practitioner with appropriate privileges.**
(ii) Arranges for, or refers patients to, needed services that cannot be furnished at the CAH, and assures that adequate patient health records are maintained and transferred as required when patients are referred.		**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 • Maintains and transfers patient records when patients are referred
§485.631(c)(3) **TAG: C-0998**		**MS.16.01.03**	**The management and coordination of each patient's care, treatment, and services is the responsibility of a physician or other licensed practitioner with appropriate privileges.**
(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.		**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(d) **TAG: C-0999**			
(d) Standard: Periodic review of clinical privileges and performance. The CAH requires that—			
§485.631(d)(1) **TAG: C-0999**		**MS.17.01.03**	**The critical access hospital collects information regarding each physician's or other licensed practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.**
(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.		**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.
§485.631(d)(2) **TAG: C-0999**			
(2) The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the CAH are evaluated by—			
§485.631(d)(2)(i) **TAG: C-0999**		**MS.17.01.03**	**The critical access hospital collects information regarding each physician's or other licensed practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.**
(i) One hospital that is a member of the network, when applicable;		**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, 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.

CFR Number §485.631(d)(2)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.631(d)(2)(ii) **TAG: C-0999**		**MS.17.01.03**	**The critical access hospital collects information regarding each physician's or other licensed practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.**
(ii) One Quality Improvement Organization (QIO) or equivalent entity;		**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, 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.
§485.631(d)(2)(iii) **TAG: C-0999**		**MS.17.01.03**	**The critical access hospital collects information regarding each physician's or other licensed practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.**
(iii) One other appropriate and qualified entity identified in the State rural health care plan;		**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, 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.
§485.631(d)(2)(iv) **TAG: C-0999**		**MS.17.01.03**	**The critical access hospital collects information regarding each physician's or other licensed practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.**
(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		**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, 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.
§485.631(d)(2)(v) **TAG: C-0999**		**MS.17.01.03**	**The critical access hospital collects information regarding each physician's or other licensed practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.**
(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.		**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, 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.

CFR Number §485.631(d)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.631(d)(3) TAG: C-0999		**MS.17.01.03**	**The critical access hospital collects information regarding each physician's or other licensed practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.**
(3) The CAH staff consider the findings of the evaluation and make the necessary changes as specified in paragraphs (b) through (d) of this section.		**EP 10**	The critical access hospital's medical staff reviews the findings from the evaluations of doctors of medicine or osteopathy, including any findings or recommendations of the quality improvement organization, and makes the necessary changes as specified in 42 CFR 485.631 paragraphs (b) through (d).
§485.631(e)			
(e) Standard: Unified and integrated medical staff for a CAH in a multifacility 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)		**MS.14.03.01**	**Multihospital systems can choose to establish a unified and integrated medical staff in accordance with state and local laws.**
(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;		**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)(2)		**MS.14.03.01**	**Multihospital systems can choose to establish a unified and integrated medical staff in accordance with state and local laws.**
(2) The unified and integrated medical staff has bylaws, rules, and requirements that 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;		**EP 4**	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
§485.631(e)(3)		**MS.14.03.01**	**Multihospital systems can choose to establish a unified and integrated medical staff in accordance with state and local laws.**
(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		**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.

CFR Number §485.631(e)(4)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.631(e)(4)		**MS.14.03.01**	**Multihospital systems can choose to establish a unified and integrated medical staff in accordance with state and local laws.**
(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.		**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 develops 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.
§485.635 **TAG: C-1004**			
§485.635 Condition of Participation: Provision of Services			
§485.635(a) **TAG: C-1006**			
§485.635(a) Standard: Patient Care Policies			
§485.635(a)(1) **TAG: C-1006**		**LD.13.01.09**	**The critical access hospital has policies and procedures that guide and support patient care, treatment, and services.**
(1) The CAH'S health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.		**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)(2) **TAG: C-1008**		**LD.13.01.09**	**The critical access hospital has policies and procedures that guide and support patient care, treatment, and services.**
(2) The policies are developed with the advice of members of the CAH's professional healthcare staff, including one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the provisions of § 485.631(a)(1).		**EP 3**	The critical access hospital develops health care service policies and procedures with the advice of members of its professional health care staff, including one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists if they are on staff.
§485.635(a)(3) **TAG: C-1010**			
(3) The policies include the following:			

CFR Number §485.635(a)(3)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.635(a)(3)(i) **TAG: C-1010**		**LD.13.01.09**	**The critical access hospital has policies and procedures that guide and support patient care, treatment, and services.**
(i) A description of the services the CAH furnishes, including those furnished through agreement or arrangement.		**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)(ii) **TAG: C-1012**		**LD.13.01.09**	**The critical access hospital has policies and procedures that guide and support patient care, treatment, and services.**
(ii) Policies and procedures for emergency medical services.		**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)(iii) **TAG: C-1014**		**LD.13.01.09**	**The critical access hospital has policies and procedures that guide and support patient care, treatment, and services.**
(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.		**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.

CFR Number §485.635(a)(3)(iv)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.635(a)(3)(iv) **TAG: C-1016**		**LD.13.01.09**	**The critical access hospital has policies and procedures that guide and support patient care, treatment, and services.**
(iv) Rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must 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.		**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.
		MM.13.01.01	**The critical access hospital safely stores medications.**
		EP 1	The critical access hospital maintains current and accurate records of the receipt and disposition of all scheduled drugs.
		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	**Medications are labeled.**
		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.
§485.635(a)(3)(v) **TAG: C-1018**		**MM.17.01.01**	**The critical access hospital responds to actual or potential adverse drug events, significant adverse drug reactions, and medication errors.**
(v) Procedures for reporting adverse drug reactions and errors in the administration of drugs.		**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)(vi) **TAG: C-1020**		**PC.12.01.01**	**The critical access hospital provides care, treatment, and services as ordered or prescribed and in accordance with law and regulation.**
(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.		**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 dietetic 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.

CFR Number §485.635(a)(3)(vi)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		PC.12.01.09	**The critical access hospital makes food and nutrition products available to its patients.**
		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.
§485.635(a)(3)(viii)		**LD.13.01.09**	**The critical access hospital has policies and procedures that guide and support patient care, treatment, and services.**
(viii) Policies and procedures that address the post-acute care needs of patients receiving CAH services.		**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)(4) TAG: C-1008, C-1022		**LD.13.01.09**	**The critical access hospital has policies and procedures that guide and support patient care, treatment, and services.**
(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.		**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(b) TAG: C-1024			
§485.635(b) Standard: Patient Services			
§485.635(b)(1)(i) TAG: C-1024		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(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.		**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)(1)(ii) TAG: C-1026		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(1)(ii) The CAH furnishes acute care inpatient services.		**EP 3**	The critical access hospital provides acute care inpatient services.
§485.635(b)(2) TAG: C-1028			
(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:			

CFR Number §485.635(b)(2)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.635(b)(2)(i)	**TAG: C-1028**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(i) Chemical examination of urine by stick or tablet method or both (including urine ketones).		**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)(ii)	**TAG: C-1028**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(ii) Hemoglobin or hematocrit.		**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)(iii)	**TAG: C-1028**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(iii) Blood glucose.		**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.

CFR Number §485.635(b)(2)(iv)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.635(b)(2)(iv) **TAG: C-1028**		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(iv) Examination of stool specimens for occult blood.		**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)(v) **TAG: C-1028**		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(v) Pregnancy tests.		**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)(vi) **TAG: C-1028**		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(vi) Primary culturing for transmittal to a certified laboratory.		**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.

CFR Number §485.635(b)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.635(b)(3) **TAG: C-1030**		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(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.		**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.
		NPG.12.01.01	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
		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.

CFR Number §485.635(b)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		PE.02.01.01	**The critical access hospital manages risks related to hazardous materials and waste.**
		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 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 personal 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)
		EP 5	Radiation workers are checked periodically, using exposure meters or badge tests, for the amount of radiation exposure.
§485.635(b)(4) TAG: C-1032		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(4) Emergency procedures. In accordance with the requirements of §485.618, the CAH provides medical services as a first response to common life-threatening injuries and acute illness.		**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.
§485.635(c) TAG: C-1034			
§485.635(c) Standard: Services Provided Through Agreements or Arrangements			
§485.635(c)(1) TAG: C-1034			
(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--			
§485.635(c)(1)(i) TAG: C-1036		**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
(i) Services of doctors of medicine or osteopathy;		**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

CFR Number §485.635(c)(1)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.635(c)(1)(ii) **TAG: C-1038**		**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
(ii) Additional or specialized diagnostic and clinical laboratory services that are not available at the CAH; and		**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)(iii) **TAG: C-1040**		**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
(iii) Food and other services to meet inpatients' nutritional needs to the extent these services are not provided directly by the CAH.		**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)(2)		**LD.13.01.09**	**The critical access hospital has policies and procedures that guide and support patient care, treatment, and services.**
(2) If the agreements or arrangements are not in writing, the CAH is able to present evidence that patients referred by the CAH are being accepted and treated.		**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(c)(3) **TAG: C-1042**		**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
(3) The CAH maintains a list of all services furnished under arrangements or agreements. The list describes the nature and scope of the services provided.		**EP 1**	The critical access hospital maintains a current list of all patient care services provided under contract, arrangement, or agreement. The list describes nature and scope of services provided.
§485.635(c)(4) **TAG: C-1044**			
(4) The person principally responsible for the operation of the CAH under §485.627(b)(2) of this chapter is also responsible for the following:			

CFR Number §485.635(c)(4)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.635(c)(4)(i)	**TAG: C-1044**	**LD.11.01.03**	**The critical access hospital identifies the responsibilities of its leaders.**
(i) Services furnished in the CAH whether or not they are furnished under arrangements or agreements.		**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
§485.635(c)(4)(ii)	**TAG: C-1044**	**LD.11.01.03**	**The critical access hospital identifies the responsibilities of its leaders.**
(ii) Ensuring that a contractor of services (including one for shared services and joint ventures) furnishes services that enable the CAH to comply with all applicable conditions of participation and standards for the contracted services.		**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
§485.635(c)(5)	**TAG: C-1034**	**MS.20.01.01**	**Physicians or other licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.**
(5) 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, the distant-site telemedicine entity is not required to be a Medicare-participating provider or supplier.		**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 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 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). (See also MS.14.01.01, EP 2)

CFR Number §485.635(d)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.635(d)	**TAG: C-1046**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§485.635(d) Standard: Nursing Services Nursing services must meet the needs of patients.		**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.
§485.635(d)(1)	**TAG: C-1046**	**NPG.12.02.01**	**The nurse executive directs the implementation of a nurse staffing plan(s).**
(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.		**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 488.54(c) are not required to have 24-hour nursing services.
§485.635(d)(2)	**TAG: C-1048**	**NR.11.01.01**	**The nurse executive directs the implementation of nursing policies and procedures, nursing standards, and a nurse staffing plan(s).**
(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.		**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.
§485.635(d)(3)	**TAG: C-1049**	**MM.11.01.01**	**The critical access hospital safely manages pharmaceutical services.**
(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.		**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	**The critical access hospital safely administers medications.**
		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 requirements, and in accordance with the approved medical staff policies and procedures.
§485.635(d)(4)	**TAG: C-1050**	**PC.11.03.01**	**The critical access hospital plans the patient's care.**
(4) A nursing care plan must be developed and kept current for each inpatient.		**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 professional staff who provide services to the patient.

CFR Number §485.635(e)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.635(e)	**TAG: C-1052**	**HR.11.02.01**	**The critical access hospital defines and verifies staff qualifications.**
§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.		**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.
§485.638	**TAG: C-1100**		
§485.638 Condition of Participation: Clinical Records			
§485.638(a)	**TAG: C-1102**		
§485.638(a) Standard: Records System			
§485.638(a)(1)	**TAG: C-1102**	**RC.11.01.01**	**The critical access hospital maintains complete and accurate medical records for each individual patient.**
(1) The CAH maintains a clinical records system in accordance with written policies and procedures.		**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)(2)	**TAG: C-1104**	**RC.11.01.01**	**The critical access hospital maintains complete and accurate medical records for each individual patient.**
(2) The records are legible, complete, accurately documented, readily accessible, and systematically organized.		**EP 4**	The critical access hospital develops and implements policies and procedures for accurate, legible, complete, signed, dated, and 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)(3)	**TAG: C-1106**	**RC.11.01.01**	**The critical access hospital maintains complete and accurate medical records for each individual patient.**
(3) A designated member of the professional staff is responsible for maintaining the records and for ensuring that they are completely and accurately documented, readily accessible, and systematically organized.		**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)(4)	**TAG: C-1110**		
(4) For each patient receiving health care services, the CAH maintains a record that includes, as applicable--			
§485.638(a)(4)(i)	**TAG: C-1110**	**RC.12.01.01**	**The medical record contains information that reflects the patient's care, treatment, and services.**
(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;		**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.

CFR Number §485.638(a)(4)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		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 • 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 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.
		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.

CFR Number §485.638(a)(4)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.638(a)(4)(ii) **TAG: C-1114**		**RC.12.01.01**	**The medical record contains information that reflects the patient's care, treatment, and services.**
(ii) Reports of physical examinations, diagnostic and laboratory test results, including clinical laboratory services, and consultative findings;		**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 • 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 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.

CFR Number §485.638(a)(4)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.638(a)(4)(iii) **TAG: C-1116**		**RC.12.01.01**	**The medical record contains information that reflects the patient's care, treatment, and services.**
(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		**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 • 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 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.
§485.638(a)(4)(iv) **TAG: C-1118**		**RC.11.02.01**	**Entries in the medical record are authenticated.**
(iv) Dated signatures of the doctor of medicine or osteopathy or other health care professional.		**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 patient's care 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(b) **TAG: C-1120**			
§485.638(b) Standard: Protection of Record Information			
§485.638(b)(1) **TAG: C-1120**		**IM.12.01.01**	**The critical access hospital protects the privacy and confidentiality of health information.**
(1) The CAH maintains the confidentially of record information and provides safeguards against loss, destruction, or unauthorized use.		**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)(2) **TAG: C-1122**		**IM.12.01.01**	**The critical access hospital protects the privacy and confidentiality of health information.**
(2) Written policies and procedures govern the use and removal of records from the CAH and the conditions for the release of information.		**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.

CFR Number §485.638(b)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		IM.12.01.03	**The critical access hospital maintains the security and integrity of health information.**
		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 • 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.
§485.638(b)(3)	**TAG: C-1124**	**IM.12.01.01**	**The critical access hospital protects the privacy and confidentiality of health information.**
(3) The patient's written consent is required for release of information not required by law.		**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(c)	**TAG: C-1126**	**RC.11.03.01**	**The critical access hospital retains its medical records.**
§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.		**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(d)	**TAG: C-1127**		
§485.638(d) Standard: Electronic notifications. If the CAH utilizes an electronic medical records system or other electronic administrative system, which is conformant with the content exchange standard at 45 CFR 170.205(d)(2), then the CAH must demonstrate that—			
§485.638(d)(1)	**TAG: C-1127**	**IM.13.01.05**	**The critical access hospital meets requirements for the electronic exchange of patient health information. Note: This standard only applies to critical access hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).**
(1) The system's notification capacity is fully operational and the CAH uses it in accordance with all State and Federal statutes and regulations applicable to the CAH's exchange of patient health information.		**EP 1**	The critical access hospital demonstrates that its electronic health records system's (or other electronic administrative system's) notification capacity is fully operational and is used in accordance with applicable state and federal laws and regulations for the exchange of patient health information.
§485.638(d)(2)	**TAG: C-1127**	**IM.13.01.05**	**The critical access hospital meets requirements for the electronic exchange of patient health information. Note: This standard only applies to critical access hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).**
(2) The system sends notifications that must include at least patient name, treating practitioner name, and sending institution name.		**EP 2**	The critical access hospital demonstrates that its electronic health records system (or other electronic administrative system) sends notifications that include, at a minimum, the patient's name, treating licensed practitioner's name, and sending institution's name.

CFR Number §485.638(d)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.638(d)(3) **TAG: C-1127**		**IM.13.01.05**	**The critical access hospital meets requirements for the electronic exchange of patient health information. Note: This standard only applies to critical access hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).**
(3) To the extent permissible under applicable federal and state law and regulations, and not inconsistent with the patient's expressed privacy preferences, the system sends notifications directly, or through an intermediary that facilitates exchange of health information, at the time of:		**EP 3**	In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the critical access hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, at the following times, when applicable: • The patient's emergency department registration • The patient's inpatient admission
§485.638(d)(3)(i) **TAG: C-1127**		**IM.13.01.05**	**The critical access hospital meets requirements for the electronic exchange of patient health information. Note: This standard only applies to critical access hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).**
(i) The patient's registration in the CAH's emergency department (if applicable).		**EP 3**	In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the critical access hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, at the following times, when applicable: • The patient's emergency department registration • The patient's inpatient admission
§485.638(d)(3)(ii) **TAG: C-1127**		**IM.13.01.05**	**The critical access hospital meets requirements for the electronic exchange of patient health information. Note: This standard only applies to critical access hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).**
(ii) The patient's admission to the CAH's inpatient services (if applicable).		**EP 3**	In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the critical access hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, at the following times, when applicable: • The patient's emergency department registration • The patient's inpatient admission
§485.638(d)(4) **TAG: C-1127**		**IM.13.01.05**	**The critical access hospital meets requirements for the electronic exchange of patient health information. Note: This standard only applies to critical access hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).**
(4) To the extent permissible under applicable federal and state law and regulations, and not inconsistent with the patient's expressed privacy preferences, the system sends notifications directly, or through an intermediary that facilitates exchange of health information, either immediately prior to, or at the time of:		**EP 4**	In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the critical access hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, either immediately prior to or at the time of the patient's discharge or transfer from the critical access hospital's emergency department or inpatient services.
§485.638(d)(4)(i) **TAG: C-1127**		**IM.13.01.05**	**The critical access hospital meets requirements for the electronic exchange of patient health information. Note: This standard only applies to critical access hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).**
(i) The patient's discharge or transfer from the CAH's emergency department (if applicable).		**EP 4**	In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the critical access hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, either immediately prior to or at the time of the patient's discharge or transfer from the critical access hospital's emergency department or inpatient services.

CFR Number §485.638(d)(4)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.638(d)(4)(ii) **TAG: C-1127**		**IM.13.01.05**	**The critical access hospital meets requirements for the electronic exchange of patient health information. Note: This standard only applies to critical access hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).**
(ii) The patient's discharge or transfer from the CAH's inpatient services (if applicable).		**EP 4**	In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the critical access hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, either immediately prior to or at the time of the patient's discharge or transfer from the critical access hospital's emergency department or inpatient services.
§485.638(d)(5) **TAG: C-1128**		**IM.13.01.05**	**The critical access hospital meets requirements for the electronic exchange of patient health information. Note: This standard only applies to critical access hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).**
(5) The CAH has made a reasonable effort to ensure that the system sends the notifications to all applicable post- acute care services providers and suppliers, as well as to any of the following practitioners and entities, which need to receive notification of the patient's status for treatment, care coordination, or quality improvement purposes:		**EP 5**	The critical access hospital makes a reasonable effort to confirm that its electronic health records system (or other electronic administrative system) sends the notifications to all applicable post–acute care service providers and suppliers, as well as any of the following who need to receive notification of the patient's status for treatment, care coordination, or quality improvement purposes: • Patient's established primary care licensed practitioner • Patient's established primary care practice group or entity • Other licensed practitioners, or other practice groups or entities, identified by the patient as primarily responsible for the patient's care Note: The term "reasonable effort" means that the critical access hospital has a process to send patient event notifications while working within the constraints of its technology infrastructure. There may be instances in which the critical access hospital (or its intermediary) cannot identify an applicable recipient for a patient event notification despite establishing processes for identifying recipients. In addition, some recipients may not be able to receive patient event notifications in a manner consistent with the critical access hospital system's capabilities.
§485.638(d)(5)(i) **TAG: C-1128**		**IM.13.01.05**	**The critical access hospital meets requirements for the electronic exchange of patient health information. Note: This standard only applies to critical access hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).**
(i) The patient's established primary care practitioner;		**EP 5**	The critical access hospital makes a reasonable effort to confirm that its electronic health records system (or other electronic administrative system) sends the notifications to all applicable post–acute care service providers and suppliers, as well as any of the following who need to receive notification of the patient's status for treatment, care coordination, or quality improvement purposes: • Patient's established primary care licensed practitioner • Patient's established primary care practice group or entity • Other licensed practitioners, or other practice groups or entities, identified by the patient as primarily responsible for the patient's care Note: The term "reasonable effort" means that the critical access hospital has a process to send patient event notifications while working within the constraints of its technology infrastructure. There may be instances in which the critical access hospital (or its intermediary) cannot identify an applicable recipient for a patient event notification despite establishing processes for identifying recipients. In addition, some recipients may not be able to receive patient event notifications in a manner consistent with the critical access hospital system's capabilities.

CFR Number §485.638(d)(5)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.638(d)(5)(ii) **TAG: C-1128**		**IM.13.01.05**	**The critical access hospital meets requirements for the electronic exchange of patient health information. Note: This standard only applies to critical access hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).**
(ii) The patient's established primary care practice group or entity; or		**EP 5**	The critical access hospital makes a reasonable effort to confirm that its electronic health records system (or other electronic administrative system) sends the notifications to all applicable post–acute care service providers and suppliers, as well as any of the following who need to receive notification of the patient's status for treatment, care coordination, or quality improvement purposes: • Patient's established primary care licensed practitioner • Patient's established primary care practice group or entity • Other licensed practitioners, or other practice groups or entities, identified by the patient as primarily responsible for the patient's care Note: The term "reasonable effort" means that the critical access hospital has a process to send patient event notifications while working within the constraints of its technology infrastructure. There may be instances in which the critical access hospital (or its intermediary) cannot identify an applicable recipient for a patient event notification despite establishing processes for identifying recipients. In addition, some recipients may not be able to receive patient event notifications in a manner consistent with the critical access hospital system's capabilities.
§485.638(d)(5)(iii) **TAG: C-1128**		**IM.13.01.05**	**The critical access hospital meets requirements for the electronic exchange of patient health information. Note: This standard only applies to critical access hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).**
(iii) Other practitioner, or other practice group or entity, identified by the patient as the practitioner, or practice group or entity, primarily responsible for his or her care.		**EP 5**	The critical access hospital makes a reasonable effort to confirm that its electronic health records system (or other electronic administrative system) sends the notifications to all applicable post–acute care service providers and suppliers, as well as any of the following who need to receive notification of the patient's status for treatment, care coordination, or quality improvement purposes: • Patient's established primary care licensed practitioner • Patient's established primary care practice group or entity • Other licensed practitioners, or other practice groups or entities, identified by the patient as primarily responsible for the patient's care Note: The term "reasonable effort" means that the critical access hospital has a process to send patient event notifications while working within the constraints of its technology infrastructure. There may be instances in which the critical access hospital (or its intermediary) cannot identify an applicable recipient for a patient event notification despite establishing processes for identifying recipients. In addition, some recipients may not be able to receive patient event notifications in a manner consistent with the critical access hospital system's capabilities.

CFR Number §485.639	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.639 **TAG: C-1140**		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§485.639 Condition of Participation: Surgical Services. If a CAH provides surgical services, surgical procedures must be performed in a safe manner by qualified practitioners who have been granted clinical privileges by the governing body, or responsible individual, of the CAH in accordance with the designation requirements under paragraph (a) of this section.		**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.
		EP 10	If the critical access hospital provides outpatient surgical services, the services are consistent with the quality of inpatient surgical care.
		MS.17.02.01	**The decision to grant or deny a privilege(s) and/or to renew an existing privilege(s) is an objective, evidence-based process.**
		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
§485.639(a) **TAG: C-1142**		**MS.17.02.01**	**The decision to grant or deny a privilege(s) and/or to renew an existing privilege(s) is an objective, evidence-based process.**
§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--		**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

CFR Number §485.639(a)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.639(a)(1) **TAG: C-1142**		**MS.17.02.01**	**The decision to grant or deny a privilege(s) and/or to renew an existing privilege(s) is an objective, evidence-based process.**
(1) A doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Act;		**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
§485.639(a)(2) **TAG: C-1142**		**MS.17.02.01**	**The decision to grant or deny a privilege(s) and/or to renew an existing privilege(s) is an objective, evidence-based process.**
(2) A doctor of dental surgery or dental medicine; or		**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
§485.639(a)(3) **TAG: C-1142**		**MS.17.02.01**	**The decision to grant or deny a privilege(s) and/or to renew an existing privilege(s) is an objective, evidence-based process.**
(3) A doctor of podiatric medicine.		**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
§485.639(b) **TAG: C-1144**			
§485.639(b) Standard: Anesthetic Risk and Evaluation			
§485.639(b)(1) **TAG: C-1144**		**PC.13.01.03**	**The critical access hospital provides the patient with care before and after operative or other high-risk procedures.**
(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.		**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.
§485.639(b)(2) **TAG: C-1144**		**PC.13.01.03**	**The critical access hospital provides the patient with care before and after operative or other high-risk procedures.**
(2) A qualified practitioner, as specified in paragraph (c) of this section, must examine each patient before surgery to evaluate the risk of anesthesia.		**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.
§485.639(b)(3) **TAG: C-1144**		**PC.13.01.03**	**The critical access hospital provides the patient with care before and after operative or other high-risk procedures.**
(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.		**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.

CFR Number §485.639(c)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.639(c) **TAG: C-1145**		**MS.17.02.01**	**The decision to grant or deny a privilege(s) and/or to renew an existing privilege(s) is an objective, evidence-based process.**
§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 policies and procedures and with State scope-of-practice laws.		**EP 1**	The critical access hospital, based on recommendations by the organized medical staff and approval by the governing body, develops and implements criteria that determine if a physician or other licensed practitioner is allowed to provide patient care, treatment, and services within the scope of 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
§485.639(c)(1) **TAG: C-1145**			
(1) Anesthesia must be administered by only--			
§485.639(c)(1)(i) **TAG: C-1145**		**PC.13.01.01**	**The critical access hospital plans operative or other high-risk procedures. Note: Equipment identified in the elements of performance is available to the operating room suites.**
(i) A qualified anesthesiologist;		**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), 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.

CFR Number §485.639(c)(1)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.639(c)(1)(ii) **TAG: C-1145**		**PC.13.01.01**	**The critical access hospital plans operative or other high-risk procedures. Note: Equipment identified in the elements of performance is available to the operating room suites.**
(ii) A doctor of medicine or osteopathy other than an anesthesiologist; including an osteopathic practitioner recognized under section 1101(a)(7) of the Act;		**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), 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.

CFR Number §485.639(c)(1)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.639(c)(1)(iii) **TAG: C-1145**		**PC.13.01.01**	**The critical access hospital plans operative or other high-risk procedures. Note: Equipment identified in the elements of performance is available to the operating room suites.**
(iii) A doctor of dental surgery or dental medicine;		**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), 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.

CFR Number §485.639(c)(1)(iv)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.639(c)(1)(iv) **TAG: C-1145**		**PC.13.01.01**	**The critical access hospital plans operative or other high-risk procedures. Note: Equipment identified in the elements of performance is available to the operating room suites.**
(iv) A doctor of podiatric medicine;		**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), 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.

CFR Number §485.639(c)(1)(v)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.639(c)(1)(v) **TAG: C-1145**		**PC.13.01.01**	**The critical access hospital plans operative or other high-risk procedures. Note: Equipment identified in the elements of performance is available to the operating room suites.**
(v) A certified registered nurse anesthetist (CRNA), as defined in Sec. 410.69(b) of this chapter;		**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), 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.

CFR Number §485.639(c)(1)(vi)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.639(c)(1)(vi) **TAG: C-1145**		**PC.13.01.01**	**The critical access hospital plans operative or other high-risk procedures. Note: Equipment identified in the elements of performance is available to the operating room suites.**
(vi) An anesthesiologist's assistant, as defined in Sec. 410.69(b) of this chapter; or		**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), 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.

CFR Number §485.639(c)(1)(vii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.639(c)(1)(vii) TAG: C-1145		**PC.13.01.01**	**The critical access hospital plans operative or other high-risk procedures. Note: Equipment identified in the elements of performance is available to the operating room suites.**
(vii) A supervised trainee in an approved educational program, as described in §413.85 or §§ 413.76 through 413.83 of this chapter.		**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), 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.

CFR Number §485.639(c)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.639(c)(2) **TAG: C-1147**		**PC.13.01.01**	**The critical access hospital plans operative or other high-risk procedures. Note: Equipment identified in the elements of performance is available to the operating room suites.**
(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.		**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), 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.
§485.639(d) **TAG: C-1149**		**PC.13.01.03**	**The critical access hospital provides the patient with care before and after operative or other high-risk procedures.**
§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.		**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 procedure determines the patient may leave unaccompanied.
§485.639(e) **TAG: C-1150**			
§485.639(e) Standard: State Exemption			

CFR Number §485.639(e)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.639(e)(1) **TAG: C-1150**		**PC.13.01.01**	**The critical access hospital plans operative or other high-risk procedures. Note: Equipment identified in the elements of performance is available to the operating room suites.**
(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.		**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), 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.

CFR Number §485.639(e)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.639(e)(2) **TAG: C-1150**		**PC.13.01.01**	**The critical access hospital plans operative or other high-risk procedures. Note: Equipment identified in the elements of performance is available to the operating room suites.**
(2) 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.		**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), 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.

CFR Number §485.640	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.640	**TAG: C-1200**	**IC.04.01.01**	**The critical access hospital has a hospitalwide infection prevention and control program for the surveillance, prevention, and control of health care–associated infections (HAIs) and other infectious diseases.**
§485.640 Condition of participation: Infection prevention and control and antibiotic stewardship programs. The CAH must have active hospital-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 collaboration with the hospital-wide quality assessment and performance improvement (QAPI) program.		**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 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). (See also PE.04.01.05, EP 2)
		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 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/infection-control/hcp/disinfection-sterilization/introduction-methods-definition-of-terms.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.
		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. (See also LD.11.01.01, EP 10)

CFR Number §485.640	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		IC.05.01.01	**The critical access hospital's governing body, or responsible individual, is accountable for the implementation, performance, and sustainability of the infection prevention and control program.**
		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. 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.
		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	**The critical access hospital implements its infection prevention and control program through surveillance, prevention, and control activities.**
		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. (See also NPG.05.03.01, EP 1)
		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.
		EP 3	The leader(s) of the antibiotic stewardship program is responsible for the following: • Development and implementation 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.
		PE.04.01.01	**The critical access hospital addresses building safety and facility management.**
		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.
§485.640(a)	**TAG: C-1204**		
(a) Standard: Infection prevention and control program organization and policies. The CAH must demonstrate that:			

CFR Number §485.640(a)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.640(a)(1) **TAG: C-1204**		**HR.11.02.01**	**The critical access hospital defines and verifies staff qualifications.**
(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;		**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.
		NPG.12.01.01	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
		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.
§485.640(a)(2) **TAG: C-1206**		**IC.04.01.01**	**The critical access hospital has a hospitalwide infection prevention and control program for the surveillance, prevention, and control of health care–associated infections (HAIs) and other infectious diseases.**
(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;		**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 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/infection-control/hcp/disinfection-sterilization/introduction-methods-definition-of-terms.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.

CFR Number §485.640(a)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		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 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.
§485.640(a)(3) TAG: C-1208 (3) 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		**IC.06.01.01**	**The critical access hospital implements its infection prevention and control program through surveillance, prevention, and control activities.**
		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. (See also NPG.05.03.01, EP 1)
		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
		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

CFR Number §485.640(a)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		PE.01.01.01	**The critical access hospital has a safe and adequate physical environment.**
		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	**The critical access hospital has a water management program that addresses Legionella and other waterborne pathogens. Note: The water management program is in accordance with law and regulation.**
		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.
		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 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, EP 2)
§485.640(a)(4) **TAG: C-1210** (4) The infection prevention and control program reflects the scope and complexity of the CAH services provided.		**IC.04.01.01**	**The critical access hospital has a hospitalwide infection prevention and control program for the surveillance, prevention, and control of health care–associated infections (HAIs) and other infectious diseases.**
		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. (See also LD.11.01.01, EP 10)
§485.640(b) **TAG: C-1212** (b) Standard: Antibiotic stewardship program organization and policies. The CAH must demonstrate that:			
§485.640(b)(1) **TAG: C-1212** (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;		**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, 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.

CFR Number §485.640(b)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.640(b)(2) **TAG: C-1218**			
(2) The facility-wide antibiotic stewardship program:			
§485.640(b)(2)(i) **TAG: C-1218**		**MM.18.01.01**	**The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its 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;		**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 QAPI 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)(ii) **TAG: C-1219**		**MM.18.01.01**	**The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.**
(ii) Documents the evidence-based use of antibiotics in all departments and services of the CAH; and		**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 QAPI 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)(iii) **TAG: C-1220**		**MM.18.01.01**	**The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.**
(iii) Documents any improvements, including sustained improvements, in proper antibiotic use;		**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 QAPI 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)(3) **TAG: C-1221**		**MM.18.01.01**	**The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.**
(3) The antibiotic stewardship program adheres to nationally recognized guidelines, as well as best practices, for improving antibiotic use; and		**EP 6**	The antibiotic stewardship program adheres to nationally recognized guidelines, as well as best practices, for improving antibiotic use.
§485.640(b)(4) **TAG: C-1223**		**MM.18.01.01**	**The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.**
(4) The antibiotic stewardship program reflects the scope and complexity of the CAH services provided.		**EP 1**	The antibiotic stewardship program reflects the scope and complexity of the critical access hospital services provided.
§485.640(c) **TAG: C-1225**			
(c) Standard: Leadership responsibilities.			
§485.640(c)(1) **TAG: C-1225**			
(1) The governing body, or responsible individual, must ensure all of the following:			

CFR Number §485.640(c)(1)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.640(c)(1)(i) **TAG: C-1225**		**IC.05.01.01**	**The critical access hospital's governing body, or responsible individual, is accountable for the implementation, performance, and sustainability of the infection prevention and control program.**
(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 implementation, success, and sustainability of such activities.		**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. 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	**The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.**
		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.
§485.640(c)(1)(ii) **TAG: C-1229**		**IC.05.01.01**	**The critical access hospital's governing body, or responsible individual, is accountable for the implementation, performance, and sustainability of the infection prevention and control program.**
(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 CAH QAPI leadership.		**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	**The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.**
		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)(2) **TAG: C-1231**			
(2) The infection preventionist(s)/infection control professional(s) is responsible for:			

CFR Number §485.640(c)(2)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.640(c)(2)(i) **TAG: C-1231**		**IC.04.01.01**	**The critical access hospital has a hospitalwide infection prevention and control program for the surveillance, prevention, and control of health care–associated infections (HAIs) and other infectious diseases.**
(i) The development and implementation of facility-wide infection surveillance, prevention, and control policies and procedures that adhere to nationally recognized guidelines.		**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 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). (See also PE.04.01.05, EP 2)
§485.640(c)(2)(ii) **TAG: C-1235**		**IC.04.01.01**	**The critical access hospital has a hospitalwide infection prevention and control program for the surveillance, prevention, and control of health care–associated infections (HAIs) and other infectious diseases.**
(ii) All documentation, written or electronic, of the infection prevention and control program and its surveillance, prevention, and control activities.		**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 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). (See also PE.04.01.05, EP 2)

CFR Number §485.640(c)(2)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.640(c)(2)(iii) **TAG: C-1237**		**IC.04.01.01**	**The critical access hospital has a hospitalwide infection prevention and control program for the surveillance, prevention, and control of health care–associated infections (HAIs) and other infectious diseases.**
(iii) Communication and collaboration with the CAH's QAPI program on infection prevention and control issues.		**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 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). (See also PE.04.01.05, EP 2)
§485.640(c)(2)(iv) **TAG: C-1239**		**HR.11.03.01**	**The critical access hospital provides orientation, education, and training to their staff.**
(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.		**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	**The critical access hospital evaluates staff competence and performance.**
		EP 1	Staff competence is initially assessed and documented as part of orientation and once every three years, or more frequently as required by critical access hospital policy or in accordance with law and regulation.

CFR Number §485.640(c)(2)(iv)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		IC.04.01.01	**The critical access hospital has a hospitalwide infection prevention and control program for the surveillance, prevention, and control of health care–associated infections (HAIs) and other infectious diseases.**
		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 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). (See also PE.04.01.05, EP 2)
§485.640(c)(2)(v) TAG: C-1240 (v) The prevention and control of HAIs, including auditing of adherence to infection prevention and control policies and procedures by CAH personnel.		**IC.04.01.01**	**The critical access hospital has a hospitalwide infection prevention and control program for the surveillance, prevention, and control of health care–associated infections (HAIs) and other infectious diseases.**
		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 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). (See also PE.04.01.05, EP 2)

CFR Number §485.640(c)(2)(vi)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.640(c)(2)(vi) **TAG: C-1242**		**IC.04.01.01**	**The critical access hospital has a hospitalwide infection prevention and control program for the surveillance, prevention, and control of health care–associated infections (HAIs) and other infectious diseases.**
(vi) Communication and collaboration with the antibiotic stewardship program.		**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 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). (See also PE.04.01.05, EP 2)
§485.640(c)(3) **TAG: C-1244**			
(3) The leader(s) of the antibiotic stewardship program is responsible for:			
§485.640(c)(3)(i) **TAG: C-1244**		**MM.18.01.01**	**The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.**
(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.		**EP 3**	The leader(s) of the antibiotic stewardship program is responsible for the following: • Development and implementation 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)(ii) **TAG: C-1246**		**MM.18.01.01**	**The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.**
(ii) All documentation, written or electronic, of antibiotic stewardship program activities.		**EP 3**	The leader(s) of the antibiotic stewardship program is responsible for the following: • Development and implementation 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.

CFR Number §485.640(c)(3)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.640(c)(3)(iii) TAG: C-1248		**MM.18.01.01**	**The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.**
(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.		**EP 3**	The leader(s) of the antibiotic stewardship program is responsible for the following: • Development and implementation 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)(iv) TAG: C-1250		**MM.18.01.01**	**The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.**
(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.		**EP 3**	The leader(s) of the antibiotic stewardship program is responsible for the following: • Development and implementation 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(g)		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(g) Standard: Unified and integrated infection prevention and control and antibiotic stewardship programs 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 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:		**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 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 • 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 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)

CFR Number §485.640(g)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.640(g)(1)		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(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;		**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 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 • 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 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)

CFR Number §485.640(g)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.640(g)(2)		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(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;		**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 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 • 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 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)

CFR Number §485.640(g)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.640(g)(3)		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(3) The unified and integrated infection prevention and control and antibiotic stewardship programs have mechanisms in place to ensure that issues localized to particular CAHs are duly considered and addressed; and		**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 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 • 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 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)

CFR Number §485.640(g)(4)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.640(g)(4)		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(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.		**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 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 • 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 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)
§485.641 TAG: C-1300		**LD.12.01.01**	**Leaders establish priorities for performance improvement. (Refer to the "Performance Improvement" [PI] chapter.)**
§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.		**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(a) TAG: C-1300		Refer to the glossary for The Joint Commission's definition of medical error, close call, adverse event, and sentinel event.	
(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.			

CFR Number §485.641(b)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.641(b) **TAG: C-1302**			
(b) Standard: QAPI Program Design and scope. The CAH's QAPI program must:			
§485.641(b)(1) **TAG: C-1302**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(1) Be appropriate for the complexity of the CAH's organization and services provided.		**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 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.13.03.03) 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.
§485.641(b)(2) **TAG: C-1306**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(2) Be ongoing and comprehensive.		**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 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.13.03.03) 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.
§485.641(b)(3) **TAG: C-1306**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(3) Involve all departments of the CAH and services (including those services furnished under contract or arrangement).		**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 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.13.03.03) 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.
§485.641(b)(4) **TAG: C-1309**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(4) Use objective measures to evaluate its organizational processes, functions and services.		**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 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.13.03.03) 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.

CFR Number §485.641(b)(5)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.641(b)(5) **TAG: C-1311**		**PI.11.01.01**	**The critical access hospital has an ongoing quality assessment and performance improvement program.**
(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.		**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
§485.641(c) **TAG: C-1313**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(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 program meets the requirements of paragraph (b) of this section.		**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 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.13.03.03) 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.
§485.641(d) **TAG: C-1315**			
(d) Standard: Program activities. For each of the areas listed in paragraph (b) of this section, the CAH must:			
§485.641(d)(1) **TAG: C-1315**		**LD.12.01.01**	**Leaders establish priorities for performance improvement. (Refer to the "Performance Improvement" [PI] chapter.)**
(1) Focus on measures related to improved health outcomes that are shown to be predictive of desired patient outcomes.		**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
§485.641(d)(2) **TAG: C-1319**		**LD.12.01.01**	**Leaders establish priorities for performance improvement. (Refer to the "Performance Improvement" [PI] chapter.)**
(2) Use the measures to analyze and track its performance.		**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

CFR Number §485.641(d)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.641(d)(3) **TAG: C-1321**		**LD.12.01.01**	**Leaders establish priorities for performance improvement. (Refer to the "Performance Improvement" [PI] chapter.)**
(3) Set priorities for performance improvement, considering either high-volume, high-risk services, or problem-prone areas.		**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
§485.641(e) **TAG: C-1325**		**PI.11.01.01**	**The critical access hospital has an ongoing quality assessment and performance improvement program.**
(e) Standard: Program data collection and analysis. The program must incorporate quality indicator data including patient care data, and other relevant data, in order to achieve the goals of the QAPI program.		**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	**The critical access hospital improves performance.**
		EP 1	The critical access hospital acts on improvement priorities.
§485.641(f)		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(f) Standard: Unified and integrated QAPI program for a CAH in a multifacility system. If a CAH is 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 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:		**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 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 • 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.

CFR Number §485.641(f)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.641(f)(1)		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(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		**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 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 • 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.
§485.641(f)(2)		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(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 issues localized to particular CAHs are duly considered and addressed.		**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 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 • 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.

CFR Number §485.642	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.642	**TAG: C-1400**	**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
§ 485.642 Condition of participation: Discharge planning. A Critical Access Hospital (CAH) must have an effective discharge planning process that focuses on the patient's goals and treatment preferences and includes the patient and his or her caregivers/support person(s) as active partners in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals for care and his or her treatment preferences, ensure an effective transition of the patient from the CAH to post-discharge care, and reduce the factors leading to preventable CAH and hospital readmissions.		**EP 1**	The critical access hospital has an effective discharge planning process that focuses on, and is consistent with, the patient's goals and treatment preferences; makes certain there is an effective transition of the patient from the critical access hospital to postdischarge care; and reduces the factors leading to preventable critical access hospital and hospital readmissions. Note: The critical access hospital's discharge planning process requires regular reevaluation of the patient's condition to identify changes that require modification of the discharge plan. The discharge plan is updated as needed to reflect these changes.
		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 postdischarge 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). 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.
§485.642(a)	**TAG: C-1404**	**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(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.		**EP 2**	The critical access hospital begins the discharge planning process early in the patient's episode of care, treatment, and services.
		EP 5	The critical access hospital performs a discharge planning evaluation and creates a discharge plan for those patients it identifies at an early stage of hospitalization are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning or at the request of the patient, patient's representative, or the patient's physician. Note 1: The discharge planning evaluation is completed in a timely manner so that appropriate arrangements for post–hospital care are made before discharge and unnecessary delays in discharge are avoided. Note 2: The discharge planning evaluation is performed and subsequent discharge plan is created by, or under the supervision of, a registered nurse, social worker, or other qualified person.
§485.642(a)(1)	**TAG: C-1406**	**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(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.		**EP 5**	The critical access hospital performs a discharge planning evaluation and creates a discharge plan for those patients it identifies at an early stage of hospitalization are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning or at the request of the patient, patient's representative, or the patient's physician. Note 1: The discharge planning evaluation is completed in a timely manner so that appropriate arrangements for post–hospital care are made before discharge and unnecessary delays in discharge are avoided. Note 2: The discharge planning evaluation is performed and subsequent discharge plan is created by, or under the supervision of, a registered nurse, social worker, or other qualified person.

CFR Number §485.642(a)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.642(a)(2) TAG: C-1408		**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(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.		**EP 3**	As part of the discharge planning evaluation, the critical access hospital evaluates the patient's need for appropriate post–critical access hospital services, including but not limited to hospice care services, extended care services, home health services, and non–health care services and community-based care providers. The critical access hospital also evaluates the availability of the appropriate services and the patient's access to those services as part of the discharge planning evaluation.
§485.642(a)(3) TAG: C-1410		**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(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).		**EP 6**	The critical access hospital discusses the results of the discharge planning evaluation with the patient or their representative, including any reevaluations performed and any arrangements made.
		RC.12.01.01	**The medical record contains information that reflects the patient's care, treatment, and services.**
		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 • 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 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.

CFR Number §485.642(a)(4)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.642(a)(4)	**TAG: C-1412**	**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(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.		**EP 5**	The critical access hospital performs a discharge planning evaluation and creates a discharge plan for those patients it identifies at an early stage of hospitalization are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning or at the request of the patient, patient's representative, or the patient's physician. Note 1: The discharge planning evaluation is completed in a timely manner so that appropriate arrangements for post–hospital care are made before discharge and unnecessary delays in discharge are avoided. Note 2: The discharge planning evaluation is performed and subsequent discharge plan is created by, or under the supervision of, a registered nurse, social worker, or other qualified person.
§485.642(a)(5)	**TAG: C-1417**	**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(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.		**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 postdischarge 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). 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.
§485.642(a)(6)	**TAG: C-1420**	**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(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.		**EP 1**	The critical access hospital has an effective discharge planning process that focuses on, and is consistent with, the patient's goals and treatment preferences; makes certain there is an effective transition of the patient from the critical access hospital to postdischarge care; and reduces the factors leading to preventable critical access hospital and hospital readmissions. Note: The critical access hospital's discharge planning process requires regular reevaluation of the patient's condition to identify changes that require modification of the discharge plan. The discharge plan is updated as needed to reflect these changes.
§485.642(a)(7)	**TAG: C-1422**	**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(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.		**EP 14**	The critical access hospital assesses its discharge planning process on a regular basis, as defined by the critical access hospital. The assessment includes an ongoing, periodic review of a representative sample of discharge plans, including plans for patients who were readmitted within 30 days of a previous admission, to make certain that the plans are responsive to patient postdischarge needs.
§485.642(a)(8)	**TAG: C-1425**	**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(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.		**EP 7**	The critical access hospital assists the patient, their family, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes but is not limited to home health agency, skilled nursing facility, inpatient rehabilitation facility, and long-term care hospital data on quality measures and resource-use measures. The critical access hospital makes certain that the post–acute care data on quality measures and resource-use measures is relevant and applicable to the patient's goals of care and treatment preferences.

CFR Number §485.642(b)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.642(b) **TAG: C-1430**		**PC.14.02.03**	**When a patient is discharged or transferred, the critical access hospital gives information about the care, treatment, and services provided to the patient to other service providers who will provide the patient with care, treatment, or services.**
(b) Standard: Discharge of the patient and provision and transmission of the patient's necessary medical information. 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, postdischarge 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.		**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
§485.643 **TAG: C-1500**			
§485.643 Condition of Participation: Organ, Tissue, and Eye Procurement The CAH must have and implement written protocols that:			

CFR Number §485.643(a)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.643(a)	**TAG: C-1503**	**TS.11.01.01**	**The critical access hospital, with the medical staff's participation, develops and implements written policies and procedures for donating and procuring organs, tissues, and 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;		**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 requires the critical access hospital to 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 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, to the extent 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 • 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 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.

CFR Number §485.643(b)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.643(b)	**TAG: C-1505**	**TS.11.01.01**	**The critical access hospital, with the medical staff's participation, develops and implements written policies and procedures for donating and procuring organs, tissues, and eyes.**
§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, insofar as such an agreement does not interfere with organ procurement;		**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 requires the critical access hospital to 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 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, to the extent 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 • 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 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.

CFR Number §485.643(c)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.643(c) **TAG: C-1507**		**TS.11.01.01**	**The critical access hospital, with the medical staff's participation, develops and implements written policies and procedures for donating and procuring organs, tissues, and eyes.**
§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;		**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 requires the critical access hospital to 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 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, to the extent 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 • 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 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.
		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.

CFR Number §485.643(d)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.643(d)	**TAG: C-1509**	**TS.11.01.01**	**The critical access hospital, with the medical staff's participation, develops and implements written policies and procedures for donating and procuring organs, tissues, and eyes.**
§485.643(d) Encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of the family of potential donors;		**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 requires the critical access hospital to 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 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, to the extent 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 • 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 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.
§485.643(e)	**TAG: C-1511**	**TS.11.01.01**	**The critical access hospital, with the medical staff's participation, develops and implements written policies and procedures for donating and procuring organs, tissues, and eyes.**
§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.		**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

CFR Number §485.643(f)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.643(f) **TAG: C-1511**		**TS.11.01.01**	**The critical access hospital, with the medical staff's participation, develops and implements written policies and procedures for donating and procuring organs, tissues, and eyes.**
§485.643(f) For purpose of these standards, the term “organ” means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs).		**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 requires the critical access hospital to 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 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, to the extent 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 • 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 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.
		The glossary includes this Medicare definition. Organ: A human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs).	
§483.5 **TAG: C-1610**		The glossary includes this Medicare definition.	
§483.5 Definitions. 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.			
§483.10			
§483.10 Resident rights.			

CFR Number §483.10(b)(7)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.10(b)(7) **TAG: C-1608**		**RI.12.01.01**	**The critical access hospital respects the patient's right to participate in decisions about their care, treatment, and services. Note: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.**
(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.		**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 decisions 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.
§483.10(b)(7)(i) **TAG: C-1608**		**RI.12.01.01**	**The critical access hospital respects the patient's right to participate in decisions about their care, treatment, and services. Note: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.**
(i) In the case of a resident representative whose 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.		**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 decisions 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.
§483.10(b)(7)(ii) **TAG: C-1608**		**RI.12.01.01**	**The critical access hospital respects the patient's right to participate in decisions about their care, treatment, and services. Note: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.**
(ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative.		**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 decisions 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.

CFR Number §483.10(b)(7)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.10(b)(7)(iii) **TAG: C-1608**		**RI.12.01.01**	**The critical access hospital respects the patient's right to participate in decisions about their care, treatment, and services. Note: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.**
(iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.		**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 decisions 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.
§483.10(c)		**RI.12.01.01**	**The critical access hospital respects the patient's right to participate in decisions about their care, treatment, and services. Note: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.**
(c) Planning and implementing care. The resident has the right to be informed of, and participate in, his or her treatment, including:		**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 or services deemed medically unnecessary or inappropriate.
§483.10(c)(1) **TAG: C-1608**		**RI.11.02.01**	**The critical access hospital respects the patient's right to receive information in a manner the patient understands.**
(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.		**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.
§483.10(c)(2)			
(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:			
§483.10(c)(2)(iii) **TAG: C-1608**		**PC.11.03.01**	**The critical access hospital plans the patient's care.**
(iii) The right to be informed, in advance, of changes to the plan of care.		**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.
§483.10(c)(6) **TAG: C-1608**		**RI.12.01.01**	**The critical access hospital respects the patient's right to participate in decisions about their care, treatment, and services. Note: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.**
(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.		**EP 4**	For swing beds in critical access hospitals: The resident has 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.

CFR Number §483.10(d)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.10(d) **TAG: C-1608**		**RI.12.01.01**	**The critical access hospital respects the patient's right to participate in decisions about their care, treatment, and services. Note: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.**
(d) Choice of attending physician. The resident has the right to choose his or her attending physician.		**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 the 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.
§483.10(d)(1) **TAG: C-1608**		**RI.12.01.01**	**The critical access hospital respects the patient's right to participate in decisions about their care, treatment, and services. Note: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.**
(1) The physician must be licensed to practice, and		**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 the 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.
§483.10(d)(2) **TAG: C-1608**		**RI.12.01.01**	**The critical access hospital respects the patient's right to participate in decisions about their care, treatment, and services. Note: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.**
(2) 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.		**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 the 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.
§483.10(d)(3) **TAG: C-1608**			
(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.			

CFR Number §483.10(d)(4)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.10(d)(4)	**TAG: C-1608**	**RI.12.01.01**	**The critical access hospital respects the patient's right to participate in decisions about their care, treatment, and services. Note: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.**
(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.		**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 the 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.
§483.10(d)(5)	**TAG: C-1608**	**RI.12.01.01**	**The critical access hospital respects the patient's right to participate in decisions about their care, treatment, and services. Note: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.**
(5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.		**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 the 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.
§483.10(e)			
(e) Respect and dignity. The resident has a right to be treated with respect and dignity, including:			
§483.10(e)(2)	**TAG: C-1608**	**RI.13.01.03**	**The patient has the right to an environment that preserves respect and dignity.**
(2) The right to retain and use personal possession, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.		**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.
§483.10(e)(4)	**TAG: C-1608**	**RI.13.01.03**	**The patient has the right to an environment that preserves respect and dignity.**
(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.		**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 and when both individuals consent to the arrangement.
§483.10(f)(4)(ii)	**TAG: C-1608**	**RI.11.01.01**	**The critical access hospital respects, protects, and promotes patient rights.**
(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;		**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.
§483.10(f)(4)(iii)	**TAG: C-1608**	**RI.11.01.01**	**The critical access hospital respects, protects, and promotes patient rights.**
(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;		**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.

CFR Number §483.10(g)(8)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.10(g)(8) **TAG: C-1608**		**RI.13.01.03**	**The patient has the right to an environment that preserves respect and dignity.**
(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:		**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 expense.
§483.10(g)(8)(i) **TAG: C-1608**		**RI.13.01.03**	**The patient has the right to an environment that preserves respect and dignity.**
(i) Privacy of such communications consistent with this section; and		**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 expense.
§483.10(g)(8)(ii) **TAG: C-1608**		**RI.13.01.03**	**The patient has the right to an environment that preserves respect and dignity.**
(ii) Access to stationery, postage, and writing implements at the resident's own expense.		**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 expense.
§483.10(g)(17) **TAG: C-1608**			
(17) The facility must—			
§483.10(g)(17)(i) **TAG: C-1608**			
(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—			
§483.10(g)(17)(i)(A) **TAG: C-1608**		**LD.13.02.01**	**Ethical principles guide the critical access hospital's business practices.**
(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;		**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 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.
§483.10(g)(17)(i)(B) **TAG: C-1608**		**LD.13.02.01**	**Ethical principles guide the critical access hospital's business practices.**
(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		**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 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.
§483.10(g)(17)(ii) **TAG: C-1608**		**LD.13.02.01**	**Ethical principles guide the critical access hospital's business practices.**
(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.		**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 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.

CFR Number §483.10(g)(18)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.10(g)(18)	**TAG: C-1608**	**LD.13.02.01**	**Ethical principles guide the critical access hospital's business practices.**
(18) 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.		**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.
§483.10(h)	**TAG: C-1608**	**IM.12.01.01**	**The critical access hospital protects the privacy and confidentiality of health information.**
(h) Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.		**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.
§483.10(h)(1)	**TAG: C-1608**	**RI.11.01.01**	**The critical access hospital respects, protects, and promotes patient rights.**
(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.		**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.
§483.10(h)(2)	**TAG: C-1608**	**RI.11.01.01**	**The critical access hospital respects, protects, and promotes patient rights.**
(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.		**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.
		RI.13.01.03	**The patient has the right to an environment that preserves respect and dignity.**
		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 expense.
§483.10(h)(3)	**TAG: C-1608**	**IM.12.01.01**	**The critical access hospital protects the privacy and confidentiality of health information.**
(3) The resident has a right to secure and confidential personal and medical records.		**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.
§483.10(h)(3)(i)	**TAG: C-1608**	**IM.12.01.01**	**The critical access hospital protects the privacy and confidentiality of health information.**
(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.		**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.

CFR Number §483.10(h)(3)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.10(h)(3)(ii)	**TAG: C-1608**	**IM.12.01.01**	**The critical access hospital protects the privacy and confidentiality of health information.**
(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.		**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.
§483.12(a)			
(a) The facility must—			
§483.12(a)(1)	**TAG: C-1612**	**RI.13.01.01**	**The patient has the right to be free from harassment, neglect, exploitation, and verbal, mental, physical, and sexual abuse.**
(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;		**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.
§483.12(a)(2)	**TAG: C-1612**	**PC.13.02.01**	**The critical access hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others. Note: See Glossary for the definitions of restraint and seclusion.**
(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.		**EP 3**	For swing beds in critical access hospitals: The critical access hospital does not use physical or chemical restraints that are imposed for purposes of discipline or convenience and are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the critical access hospital uses the least restrictive alternative for the least amount of time and documents ongoing reevaluation of the need for restraints.
§483.12(a)(3)	**TAG: C-1612**		
(3) Not employ or otherwise engage individuals who—			
§483.12(a)(3)(i)	**TAG: C-1612**	**HR.11.02.01**	**The critical access hospital defines and verifies staff qualifications.**
(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;		**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.
§483.12(a)(3)(ii)	**TAG: C-1612**	**HR.11.02.01**	**The critical access hospital defines and verifies staff qualifications.**
(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or		**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.
§483.12(a)(4)	**TAG: C-1612**	**RI.13.01.01**	**The patient has the right to be free from harassment, neglect, exploitation, and verbal, mental, physical, and sexual abuse.**
(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.		**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.
§483.12(b)	**TAG: C-1612**		
(b) The facility must develop and implement written policies and procedures that:			

CFR Number §483.12(b)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.12(b)(1) **TAG: C-1612**		**RI.13.01.01**	**The patient has the right to be free from harassment, neglect, exploitation, and verbal, mental, physical, and sexual abuse.**
(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,		**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.
§483.12(b)(2) **TAG: C-1612**		**RI.13.01.01**	**The patient has the right to be free from harassment, neglect, exploitation, and verbal, mental, physical, and sexual abuse.**
(2) Establish policies and procedures to investigate any such allegations, and		**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.
§483.12(c) **TAG: C-1612**			
(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:			
§483.12(c)(1) **TAG: C-1612**		**RI.13.01.01**	**The patient has the right to be free from harassment, neglect, exploitation, and verbal, mental, physical, and sexual abuse.**
(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.		**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 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 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
§483.12(c)(2) **TAG: C-1612**		**RI.13.01.01**	**The patient has the right to be free from harassment, neglect, exploitation, and verbal, mental, physical, and sexual abuse.**
(2) Have evidence that all alleged violations are thoroughly investigated.		**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.
§483.12(c)(3) **TAG: C-1612**		**RI.13.01.01**	**The patient has the right to be free from harassment, neglect, exploitation, and verbal, mental, physical, and sexual abuse.**
(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.		**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.

CFR Number §483.12(c)(4)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.12(c)(4) **TAG: C-1612**		**RI.13.01.01**	**The patient has the right to be free from harassment, neglect, exploitation, and verbal, mental, physical, and sexual abuse.**
(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.		**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.
§483.15(c)			
(c) Transfer and discharge—			
§483.15(c)(1) **TAG: C-1610**			
(1) Facility requirements—			
§483.15(c)(1)(i) **TAG: C-1610**			
(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—			
§483.15(c)(1)(i)(A) **TAG: C-1610**		**PC.14.01.03**	**For swing beds in critical access hospitals: Residents are not transferred or discharged from the critical access hospital unless they meet specific criteria, in accordance with law and regulation.**
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;		**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 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.

CFR Number §483.15(c)(1)(i)(B)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.15(c)(1)(i)(B) TAG: C-1610		**PC.14.01.03**	**For swing beds in critical access hospitals: Residents are not transferred or discharged from the critical access hospital unless they meet specific criteria, in accordance with law and regulation.**
(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 facility;		**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 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.
§483.15(c)(1)(i)(C) TAG: C-1610		**PC.14.01.03**	**For swing beds in critical access hospitals: Residents are not transferred or discharged from the critical access hospital unless they meet specific criteria, in accordance with law and regulation.**
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;		**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 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.

CFR Number §483.15(c)(1)(i)(D)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.15(c)(1)(i)(D) TAG: C-1610 (D) The health of individuals in the facility would otherwise be endangered;		**PC.14.01.03**	**For swing beds in critical access hospitals: Residents are not transferred or discharged from the critical access hospital unless they meet specific criteria, in accordance with law and regulation.**
		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 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.
§483.15(c)(1)(i)(E) TAG: C-1610 (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. 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 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		**PC.14.01.03**	**For swing beds in critical access hospitals: Residents are not transferred or discharged from the critical access hospital unless they meet specific criteria, in accordance with law and regulation.**
		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 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.

CFR Number §483.15(c)(1)(i)(F)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.15(c)(1)(i)(F) **TAG: C-1610**		**PC.14.01.03**	**For swing beds in critical access hospitals: Residents are not transferred or discharged from the critical access hospital unless they meet specific criteria, in accordance with law and regulation.**
(F) The facility ceases to operate.		**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 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.
§483.15(c)(1)(ii) **TAG: C-1610**		**PC.14.01.03**	**For swing beds in critical access hospitals: Residents are not transferred or discharged from the critical access hospital unless they meet specific criteria, in accordance with law and regulation.**
(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.		**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 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.

CFR Number §483.15(c)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.15(c)(2) **TAG: C-1610**		**RC.12.03.01**	**The patient's medical record contains discharge information.**
(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.		**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.
§483.15(c)(2)(i) **TAG: C-1610**			
(i) Documentation in the resident's medical record must include:			
§483.15(c)(2)(i)(A) **TAG: C-1610**		**RC.12.03.01**	**The patient's medical record contains discharge information.**
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.		**EP 2**	For swing beds in critical access hospitals: The resident's 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
§483.15(c)(2)(i)(B) **TAG: C-1610**		**RC.12.03.01**	**The patient's medical record contains discharge information.**
(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).		**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 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.
§483.15(c)(2)(ii) **TAG: C-1610**			
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by—			
§483.15(c)(2)(ii)(A) **TAG: C-1610**		**RC.12.03.01**	**The patient's medical record contains discharge information.**
(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and		**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.

CFR Number §483.15(c)(2)(ii)(B)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.15(c)(2)(ii)(B)	**TAG: C-1610**	**RC.12.03.01**	**The patient's medical record contains discharge information.**
(B) A physician when transfer or discharge is necessary under paragraph (b)(1)(i)(C) or (D) of this section.		**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.
§483.15(c)(2)(iii)	**TAG: C-1610**		
(iii) Information provided to the receiving provider must include a minimum of the following:			
§483.15(c)(2)(iii)(A)	**TAG: C-1610**	**PC.14.02.03**	**When a patient is discharged or transferred, the critical access hospital gives information about the care, treatment, and services provided to the patient to other service providers who will provide the patient with care, treatment, or services.**
(A) Contact information of the practitioner responsible for the care of the resident		**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

CFR Number §483.15(c)(2)(iii)(B)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.15(c)(2)(iii)(B) TAG: C-1610		**PC.14.02.03**	**When a patient is discharged or transferred, the critical access hospital gives information about the care, treatment, and services provided to the patient to other service providers who will provide the patient with care, treatment, or services.**
(B) Resident representative information including contact information.		**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
§483.15(c)(2)(iii)(C) TAG: C-1610		**PC.14.02.03**	**When a patient is discharged or transferred, the critical access hospital gives information about the care, treatment, and services provided to the patient to other service providers who will provide the patient with care, treatment, or services.**
(C) Advance Directive information.		**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

CFR Number §483.15(c)(2)(iii)(D)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.15(c)(2)(iii)(D) TAG: C-1610		**PC.14.02.03**	**When a patient is discharged or transferred, the critical access hospital gives information about the care, treatment, and services provided to the patient to other service providers who will provide the patient with care, treatment, or services.**
(D) All special instructions or precautions for ongoing care, as appropriate.		**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
§483.15(c)(2)(iii)(E) TAG: C-1610		**PC.14.02.03**	**When a patient is discharged or transferred, the critical access hospital gives information about the care, treatment, and services provided to the patient to other service providers who will provide the patient with care, treatment, or services.**
(E) Comprehensive care plan goals,		**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

CFR Number §483.15(c)(2)(iii)(F)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.15(c)(2)(iii)(F) TAG: C-1610		**PC.14.02.03**	**When a patient is discharged or transferred, the critical access hospital gives information about the care, treatment, and services provided to the patient to other service providers who will provide the patient with care, treatment, or services.**
(F) All other necessary information, including a copy of the residents 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.		**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
§483.15(c)(3) TAG: C-1610			
(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must—			
§483.15(c)(3)(i) TAG: C-1610		**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(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.		**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 postdischarge 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). 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.
		RI.11.02.01	**The critical access hospital respects the patient's right to receive information in a manner the patient understands.**
		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.

CFR Number §483.15(c)(3)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.15(c)(3)(ii)	**TAG: C-1610**	**RC.12.03.01**	**The patient's medical record contains discharge information.**
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and		**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).
§483.15(c)(3)(iii)	**TAG: C-1610**	**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(iii) Include in the notice the items described in paragraph (b)(5) of this section.		**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 postdischarge 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). 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.
		RI.11.02.01	**The critical access hospital respects the patient's right to receive information in a manner the patient understands.**
		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.
§483.15(c)(4)	**TAG: C-1610**		
(4) Timing of the notice.			
§483.15(c)(4)(i)	**TAG: C-1610**	**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(i) Except as specified in paragraphs (b)(4)(ii) and (b)(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.		**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 of the individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, 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.
§483.15(c)(4)(ii)	**TAG: C-1610**		
(ii) Notice must be made as soon as practicable before transfer or discharge when—			
§483.15(c)(4)(ii)(A)	**TAG: C-1610**	**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(A) The safety of individuals in the facility would be endangered under paragraph (b)(1)(ii)(C) of this section;		**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 of the individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, 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.

CFR Number §483.15(c)(4)(ii)(B)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.15(c)(4)(ii)(B) **TAG: C-1610**		**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of this section;		**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 of the individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, 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.
§483.15(c)(4)(ii)(C) **TAG: C-1610**		**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (b)(1)(ii)(B) of this section;		**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 of the individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, 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.
§483.15(c)(4)(ii)(D) **TAG: C-1610**		**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this section; or		**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 of the individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, 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.
§483.15(c)(4)(ii)(E) **TAG: C-1610**		**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(E) A resident has not resided in the facility for 30 days.		**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 of the individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, 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.
§483.15(c)(5) **TAG: C-1610**			
(5) Contents of the notice. The written notice specified in paragraph (b)(3) of this section must include the following:			

CFR Number §483.15(c)(5)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.15(c)(5)(i) **TAG: C-1610**		**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(i) The reason for transfer or discharge;		**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, 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
§483.15(c)(5)(ii) **TAG: C-1610**		**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(ii) The effective date of transfer or discharge;		**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, 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

CFR Number §483.15(c)(5)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.15(c)(5)(iii) **TAG: C-1610**		**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(iii) The location to which the resident is transferred or discharged;		**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, 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
§483.15(c)(5)(iv) **TAG: C-1610**		**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(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;		**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, 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

CFR Number §483.15(c)(5)(v)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.15(c)(5)(v) TAG: C-1610		**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;		**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, 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
§483.15(c)(5)(vi) TAG: C-1610		**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(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		**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, 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

CFR Number §483.15(c)(5)(vii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.15(c)(5)(vii) TAG: C-1610		**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(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.		**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, 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
§483.15(c)(7) TAG: C-1610		**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(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.		**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 postdischarge 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). 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.
§483.15(c)(8) TAG: C-1610		**PC.14.01.03**	**For swing beds in critical access hospitals: Residents are not transferred or discharged from the critical access hospital unless they meet specific criteria, in accordance with law and regulation.**
(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).		**EP 2**	For critical access hospitals with swing beds: In the case of critical access hospital closure, 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 residents' representatives, as well as the plan for the transfer and adequate relocation of the residents.
§483.15(c)(9) TAG: C-1610		**RI.13.01.03**	**The patient has the right to an environment that preserves respect and dignity.**
(9) Room changes in a composite 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.		**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.

CFR Number §483.20(b)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.20(b) **TAG: C-1620** (b) Comprehensive assessments –			
§483.20(b)(1) **TAG: C-1620** (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:		**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
		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 the resident's preferences indicate otherwise.
§483.20(b)(1)(i) **TAG: C-1620** (i) Identification and demographic information.		**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
		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 the resident's preferences indicate otherwise.

CFR Number §483.20(b)(1)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.20(b)(1)(ii) **TAG: C-1620**		**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(ii) Customary routine.		**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 the resident's preferences indicate otherwise.
§483.20(b)(1)(iii) **TAG: C-1620**		**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(iii) Cognitive patterns.		**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 the resident's preferences indicate otherwise.

CFR Number §483.20(b)(1)(iv)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.20(b)(1)(iv)	**TAG: C-1620**	**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(iv) Communication.		**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 the resident's preferences indicate otherwise.
§483.20(b)(1)(v)	**TAG: C-1620**	**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(v) Vision.		**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 the resident's preferences indicate otherwise.

CFR Number §483.20(b)(1)(vi)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.20(b)(1)(vi) **TAG: C-1620**		**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(vi) Mood and behavior patterns.		**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 the resident's preferences indicate otherwise.
§483.20(b)(1)(vii) **TAG: C-1620**		**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(vii) Psychosocial well-being.		**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 the resident's preferences indicate otherwise.

CFR Number §483.20(b)(1)(viii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.20(b)(1)(viii) **TAG: C-1620**		**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(viii) Physical functioning and structural problems.		**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 the resident's preferences indicate otherwise.
§483.20(b)(1)(ix) **TAG: C-1620**		**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(ix) Continence.		**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 the resident's preferences indicate otherwise.

CFR Number §483.20(b)(1)(x)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.20(b)(1)(x) **TAG: C-1620**		**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(x) Disease diagnoses and health conditions.		**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 the resident's preferences indicate otherwise.
§483.20(b)(1)(xi) **TAG: C-1620**		**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(xi) Dental and nutritional status.		**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 the resident's preferences indicate otherwise.

CFR Number §483.20(b)(1)(xii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.20(b)(1)(xii) **TAG: C-1620**		**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(xii) Skin condition.		**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 the resident's preferences indicate otherwise.
§483.20(b)(1)(xiii) **TAG: C-1620**		**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(xiii) Activity pursuit.		**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 the resident's preferences indicate otherwise.

CFR Number §483.20(b)(1)(xiv)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.20(b)(1)(xiv) **TAG: C-1620**		**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(xiv) Medications.		**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 the resident's preferences indicate otherwise.
§483.20(b)(1)(xv) **TAG: C-1620**		**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(xv) Special treatments and procedures.		**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 the resident's preferences indicate otherwise.

CFR Number §483.20(b)(1)(xvi)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.20(b)(1)(xvi)	**TAG: C-1620**	**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(xvi) Discharge planning.		**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 the resident's preferences indicate otherwise.
§483.20(b)(1)(xvii)	**TAG: C-1620**	**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).		**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.
§483.20(b)(1)(xviii)	**TAG: C-1620**	**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(xviii) Documentation of participation in assessment. The assessment 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.		**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.
§483.20(b)(2)	**TAG: C-1620**	**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(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.		**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 critical access hospital 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 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.
		EP 8	For swing beds in critical access hospitals: Each resident receives a comprehensive assessment no less often than every 12 months.

CFR Number §483.20(b)(2)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.20(b)(2)(i)	**TAG: C-1620**	**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(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.)		**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 critical access hospital following a temporary absence for hospitalization or for therapeutic leave.
§483.20(b)(2)(ii)	**TAG: C-1620**	**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(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.)		**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 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.
§483.20(b)(2)(iii)	**TAG: C-1620**	**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(iii) Not less often than once every 12 months.		**EP 8**	For swing beds in critical access hospitals: Each resident receives a comprehensive assessment no less often than every 12 months.
§483.21(b)	**TAG: C-1620**		
(b) Comprehensive care plans.			
§483.21(b)(1)	**TAG: C-1620**	**PC.11.03.01**	**The critical access hospital plans the patient's care.**
(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at § 483.10(c)(2) and § 483.10(c)(3), that includes 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:		**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 any 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 included in the resident's medical record.
§483.21(b)(1)(i)	**TAG: C-1620**	**PC.11.03.01**	**The critical access hospital plans the patient's care.**
(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		**EP 7**	For swing beds in critical access hospitals: The resident's comprehensive treatment plan includes the services to be provided to attain or maintain the resident's optimal physical, mental, and psychosocial well-being. Note: The comprehensive treatment plan includes any services that would otherwise be required under 42 CFR 483.24, 483.25, or 483.40 but are not provided due to the resident's exercise of rights, including the right to refuse treatment.

CFR Number §483.21(b)(1)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.21(b)(1)(ii) **TAG: C-1620**		**PC.11.03.01**	**The critical access hospital plans the patient's care.**
(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).		**EP 7**	For swing beds in critical access hospitals: The resident's comprehensive treatment plan includes the services to be provided to attain or maintain the resident's optimal physical, mental, and psychosocial well-being. Note: The comprehensive treatment plan includes any services that would otherwise be required under 42 CFR 483.24, 483.25, or 483.40 but are not provided due to the resident's exercise of rights, including the right to refuse treatment.
§483.21(b)(1)(iii) **TAG: C-1620**		**PC.11.03.01**	**The critical access hospital plans the patient's care.**
(iii) 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.		**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 any 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 included in the resident's medical record.
§483.21(b)(1)(iv) **TAG: C-1620**		**PC.11.03.01**	**The critical access hospital plans the patient's care.**
(iv) In consultation with the resident and the resident's representative(s)—		**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 any 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 included in the resident's medical record.

CFR Number §483.21(b)(1)(iv)(A)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.21(b)(1)(iv)(A) **TAG: C-1620**		**PC.11.03.01**	**The critical access hospital plans the patient's care.**
(A) The resident's goals for admission and desired outcomes.		**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 any 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 included in the resident's medical record.
§483.21(b)(1)(iv)(B) **TAG: C-1620**		**PC.11.03.01**	**The critical access hospital plans the patient's care.**
(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.		**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 any 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 included in the resident's medical record.
§483.21(b)(1)(iv)(C) **TAG: C-1620**		**PC.11.03.01**	**The critical access hospital plans the patient's care.**
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.		**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 any 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 included in the resident's medical record.

CFR Number §483.21(b)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.21(b)(2) **TAG: C-1620**			
(2) A comprehensive care plan must be—			
§483.21(b)(2)(i) **TAG: C-1620**		**PC.11.03.01**	**The critical access hospital plans the patient's care.**
(i) Developed within 7 days after completion of the comprehensive assessment.		**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.
§483.21(b)(2)(ii) **TAG: C-1620**			
(ii) Prepared by an interdisciplinary team, that includes but is not limited to—			
§483.21(b)(2)(ii)(A) **TAG: C-1620**		**PC.11.03.01**	**The critical access hospital plans the patient's care.**
(A) The attending physician.		**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.
§483.21(b)(2)(ii)(B) **TAG: C-1620**		**PC.11.03.01**	**The critical access hospital plans the patient's care.**
(B) A registered nurse with responsibility for the resident.		**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.
§483.21(b)(2)(ii)(C) **TAG: C-1620**		**PC.11.03.01**	**The critical access hospital plans the patient's care.**
(C) A nurse aide with responsibility for the resident.		**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.
§483.21(b)(2)(ii)(D) **TAG: C-1620**		**PC.11.03.01**	**The critical access hospital plans the patient's care.**
(D) A member of food and nutrition services staff.		**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.

CFR Number §483.21(b)(2)(ii)(E)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.21(b)(2)(ii)(E)	**TAG: C-1620**	**PC.11.03.01**	**The critical access hospital plans the patient's care.**
(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.		**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 any 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 included in the resident's medical record.
§483.21(b)(2)(ii)(F)	**TAG: C-1620**	**PC.11.03.01**	**The critical access hospital plans the patient's care.**
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.		**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.
§483.21(b)(2)(iii)	**TAG: C-1620**	**PC.11.03.01**	**The critical access hospital plans the patient's care.**
(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.		**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.
§483.21(b)(3)	**TAG: C-1620**		
(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—			
§483.21(b)(3)(i)	**TAG: C-1620**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(i) Meet professional standards of quality.		**EP 19**	For swing beds in critical access hospitals: The critical access hospital provides or arranges for culturally competent and trauma-informed services, as outlined by the comprehensive care plan, that meet professional standards of quality and are provided by qualified staff in accordance with each resident's written plan of care.
§483.21(b)(3)(ii)	**TAG: C-1620**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(ii) Be provided by qualified persons in accordance with each resident's written plan of care.		**EP 19**	For swing beds in critical access hospitals: The critical access hospital provides or arranges for culturally competent and trauma-informed services, as outlined by the comprehensive care plan, that meet professional standards of quality and are provided by qualified staff in accordance with each resident's written plan of care.
§483.21(b)(3)(iii)	**TAG: C-1620**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(iii) Be culturally-competent and trauma-informed.		**EP 19**	For swing beds in critical access hospitals: The critical access hospital provides or arranges for culturally competent and trauma-informed services, as outlined by the comprehensive care plan, that meet professional standards of quality and are provided by qualified staff in accordance with each resident's written plan of care.
		This regulation is not effective until November 28, 2019.	

CFR Number §483.21(c)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.21(c)(2) **TAG: C-1620**			
(2) Discharge summary. When the facility anticipates discharge a resident must have a discharge summary that includes, but is not limited to, the following:			
§483.21(c)(2)(i) **TAG: C-1620**		**RC.12.03.01**	**The patient's medical record contains discharge information.**
(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.		**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: • 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
§483.21(c)(2)(ii) **TAG: C-1620**		**RC.12.03.01**	**The patient's medical record contains discharge information.**
(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 representative.		**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: • 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
§483.21(c)(2)(iii) **TAG: C-1620**		**RC.12.03.01**	**The patient's medical record contains discharge information.**
(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).		**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: • 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

CFR Number §483.21(c)(2)(iv)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.21(c)(2)(iv) **TAG: C-1620**		**RC.12.03.01**	**The patient's medical record contains discharge information.**
(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.		**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: • 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
§483.25(g) **TAG: C-1626**			
(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—			
§483.25(g)(1) **TAG: C-1626**		**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(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;		**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 the resident's preferences indicate otherwise.
§483.25(g)(2) **TAG: C-1626**		**PC.12.01.09**	**The critical access hospital makes food and nutrition products available to its patients.**
(2) Is offered sufficient fluid intake to maintain proper hydration and health; and		**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.

CFR Number §483.40(d)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.40(d)	**TAG: C-1616**	**PC.14.02.01**	**The critical access hospital coordinates the patient's care, treatment, and services based on the patient's needs.**
(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.		**EP 2**	For swing beds in critical access hospitals: The critical access hospital provides medically related social services to attain or maintain the optimal physical, mental, and psychosocial well-being of each resident.
§483.55	**TAG: C-1624**		
§483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care.			
§483.55(a)	**TAG: C-1624**		
(a) Skilled nursing facilities. A facility			
§483.55(a)(2)	**TAG: C-1624**	**PC.14.02.01**	**The critical access hospital coordinates the patient's care, treatment, and services based on the patient's needs.**
(2) May charge a Medicare resident an additional amount for routine and emergency dental services;		**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.
§483.55(a)(3)	**TAG: C-1624**	**PC.14.02.01**	**The critical access hospital coordinates the patient's care, treatment, and services based on the patient's needs.**
(3) Must have a policy identifying those circumstances when the loss or damage 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;		**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.
§483.55(a)(4)	**TAG: C-1624**		
(4) Must if necessary or if requested, assist the resident—			
§483.55(a)(4)(i)	**TAG: C-1624**	**PC.14.02.01**	**The critical access hospital coordinates the patient's care, treatment, and services based on the patient's needs.**
(i) In making appointments; and		**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.
§483.55(a)(4)(ii)	**TAG: C-1624**	**PC.14.02.01**	**The critical access hospital coordinates the patient's care, treatment, and services based on the patient's needs.**
(ii) By arranging for transportation to and from the dental services location; and		**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.
§483.55(a)(5)	**TAG: C-1624**	**PC.14.02.01**	**The critical access hospital coordinates the patient's care, treatment, and services based on the patient's needs.**
(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.		**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.
§483.55(b)	**TAG: C-1624**		
(b) Nursing facilities. The facility			

CFR Number §483.55(b)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.55(b)(1)	**TAG: C-1624**		
(1) Must provide or obtain from an outside resource, in accordance with § 483.70(g) of this part, the following dental services to meet the needs of each resident:			
§483.55(b)(1)(i)	**TAG: C-1624**	**PC.14.02.01**	**The critical access hospital coordinates the patient's care, treatment, and services based on the patient's needs.**
(i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services;		**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.
§483.55(b)(2)	**TAG: C-1624**		
(2) Must, if necessary or if requested, assist the resident—			
§483.55(b)(2)(i)	**TAG: C-1624**	**PC.14.02.01**	**The critical access hospital coordinates the patient's care, treatment, and services based on the patient's needs.**
(i) In making appointments; and		**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.
§483.55(b)(2)(ii)	**TAG: C-1624**	**PC.14.02.01**	**The critical access hospital coordinates the patient's care, treatment, and services based on the patient's needs.**
(ii) By arranging for transportation to and from the dental services locations;		**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.
§483.55(b)(3)	**TAG: C-1624**	**PC.14.02.01**	**The critical access hospital coordinates the patient's care, treatment, and services based on the patient's needs.**
(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;		**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.
§483.55(b)(4)	**TAG: C-1624**	**PC.14.02.01**	**The critical access hospital coordinates the patient's care, treatment, and services based on the patient's needs.**
(4) Must have a policy identifying those circumstances when the loss or damage 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; and		**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.
§483.55(b)(5)	**TAG: C-1624**	**PC.14.02.01**	**The critical access hospital coordinates the patient's care, treatment, and services based on the patient's needs.**
(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.		**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.
§483.65			
§483.65 Specialized rehabilitative services.			
§483.65(a)	**TAG: C-1622**		
(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 intensity as set forth at § 483.120(c), are required in the resident's comprehensive plan of care, the facility must—			

CFR Number §483.65(a)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.65(a)(1)	**TAG: C-1622**	**PC.14.02.01**	**The critical access hospital coordinates the patient's care, treatment, and services based on the patient's needs.**
(1) Provide the required services; or		**EP 8**	For swing beds in critical access hospitals: If a resident's 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.
§483.65(a)(2)	**TAG: C-1622**	**PC.14.02.01**	**The critical access hospital coordinates the patient's care, treatment, and services based on the patient's needs.**
(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.		**EP 8**	For swing beds in critical access hospitals: If a resident's 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.
§483.65(b)	**TAG: C-1622**	**PC.12.01.01**	**The critical access hospital provides care, treatment, and services as ordered or prescribed and in accordance with law and regulation.**
(b) Qualifications. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.		**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 dietetic 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.
§485.645	**TAG: C-1600**		
§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.			
§485.645(a)	**TAG: C-1602**	This CoP is determined by CMS at the time the CAH seeks approval to provide post-hospital skilled nursing care.	
§485.645(a) Eligibility A CAH must meet the following eligibility requirements:			
§485.645(a)(1)	**TAG: C-1602**	This CoP is determined by CMS at the time the CAH seeks approval to provide post-hospital skilled nursing care.	
(1) The facility has been certified as a CAH by CMS under §485.606(b) of this subpart; and			

CFR Number §485.645(a)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.645(a)(2)	**TAG: C-1602**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
(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.		**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(b)	**TAG: C-1604**	This CoP is determined by CMS at the time the CAH seeks approval to provide post-hospital skilled nursing care.	
§485.645(b) Facilities Participating as Rural Primary Care Hospitals (RPCHs) on September 30, 1997 These facilities must meet the following requirements:			
§485.645(b)(1)	**TAG: C-1604**	This CoP is determined by CMS at the time the CAH seeks approval to provide post-hospital skilled nursing care.	
(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.			
§485.645(b)(2)	**TAG: C-1604**	This CoP is determined by CMS at the time the CAH seeks approval to provide post-hospital skilled nursing care.	
(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.			
§485.645(c)	**TAG: C-1606**	This CoP is determined by CMS at the time the CAH seeks approval to provide post-hospital skilled nursing care.	
§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 services is made in accordance with the payment provisions in §413.114 of this chapter.			
§485.645(d)	**TAG: C-1608**		
§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)	**TAG: C-1608**	**IM.12.01.01**	**The critical access hospital protects the privacy and confidentiality of health information.**
(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, and (h) of this chapter).		**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.

CFR Number §485.645(d)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		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	**Ethical principles guide the critical access hospital's business practices.**
		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 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	**The critical access hospital plans the patient's care.**
		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	**The critical access hospital respects, protects, and promotes patient rights.**
		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.
		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	**The critical access hospital respects the patient's right to receive information in a manner the patient understands.**
		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	**The critical access hospital respects the patient's right to participate in decisions about their care, treatment, and services. Note: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.**
		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 or services deemed medically unnecessary or inappropriate.

CFR Number §485.645(d)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		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 decisions 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 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 the 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	**The patient has the right to an environment that preserves respect and dignity.**
		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 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 expense.
§485.645(d)(2) TAG: C-1610		**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(2) Admission, transfer, and discharge rights (§483.5, §483.15(c)(1), (c)(2), (c)(3), (c)(4), (c)(5), (c)(7), (c)(8), and (c)(9) of this chapter).		**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 postdischarge 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). 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.

CFR Number §485.645(d)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		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 of the individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, 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, 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	**For swing beds in critical access hospitals: Residents are not transferred or discharged from the critical access hospital unless they meet specific criteria, in accordance with law and regulation.**
		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 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 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 residents' representatives, as well as the plan for the transfer and adequate relocation of the residents.

CFR Number §485.645(d)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		PC.14.02.03	**When a patient is discharged or transferred, the critical access hospital gives information about the care, treatment, and services provided to the patient to other service providers who will provide the patient with care, treatment, or services.**
		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	**The critical access hospital maintains complete and accurate medical records for each individual patient.**
		EP 2	The medical record includes the following: • 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	**The patient’s medical record contains discharge information.**
		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.

CFR Number §485.645(d)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		EP 2	For swing beds in critical access hospitals: The resident's 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 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	**The critical access hospital respects the patient's right to receive information in a manner the patient understands.**
		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	**The patient has the right to an environment that preserves respect and dignity.**
		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.
§485.645(d)(3)	**TAG: C-1612**	**HR.11.02.01**	**The critical access hospital defines and verifies staff qualifications.**
(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).		**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	**The critical access hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others. Note: See Glossary for the definitions of restraint and seclusion.**
		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.

CFR Number §485.645(d)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		RI.13.01.01	**The patient has the right to be free from harassment, neglect, exploitation, and verbal, mental, physical, and sexual abuse.**
		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.
		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 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.
§485.645(d)(4) TAG: C-1616 (4) Social services (§483.40(d) of this chapter).		**PC.14.02.01**	**The critical access hospital coordinates the patient's care, treatment, and services based on the patient's needs.**
		EP 2	For swing beds in critical access hospitals: The critical access hospital provides medically related social services to attain or maintain the optimal physical, mental, and psychosocial well-being of each resident.
§485.645(d)(5) TAG: C-1620 (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).		**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
		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 critical access hospital 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 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.

CFR Number §485.645(d)(5)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		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 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	**The critical access hospital plans the patient's care.**
		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 professional staff who provide services to the patient.

CFR Number §485.645(d)(5)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		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 any 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 included in the resident's medical record.
		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.
		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	**The patient's medical record contains discharge information.**
		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: • 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
§485.645(d)(6) TAG: C-1622		**PC.11.03.01**	**The critical access hospital plans the patient's care.**
(6) Specialized rehabilitative services (§483.65 of this chapter).		**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 professional staff who provide services to the patient.

CFR Number §485.645(d)(6)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		PC.12.01.01	**The critical access hospital provides care, treatment, and services as ordered or prescribed and in accordance with law and regulation.**
		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 dietetic 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.
		PC.14.02.01	**The critical access hospital coordinates the patient's care, treatment, and services based on the patient's needs.**
		EP 8	For swing beds in critical access hospitals: If a resident's 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.
§485.645(d)(7) TAG: C-1624 (7) Dental services (§483.55(a)(2), (3), (4), and (5) and (b) of this chapter).		**PC.14.02.01**	**The critical access hospital coordinates the patient's care, treatment, and services based on the patient's needs.**
		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.
		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.

CFR Number §485.645(d)(8)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.645(d)(8) TAG: C-1626		**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(8) Nutrition (§483.25(g)(1) and (g)(2) of this chapter).		**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 the resident's preferences indicate otherwise.
		PC.12.01.09	**The critical access hospital makes food and nutrition products available to its patients.**
		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.
§485.647			
§485.647 Condition of Participation: Psychiatric and Rehabilitation Distinct Part Units.			
§485.647(a)			
(a) Conditions.			
§485.647(a)(1) TAG: C-0500		See the beginning of this crosswalk for specific standards and EPs crosswalked to the §412 requirements. See the crosswalk titled "Medicare Hospital Requirements to 2023 CAH DPU Standards and EPs" for specific standards and EPs crosswalked to the §482 requirements. These standards and EPs will be used for scoring §485.647.	
(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.			
§485.647(a)(2) TAG: C-0700		See the beginning of this crosswalk for specific standards and EPs crosswalked to the §412 requirements. See the crosswalk titled "Medicare Hospital Requirements to 2023 CAH DPU Standards and EPs" for specific standards and EPs crosswalked to the §482 requirements. These standards and EPs will be used for scoring §485.647.	
(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.			

CFR Number §485.647(b)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.647(b)			
(b) Eligibility requirements.			
§485.647(b)(1)	**TAG: C-0501, C-0701**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
(1) To be eligible to receive Medicare payments for psychiatric or rehabilitation services as a distinct part unit, the facility provides no more than 10 beds in the distinct part unit.		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital provides no more than 10 beds in a distinct part unit. The beds are physically separate from the critical access hospital's other beds. Note 1: Beds in the rehabilitation and psychiatric distinct part units are excluded from the 25 inpatient-bed count limits specified in 42 CFR 485.620(a). Note 2: The average annual 96-hour length of stay requirement specified under 42 CFR 485.620(b) does not apply to the 10 beds in the distinct part units specified in 42 CFR 485.647(b)(1). Admissions and days of inpatient care in the distinct part units are not taken into account in determining the critical access hospital's compliance with the limits on the number of beds and length of stay in 42 CFR 485.620.
§485.647(b)(2)	**TAG: C-0501, C-0701**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
(2) The beds in the distinct part are excluded from the 25 inpatient-bed count limit specified in § 485.620(a).		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital provides no more than 10 beds in a distinct part unit. The beds are physically separate from the critical access hospital's other beds. Note 1: Beds in the rehabilitation and psychiatric distinct part units are excluded from the 25 inpatient-bed count limits specified in 42 CFR 485.620(a). Note 2: The average annual 96-hour length of stay requirement specified under 42 CFR 485.620(b) does not apply to the 10 beds in the distinct part units specified in 42 CFR 485.647(b)(1). Admissions and days of inpatient care in the distinct part units are not taken into account in determining the critical access hospital's compliance with the limits on the number of beds and length of stay in 42 CFR 485.620.
§485.647(b)(3)	**TAG: C-0501, C-0701**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
(3) The average annual 96-hour length of stay requirement specified under § 485.620(b) does not apply to the 10 beds in the distinct part units specified in paragraph (b)(1) of this section, and admissions and days of inpatient care in the distinct part units are not taken into account in determining the CAH's compliance with the limits on the number of beds and length of stay in § 485.620.		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital provides no more than 10 beds in a distinct part unit. The beds are physically separate from the critical access hospital's other beds. Note 1: Beds in the rehabilitation and psychiatric distinct part units are excluded from the 25 inpatient-bed count limits specified in 42 CFR 485.620(a). Note 2: The average annual 96-hour length of stay requirement specified under 42 CFR 485.620(b) does not apply to the 10 beds in the distinct part units specified in 42 CFR 485.647(b)(1). Admissions and days of inpatient care in the distinct part units are not taken into account in determining the critical access hospital's compliance with the limits on the number of beds and length of stay in 42 CFR 485.620.

CFR Number §485.649	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.649		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§485.649 Condition of participation: Obstetrical services. If the critical access hospital 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.		**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(a)		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(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 services must be integrated with other departments of the critical access hospital.		**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(a)(1)		**LD.13.01.07**	**The critical access hospital effectively manages its programs, services, sites, or departments.**
(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).		**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).

CFR Number §485.649(a)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§485.649(a)(2)		**MS.17.02.01**	**The decision to grant or deny a privilege(s) and/or to renew an existing privilege(s) is an objective, evidence-based process.**
(2) Obstetrical privileges must be delineated for all practitioners providing obstetrical care in accordance with the competencies of each practitioner, and consistent with credentialing agreements established under § 485.616(b).		**EP 10**	If obstetrical services are provided, obstetrical privileges are delineated for all practitioners providing obstetrical care in 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).
§485.649(b)		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(b) Standard: Delivery of service. Effective January 1, 2026, obstetrical services must be consistent with needs and resources of the critical access hospital. Policies governing obstetrical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care and safety.		**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.
§485.649(b)(1)		**PC.12.01.05**	**Resuscitative services are available throughout the critical access hospital.**
(1) The following equipment must be kept at the critical access hospital 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.		**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.
§485.649(b)(2)		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(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 critical access hospital and be readily available for treating emergency cases.		**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. 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).