Hospital Accreditation

Survey Process Guide

Hospital Accreditation Survey Process

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

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

On-site Surveys

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

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

Survey Team

Based on the size and complexity of the organization being surveyed, an accreditation survey may be conducted by one surveyor or a team of surveyors, with a minimum of at least one nurse surveyor assigned to the event. A *Life Safety Code* surveyor will also be part of every hospital survey.
The composition of an organization's survey team is based on the information provided in its E-App.

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

Pre-Survey Preparation

Surveyor Preparation

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

- Electronic Application for Accreditation (E-App) to determine the scope of survey that will be required and begins planning

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

- Report of available Basic Building Information (BBI) which contains sites/buildings information and the history and audit trail
- Organization website, if available, to compare the services noted to those reported on the E-App
- Report(s) and the organization's historical SAFER™ matrix(s) from previous survey events
- CMS complaint surveys (for deemed organizations)
- ORYX data
- 2567 Report (for deemed organizations)

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

Organization Preparation

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

- Greeting surveyors: Identify the staff usually at the main entrance of your organization. Tell them about The Joint Commission and educate them about what to do upon arrival of the surveyor(s). Explain the importance of verifying any surveyor's identity by viewing their Joint Commission identification badge. This badge is a picture ID.
- Persons to notify upon surveyor(s) arrival: Identify leaders and staff who must be notified when surveyors arrive. Create a list of names, phone numbers, or cell phone numbers. Also, include the individual who will be the surveyor's "contact person" during the survey. Identify alternate individuals if leaders and staff are unavailable.
- A location for surveyors: Ask surveyors to wait in the lobby until an organization contact person is available. The surveyor(s) will need a location that they will call their "base" throughout the survey. This location should have a desk or table, electrical outlet, phone access, and internet access.
- Validation of survey: Identify who in the organization will handle the validation of the survey and confirm the identity of the surveyor(s). and supply instructions for this activity.
- Being prepared with requested documents for surveyor(s) review. Surveyor(s) will begin the survey with an individual tracer if documentation is not readily available.
- Identifying who will provide the Safety Briefing for the surveyor(s).
    - The purpose of the Safety Briefing is for your organization to inform surveyor(s) about any current safety or security concerns and how Joint Commission staff should respond if your safety plans are implemented while they are on site.
    - **The briefing is informal, five minutes or less**, and should take place once the surveyor(s) are settled in the "base" location reserved for their use throughout the survey.
    - Situations that should be covered include fire, smoke or other emergencies; workplace violence events (including active shooter scenarios); any contemporary issues the surveyor(s) may experience during the time they are with you (for example, seasonal weather-related events, anticipated or current civil unrest, or labor action)
- Identifying who will serve as escorts for the surveyor(s).

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

Surveyor Arrival and Preliminary Planning

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

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

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

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

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

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

The organization is asked to provide the surveyor(s) with a **Safety Briefing** (informal, no more than five minutes) at this time. Refer to the Pre-Survey Preparation, Organization Preparation section above.

Confirmation of Eligibility for Survey

The surveyor(s) is required to see the following organization information before proceeding with the survey:

- Average daily census **If there are fewer than two inpatients the surveyor needs to call into central office and discuss these findings to determine next steps.**
- Scope of services to determine what specifically is included under the hospital provider number (CCN), including identifying any significant changes from information reported in the E-App.
- Evidence that the hospital meets the statutory definition of a hospital, specifically:
  - The hospital must be primarily engaged in providing by or under the supervision of physicians to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled or sick persons, or rehabilitation services for the rehabilitation of injured, disabled or sick persons. To be primarily engaged in providing inpatient care, a hospital needs to have at least two inpatients at the time of the survey.
- Hospital license, in accordance with law and regulation.
- An overall plan and budget in effect.

- Evidence that the organization maintains clinical records on all patients.
- Medical staff bylaws.
- Evidence of a requirement that every patient is under the care of a physician (patient receiving qualified psychologist services may be under the care of a clinical psychologist).
- Evidence of the provision of 24-hour nursing services rendered or supervised by a RN and has an LPN or RN on duty at all times.
- Utilization review plan.
- Discharge planning process.
- Resurveys only – Notifying the public it serves about how to contact organization management or The Joint Commission to report concerns about patient safety and quality of care. [APR.09.01.01, EP 1]

In addition to the above noted items the surveyor(s) will also require the following information to facilitate survey activity.

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

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

Additional Planning Notes

Owned and Contracted On-site Laboratory Services in a Joint Commission Accredited Hospital

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

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

Opening Conference

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

- Explain the purpose, scope, and structure of the survey.
- Introduce themselves (name, length of time with Joint Commission (optional), and one or two items of biographical information that is specific to the organization), including any additional surveyors who may join the team at a later time or at another location.
- Briefly explain the survey process.
    - Most survey activity occurs at the point where care, treatment, and services are provided. Tracer methodology will be the primary means of evaluation which includes a combination of interview, document review, and observation.
    - Interviews will be conducted privately with patients, staff, and visitors, unless requested otherwise by the interviewee
    - Emphasize with the organization the importance of surveyors being able to interact with and observe direct care givers.
    - **The surveyor(s) may occasionally request a small gathering of individuals if necessary to understand, for example, a workflow or a cross-department process, or multi-disciplinary team's function and interaction. The surveyor(s) will work with the organization's survey coordinator on arrangements.**
    - Provide a preliminary date and time for interim exit conferences when applicable (for example Life Safety Code Surveyor exiting before clinical team) and the final exit conference.
    - When a situation is identified that could be a threat to health and safety, surveyors contact the Joint Commission administrative team. The Joint Commission either sends a different surveyor to investigate the issue or the surveyor on site will be assigned to conduct the investigation. Investigations include interviews, observation of care, treatment and service delivery and document review. Your cooperation is an important part of this process. Surveyors collaborate with the Joint Commission administrative team and outcomes will be communicated to your organization when a determination is reached.
- Review the ground rules that will be observed during the survey event and invite the organization to contribute any additional rules.
- Discuss arrival times with leaders and staff for subsequent survey days.
- Answer questions about the on-site visit, activity schedule, availability of documents or people, and any other related topics.

- Ask attendees to introduce themselves (name, title, functional responsibility).

Orientation to the Organization

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

Initial On-Site Team Meeting

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

Sample Size and Selection

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

Select the number of patient records for review based on the facility's average daily census. The sample should be at least 10 percent of the average daily census, but not fewer than 30 inpatient records. For small general hospitals (this reduction does not apply to surgical or other specialty hospitals) with an average daily census of 20 patients or less, the sample should not be fewer than 20 inpatient records, provided that number of records is adequate to determine compliance. Within the sample, select at least one patient from each nursing unit (e.g., med/surg, ICU, OB, pediatrics, specialty units, etc.). In addition to the inpatient sample, select a sample of outpatients in order to determine compliance in outpatient departments, services, and locations. The sample size may be expanded as needed to assess the hospital's compliance with the CoPs.

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

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

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

Record Review Report**

Program: Hospital

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

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

Initial Surveys

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

Information Gathering and Evaluation Activity

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

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

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

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

Locations to Survey

For hospitals with either no or a small number of provider-based locations, survey*† all departments, services, and locations that bill for services under the hospital's provider number and are considered part of the hospital.

For hospitals with many provider-based locations (locations that bill for services under the hospital's provider number and are considered part of the hospital) survey*:

- All hospital departments including all types of inpatient units that provide patient care services at the main site and other hospital locations †
- Visit 100% of all moderate or deep sedation and anesthetizing locations – inpatient and outpatient
- All locations where complex out-patient care (e.g. Intensive chemotherapy, complex wound care, advanced cardiac rehab, intensive medication management for chronic conditions) is provided by the hospital; and
- Select a sample of each type of other services provided at additional outpatient locations. †
    - Sample a mix of large, medium, and small volume clinics
    - Sample both onsite and offsite clinics.
    - If Behavioral Health services are provided, all services should be sampled (100% sampling if residential; additional time is not allowed for outpatient sampling, surveyor may visit one site and perform record review to cover others.)

For hospitals that use Joint Commission accreditation for deemed status purposes: The team leader and/or the assigned clinical ambulatory surveyor for the event is expected to coordinate and communicate a plan for incorporating the off-site, provider-based locations into the survey. This includes working with both clinical and Life Safety surveyors to identify which locations will be visited during the survey. This work is expected to be performed prior to the survey so all team members understand their responsibilities and can plan their respective schedules accordingly.

*Survey methods include the following: Direct observation, interviews with staff and patients, medical record review, performance data review, personnel file and credentials file review, other documentation.

†When multiple units or outpatient locations provide the same type of care, visit one unit or location of each type. For example, in a hospital that has six medical/surgical units, surveyors must visit at least one of these types of units, and more if there are concerns. If a hospital provides the same types of rehabilitative services in three outpatient locations, surveyors must visit at least one of these outpatient locations, and more if there are concerns.

Visit the main pharmacy to include observing sterile medication compounding (if compounding occurs at the organization). In addition, visit:

- All locations which conduct High Risk (Non-Sterile to Sterile Medication Compounding)
- All locations which conduct Hazardous Sterile Medication Compounding

Note: Primary pharmacy and medication storage areas at each hospital location must be observed during survey. This includes situations where there are multiple hospitals under one CCN number. If these areas are not staffed and readily accessible 24/7, arrangements must be made with the organization to have an authorized pharmacy representative available to provide surveyor access to these areas at the time of visit.

The Life Safety Code Surveyor conducts a comprehensive assessment of compliance with all applicable standards, including surveying the physical environment and NFPA 99-2012 Health Care Facilities Code (NFPA 101-2012) at the following locations:

- Inpatient
- Surgical
- Free-standing emergency departments
- **For hospitals that use Joint Commission accreditation for deemed status purposes:** All provider-based locations selected for survey by the clinical surveyor(s) based on the criteria above.

Note: The clinical and Life Safety Code surveyor visits to locations may or may not coincide based on their respective schedule of survey activities.

"Psychiatric Hospitals" Hospital Accreditation Program – Deemed Status Business Summary

- Visit 100% of child/adolescent sites that are under inpatient, residential, or supervised living categories (including outpatient MRDD and ACT programs)
- Visit 100% of ECT sites
- Schedule to have lunch with patients/clients

Patient Review

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

Observations

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

- Patient care, including treatments and therapies in all patient care settings;
- Staff member activities, equipment, documentation, building structure, sounds, and smells;
- People, care, activities, processes, documentation, policies, equipment, etc., that are present that should not be present, as well as those that are not present that should be present;
- Integration of all services, such that the facility is functioning as one integrated whole;
- Whether quality assessment and performance improvement (QAPI) are facility-wide activities, incorporating every service and activity of the provider and whether every facility department and activity reports to, and receives reports from, the facility's central organized body managing the facility-wide QAPI program; and
- Storage, security and confidentiality of medical records.

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

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

Interviews

Interviews provide a method to request and collect information, and to verify and validate information obtained through observations. Informal interviews should be conducted throughout the duration of the survey. Use the information obtained from interviews to determine what additional observations, interviews, and document and record reviews are necessary. When conducting interviews, observe the following:

- Maintain detailed documentation of each interview conducted. Document the interview date, time, and location; the full name and title of the person interviewed; and key points made and/or topics discussed.
- Interviews with facility staff should be brief. Use a few well-phrased questions to elicit the desired information. For example, to determine if a staff member is aware of disaster procedures and his/her role in such events, simply ask, "If you smelled smoke, what would you do?"
- When interviewing staff, begin your interviews with staff that work most closely with the patient.

- Conduct patient interviews regarding their knowledge of their plan of care, the implementation of the plan, and the quality of the services received. Other topics for patient or family interview may include patient rights, advanced directives, and the facility's grievance/complaint procedure.
- Interviews with patients must be conducted in privacy and with the patient's prior permission.
- Use open-ended questions during your interview.
- Validate all information obtained.
- Telephone interviews may be conducted, if necessary, but a preference should be made for in-person interviews.
- Integrate the data from interviews with data gathered through observations and document reviews.

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

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

Document Review

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

- Patient's clinical records, to validate information gained during the interviews, as well as for evidence of advanced directives, discharge planning instructions, and patient teaching. This review will provide a broad picture of the patient's care. Plans of care and discharge plans should be initiated immediately upon admission and be modified as patient care needs change. The record review for that patient who has undergone surgery would include a review of the pre-surgical assessment, informed consent, operative report, and pre-, inter-, and post-operative anesthesia notes. Although team members may have a specific area assigned during the survey, the team should avoid duplication of efforts during review of medical records and each surveyor should review the record as a whole instead of targeting the assigned area of concern. Surveyors should use open patient records rather than closed records, whenever possible;
- Closed medical records may be used to determine past practice, and the scope or frequency of a deficient practice. Closed records should also be reviewed to provide information about services that are not being provided by the hospital at the time of the survey. For example, if there are no obstetrical patients in the facility at the time of the survey, review closed OB records to determine care practices, or to evaluate past activities that cannot be evaluated using open records. In the review of closed clinical records, review all selected medical

records for an integrated plan of care, timelines of implementation of the plan of care, and the patient responses to the interventions.

- Personnel files to determine if staff members have the appropriate educational requirements, have had the necessary training required, and are licensed, if it is required;
- Credential files to determine if the facility complies with CMS requirements and State law, as well as, follows its own written policies for medical staff privileges and credentialing;
- Maintenance records to determine if equipment is periodically examined and to determine if it is in good working order and if environmental requirements have been met;
- Staffing documents to determine if adequate numbers of staff are provided according to the number and acuity of patients;
- Policy and procedure manuals. When reviewing policy and procedure manuals, verify with the person in charge of an area that the policy and procedure manuals are current; and
- Contracts, if applicable, to determine if patient care, governing body, QAPI, and other standards and CoP requirements are included.

Surveyor Planning and Team Meetings

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

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

Daily Briefings

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

Accreditation Report Preparation

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

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

Determining Standard Level and Condition Level Deficiencies

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

Exit Conference

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

The organization determines which staff will attend the exit conference.

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

Post-Survey Activities

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

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

Hospital Accreditation Survey Activity List and Descriptions

Survey Activity Name	Brief Description and Scheduling Suggestions	Suggested Organization Participants
Surveyor Arrival and Preliminary Planning (Includes the Safety Briefing)	Surveyors will learn about any current organization safety or security concerns and how they should respond if organization safety plans are implemented. Surveyor(s) will begin review of available documents to become acquainted with your organization. Surveyor(s) will plan for tracer activity. 1st day, upon arrival	The organization's accreditation contact or survey coordinator, individual or individuals that will provide the Safety Briefing to surveyors.
Opening Conference and Orientation to the Organization	Surveyors will describe the structure of the survey, and answer questions about the survey at the Opening Conference . During Orientation to the Organization, the surveyors(s) will learn how your organization is governed and operated, discuss leaders' planning priorities, and explore your organization's performance improvement process. 1st day, as early as possible	Senior leadership representing the accredited program and services; member(s) of the governing body, or organization trustee; administrators; leader(s) of the medical staff; leader(s) of the nursing staff; and accreditation contact.
Individual Tracer - Infection Control - Medication Safety and Pharmacy Review	Surveyor(s) will evaluate the organization's compliance with standards related to the care, treatment, and services provided to patients. The Individual Tracer activity occurs each day throughout the survey tracing the care experiences of patients. The number of patients that surveyors trace varies by organization. The evaluation includes processes and procedures to prevent patient harm and errors related to ordering of medications through monitoring; and evaluating medication safety practices (including medication reconciliation). Infection prevention practices (including antibiotic use, appropriate use of PPE, and hand hygiene) and infection prevention practices related to CLABSI, CAUTI, and/or MDROs will be evaluated during patient tracer activity. If travel is required to perform tracer activity (e.g., to an outpatient setting), it will be planned into this time.	Staff, physicians, other licensed practitioners, and management involved in the individual's care, treatment, and services.
Lunch	At a time negotiated with the organization	
Issue Resolution **OR** Surveyor Planning / Team Meeting	Issue Resolution is dedicated time for surveyors to explore any issues that may have surfaced during the survey and could not be resolved at the time they were identified (staff unavailable for interview, visit to another location required, documented care procedures additional file review required, etc.).	For Issue Resolution, the surveyor(s) will identify individuals if needed. None for Surveyor Planning / Team Meeting

Survey Activity Name	Brief Description and Scheduling Suggestions	Suggested Organization Participants
	End of each day except last; can be scheduled at other times as necessary	
Daily Briefing	The surveyor(s) will summarize the events of the previous day and communicate observations according to standards areas that may or may not lead to findings. Start of each survey day except the first day; can be scheduled at other times as necessary	Participants include representative(s) from governance, CEO/Administrator or Executive Director, individual coordinating the Joint Commission survey, and other staff at the discretion of organization leaders.
Competence Assessment	The surveyor will review your organization's competence assessment process for staff and review identified personnel/staff files. After some individual tracer activity has occurred; at a time negotiated with the organization	Participants include: Staff responsible for human resources functions, orientation and education of staff and assessing staff competency; individual(s) with authority to access information contained in personal files.
Medical Staff Credentialing & Privileging	The surveyor will evaluate the process used to collect data relevant to appointment decisions, the process for granting and delineating privileges, and the structures that guide consistency of implementation (e.g., bylaw requirements). The surveyor will evaluate the credentialing and privileging process for the medical staff and other physicians and licensed practitioners who are privileged through the medical staff process. This will include credentials/privileges file review. After some individual tracer activity has occurred; at a time negotiated with the organization	President of the medical staff; medical director and medical staff coordinator, if applicable; and medical staff credentials committee representatives.
Emergency Management	The surveyor will review of the hospital's emergency management program, the application and use of the emergency operations plan and policies and procedures during an emergency (real or simulated), and to assess the hospital's degree of compliance with relevant emergency management chapter standards and applicable law and regulation. After some individual tracer activity has occurred; group interview at a time negotiated with the organization May be conducted with Life Safety surveyor.	Leaders and other individuals familiar with all aspects of the Emergency Management (EM) program. Participants may include the following EM multidisciplinary team members (as available): EM program lead, Senior leadership, Nursing leadership, Medical staff, Pharmacy, Infection prevention and control, Facilities engineering, Safety & security, Ancillary staff, and Information technology.
Organization Quality and Performance Improvement	The surveyor will evaluate how data is used to monitor performance and improve processes throughout the organization; and assess how the organization is using process and outcome data to evaluate the safety and quality of care being provided to patients. After some individual tracer activity has occurred; at a time negotiated with the organization	Participants may include representatives from Quality Assessment and Performance Improvement, Staff involved in the selected performance improvement activities and projects, Infection Prevention and Control program staff, Leadership, (for example, hospital board members, senior leader(s),

Survey Activity Name	Brief Description and Scheduling Suggestions	Suggested Organization Participants
		administrator(s), Pharmacy staff, Medical Staff, and Nursing
Organization governance, administration, and management	The surveyor will evaluate the responsibilities and accountabilities of leaders for the critical access hospital's total operation (including priority setting) and for administering policies to provide quality health care in a safe environment. This is a group interview at a time negotiated with the organization.	Participants include senior leaders who have responsibility and accountability for design, planning, and implementation of organization processes. Leaders typically include but are not limited to members of the governing body/trustee, CEO, and leaders of the medical staff and clinical staff.
Report Preparation	This time for the surveyor to compile, analyze, and organize the data collected during the survey into a report reflecting your organization's compliance with the standards. This will be the last opportunity for the organization to provide any outstanding surveyor requests or further evidence to present from the last day of survey activity. Last day of survey	None
CEO Exit Briefing	The surveyor(s) will review the Summary of Survey Findings Report (organized by chapter) with the most senior leader. Surveyors will discuss any patterns or trends in performance. Last day of survey	Participants include the Chief Executive Officer (CEO) or Administrator, if available
Organization Exit Conference	The surveyor(s) will review the Summary of Survey Findings Report with participants. Discussion will include the SAFER™ matrix, Requirements for Improvement, and any patterns or trends in performance. If follow-up is required in the form of an Evidence of Standard Compliance (ESC) the surveyors explain the ESC submission process. Last day, final activity of survey	Participants include the CEO/Administrator (or designee), senior leaders and staff as identified by the CEO/Administrator or designee.
Interim Exit – w/ early departing surveyors and organization	This is an activity for a scheduled early departure of s survey team member. the LSC Surveyor and the Team Leader conduct a verbal interim exit briefing with staff designated by the organization to review your observations. At the end of any day another program surveyor or Life Safety Code surveyor is departing from the survey in advance of the team	Participants include the CEO/Administrator (or designee), senior leaders and staff as identified by the CEO/Administrator or designee.
Life Safety Code® Survey Activity		
Life Safety Code Surveyor Arrival and Preliminary Planning Session	Surveyors will learn about any current organization safety or security concerns and how they should respond if organization safety plans are implemented.	The organization's accreditation contact or survey coordinator and/or individual who manages your organization's facility(ies)

Survey Activity Name	Brief Description and Scheduling Suggestions	Suggested Organization Participants
	The surveyor(s) will begin review of available Physical Environment (PE) documents to become acquainted with your organization. LSCS survey 1st day, early	
Facility Orientation and Document Review	The surveyor will review identified building systems; life safety drawings, including construction drawings, if available; and select policies to support the building assessment (tour) activities. Take note of the building construction type identified in the SOC/BBI to prepare for discussion with the organization and confirmation with visual observation. The surveyor will determine the type of building construction and where it will be possible, without disturbing patient care, confirm by direct observation the structure and building materials used in construction. Exposed areas above the ceiling or vertical pips shafts may provide insight. At a time negotiated with the organization	Participants include the individual who manages your organization's facility(ies) and other staff at the discretion of your organization. **Due to the limited amount of time the Life Safety surveyor is on-site, please be prepared to facilitate this activity upon their arrival.**
Life Safety Code® Building Assessment	The surveyor will evaluate the degree of compliance with relevant *Life Safety Code® (NFPA 101-2012)* and *Health Care Facilities Code (NFPA 99-2012)* requirements. The surveyor will visit areas where it can be confirmed by direct observation the structure and building materials used in construction. Exposed areas above the ceilings or vertical pipe shafts may provide insight. The surveyor will conduct the appropriate scope of Life Safety Code® (NFPA 101-2012), physical environment, and NFPA 99-2012 Health Care Facilities Code assessment at the additional provider-based locations selected for survey by the clinical surveyor. The surveyor will meet with the survey team to determine the additional provider-based locations the clinical team member(s) is surveying to plan for the LSC visit and evaluation. At a time negotiated with the organization	Participants include the individual who manages organization facilities and other staff at the discretion of your organization.
Lunch	At a time negotiated with the organization	
Emergency Management (**See above description)**	At a time negotiated with the organization. May be conducted with a Clinical surveyor.	**See above**
Report Preparation	This time for the surveyor to compile, analyze, and organize the data collected during the LSC survey	None

Survey Activity Name	Brief Description and Scheduling Suggestions	Suggested Organization Participants
	into a report reflecting your organization's compliance with the Physical Environment standards. This will be the last opportunity for the organization to provide any outstanding surveyor requests or further evidence to present from the last day of survey activity. Towards the end of last day of survey	
Interim Exit	This is an activity for a scheduled early departure of a survey team member. The LSC Surveyor and the Team Leader conducts a verbal interim exit briefing with staff designated by the organization to review your observations. Last activity on last day of survey.	Participants include the individual who manages your organization's facility(ies), CEO/Administrator (or designee), senior leaders and staff as identified by the CEO/Administrator or designee.

Hospital Document List

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

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

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

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

Needed During ...	Requested Documents
	projects); internal throughput data collected by emergency department, inpatient units, diagnostic services, and support services such as patient transport and housekeeping 4. Analysis from a high-risk process 5. Most recent culture of safety and quality evaluation data 6. ORYX data – an organization should be prepared to share ORYX Performance Measurement data and/or Accelerate PI Dashboard reports.
Survey Activities	The organization's signed and dated agreement with the QIO; in the absence of an agreement with a QIO, the organization's Utilization Review plan
Survey Activities	1. Blood transfusion policy 2. Agreement with outside blood supplier 3. Autopsy policy 4. CLIA Certificates 5. Waived testing policy and quality control plan 6. Organ Procurement Organization agreement 7. Tissue and Eye Procurement Organization agreement 8. Organ, tissue, and eye procurement policies
Survey Activities	1. Organization chart 2. Governing Body minutes for the last 12 months 3. List of Contracted Services
Survey Activities	1. Abuse and neglect policy for inpatient, and ambulatory sites, if applicable 2. Fall risk assessment and policy 3. Complaint/grievance policy 4. Restraint and seclusion policy 5. Environmental risk assessment identifying features in the physical environment that could be used to attempt suicide *(Applies to psychiatric hospitals and psychiatric units in general hospitals)* 6. Medication management policy (which defines what is a complete medication order and therapeutic duplication 7. List of unapproved abbreviations
Survey Activities	1. Environment of Care data (see Life Safety & Environment of Care Document List and Review Tool) 2. Environment of Care Management Plans and annual evaluations 3. Environment of Care multidisciplinary team meeting minutes for the 12 months prior to survey

Needed During ...	Requested Documents
Survey Activities	Emergency Management documentation for each of the following (each must be updated and reviewed at least every 2 years): a) Emergency management program b) Hazard vulnerability analysis c) Emergency operation plan and policies and procedures d) Communications plan e) Continuity of operations & recovery plan f) Education and training program g) Exercises and testing program h) Emergency management program evaluation (after-action/improvement plans) i) Unified and integrated Emergency management program, plans, policies & procedures (if applicable) j) Transplant program-specific protocols (if applicable)

Hospital Compliance with Federal, State, and Local Laws Evaluation Module (482.11)

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
HR.11.01.03, EP 1: All staff who provide patient care, treatment, and services are qualified and possess a current license, certification, or registration, in accordance with law and regulation. **LD.13.01.01, EP 1:** The hospital provides care, treatment, and services in accordance with licensure requirements and federal, state, and local laws, rules, and regulations. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the Centers for Medicare & Medicaid Services' (CMS) definition of a hospital in accordance with 42 CFR 482.1(a)(1) and (b). (Refer to https://www.ecfr.gov/ for the language of this CMS requirement) **LD.13.01.01, EP 2:** The hospital is licensed, or approved as meeting the standards for licensing established by the state or responsible locality, in accordance with law and regulation, to provide the care, treatment, or services for which the hospital is seeking accreditation from The Joint Commission. **MS.17.01.03, EP 3:** The credentialing process requires that the 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	**§482.11 Condition of Participation: Compliance with Federal, State and Local Laws** **§482.11(a)** The hospital must be in compliance with applicable Federal laws related to the health and safety of patients. **§482.11(b)** The hospital must be-- (1) Licensed; or (2) Approved as meeting standards for licensing established by the agency of the State or locality responsible for licensing hospitals. §**482.11(c)** The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws.	**Interview** □ CEO or appropriate individual designated by the hospital to determine if the hospital is in compliance with Federal laws related to patient health and safety. *(For example, ask if the hospital was cited since its last survey for any violation of Section 504 of the Rehabilitation Act of 1973 related to denying people with disabilities access to care. If so, verify that satisfactory corrections have been made to bring the hospital into compliance with that law.)* **Document Review** **General** □ Prior to the survey, determine whether the hospital has a current license issued by the state or local authority in which it operates, or, if it is located within a State that does not license hospitals, verify that the responsible State agency has approved the hospital as meeting the State's established standards for the licensing of hospitals. □ Verify the hospital has established and follows procedures for determining that personnel are properly licensed, certified, and/or permitted as required by the state. □ Verify that the hospital has an established process which is followed to determine that staff and personnel meet all standards (such as continuing education, basic qualifications, hold permits) required by State and local laws or regulations. **Personnel/Credential File**

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
MS.17.02.01, EP 9: All physicians and other licensed practitioners that provide care, treatment, and services possess a current license, certification, or registration, as required by law and regulation.		□ Review a sample of personnel files to verify that licensure and/or other required credentials information is up to date. □ Verify State licensure compliance of the direct care personnel as well as administrators and supervisory personnel. □ When telemedicine is used and the practitioner and patient are located in different states is the practitioner providing the patient care service licensed and/or meets the other applicable standards that are required by State or local laws in both the state where the practitioner is located and state where the patient is located.

Hospital Governing Body Evaluation Module (482.12)

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
LD.11.01.01, EP 1: The hospital has a governing body that assumes full legal responsibility for the conduct of the hospital. If the hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital carry out the functions that pertain to the governing body.	**§482.12 Condition of Participation: Governing Body** There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body.	**Interview** ☐ Leaders to determine there is an organized governing body or there is written documentation that identifies the individual(s) responsible for the conduct of hospital operations. **Document Review** **General** ☐ If the hospital is part of a hospital system that uses one governing body for several of the hospitals separately certified within the system: o Review the governing body minutes to determine if it is clear which actions pertain to which hospitals. o Review several policies or procedures adopted by the system governing body to determine if it is clear that they apply to the hospital being surveyed. o Look for evidence that the hospital being surveyed has its own nursing service and QAPI program.
	§482.12(a*)* Medical staff. The governing body must:	
LD.11.01.01, EP 2: The governing body does the following: - Approves and is responsible for the effective operation of the grievance process - Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee - Determines, in accordance with state law, which categories of practitioners are eligible	**§482.12(a)(1)** (The governing body must:) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff;	**Document Review** **General** Governing Body Mtg Minutes/Med Staff Bylaws ☐ Verify that the governing body has determined and stated the categories of physicians and practitioners that are eligible candidates for appointment to the medical staff or to be granted medical staff privileges.

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
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 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 hospital, or are provided at the hospital but not at one or more off-campus locations		
LD.11.01.01, EP 2: The governing body does the following: - Approves and is responsible for the effective operation of the grievance process - Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee	**§482.12(a)(2)** (The governing body must:) Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff;	**Document Review** **Credential File** ☐ Review records of medical staff appointments to determine that the governing body is involved in appointments of medical staff members.

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
- 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 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 hospital, or are provided at the hospital but not at one or more off-campus locations		☐ Confirm that there is evidence that the governing body considered recommendations of the medical staff before making medical staff appointments.
LD.11.01.01, EP 2: The governing body does the following: - Approves and is responsible for the effective operation of the grievance process	**§482.12(a)(3)** (The governing body must:) Assure that the medical staff has bylaws;	**Document Review** **General** Review Medical Staff Bylaws

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
- Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee - 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 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 hospital, or are provided at the hospital but not at one or more off-campus locations		☐ Verify that the medical staff operates under current bylaws that are in accordance with Federal and State laws and regulations.

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
LD.11.01.01, EP 2: The governing body does the following: - Approves and is responsible for the effective operation of the grievance process - Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee - 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 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 hospital, or	**§482.12(a)(4)** (The governing body must:) Approve medical staff bylaws and other medical staff rules and regulations;	**Document Review** **General** ☐ Verify that the medical staff operates under current bylaws, rules and policies that have been approved by the governing body. ☐ Verify that any revisions or modifications in the medical staff bylaws, rules and policies have been approved by the medical staff and the governing body, for example, bylaws are annotated with date of last review and initialed by person(s) responsible.

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
are provided at the hospital but not at one or more off-campus locations		
LD.11.01.01, EP 2: The governing body does the following: - Approves and is responsible for the effective operation of the grievance process - Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee - 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 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	**§482.12(a)(5)** (The governing body must:) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients;	**Interview** ☐ Medical staff leaders to verify that the governing body is periodically apprised of the medical staff evaluation of patient care services provided hospital wide, at every patient care location of the hospital. **Document Review** **Credential File** ☐ Verify that any individual providing patient care services is a member of the medical staff or is accountable to a member of the medical staff qualified to evaluate the quality of services provided, and in turn, is responsible to the governing body for the quality of services provided.

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
of patients at the locations without emergency services when emergency services are not provided at the hospital, or are provided at the hospital but not at one or more off-campus locations		
LD.11.01.01, EP 2: The governing body does the following: - Approves and is responsible for the effective operation of the grievance process - Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee - 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 hospital dependent solely upon certification, fellowship, or membership in a specialty body or society	**§482.12(a)(6)** (The governing body must:) Ensure the criteria for selection are individual character, competence, training, experience, and judgment; and	**Interview** ☐ Ask medical staff leaders, hospital leaders, or medical staff office representatives how they ensure bylaws governing medical staff membership or the granting of privileges are applied equally to all practitioners in each professional category of practitioners. **Document Review** **General** Review the medical staff bylaws for the following: ☐ Description of the hospital's privileging process ☐ Written criteria for appointments to the medical staff and granting of medical staff privileges. ☐ Granting of medical staff membership or privileges, both new and renewal, is based upon an individual practitioner's meeting the medical staff's membership/privileging criteria. ☐ At a minimum, criteria for appointment to the medical staff/granting of medical staff privileges are individual character, competence, training, experience, and judgment.

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
- 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 hospital, or are provided at the hospital but not at one or more off-campus locations		
LD.11.01.01, EP 2: The governing body does the following: - Approves and is responsible for the effective operation of the grievance process - Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee - 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	**§482.12(a)(7)** (The governing body must:) 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.	**Document Review** **General** ☐ Review the medical staff bylaws to verify that written criteria for appointment to the medical staff and granting of medical staff privileges are not dependent solely upon certification, fellowship, or membership in a specialty body or society.

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
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 - 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 hospital, or are provided at the hospital but not at one or more off-campus locations		
MS.20.01.01, EP 1: When telemedicine services are furnished to the hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating 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 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 hospital's process and standards, at a minimum. - The distant-site hospital providing the	**§482.12(a)(8)** (The governing body must:) Ensure that, when telemedicine services are furnished to the hospital's patients through an agreement with a distant-site hospital, the agreement is written and that it specifies that it is the responsibility of the governing body of the distant-site hospital to meet the requirements in paragraphs (a)(1) through (a)(7) of this section with regard to the distant–site hospital's physicians and practitioners providing telemedicine services. The governing body of the hospital whose patients are receiving the telemedicine services may, in accordance with §482.22(a)(3) of this part, grant privileges based on its medical staff recommendations that rely on information provided by the distant-site hospital.	

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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 hospital whose patients are receiving the telemedicine services is located. - For distant-site physicians or other licensed practitioners privileged by the originating hospital, the originating 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 hospital's patients and complaints the hospital has received about the distant-site physician or other licensed practitioner. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: 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)		

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through (a)(7) and 482.22(a)(1) through (a)(2).		
LD.13.03.03, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: When telemedicine services are furnished to the 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 hospital. - The distant site furnishes services in a manner that permits the originating site to be in compliance with the Medicare Conditions of Participation - 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 482.12(a)(1) through (a)(9) and 482.22(a)(1) through (a)(4). Note: For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A. 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	**§482.12(a)(9)** (The governing body must:) Ensure that when telemedicine services are furnished to the hospital's patients through an agreement with a distant-site telemedicine entity, the written agreement specifies that the distant-site telemedicine entity is a contractor of services to the hospital and as such, in accordance with §482.12(e), furnishes the contracted services in a manner that permits the hospital to comply with all applicable conditions of participation for the contracted services, including, but not limited to, the requirements in paragraphs (a)(1) through (a)(7) of this section with regard to the distant-site telemedicine entity's physicians and practitioners providing telemedicine services. The governing body of the hospital whose patients are receiving the telemedicine services may, in accordance with §482.22(a)(4) of this part, grant privileges to physicians and practitioners employed by the distant-site telemedicine entity based on such hospital's medical staff recommendations; such staff recommendations may rely on information provided by the distant-site telemedicine entity.	**Interview** ☐ Ask the hospital's leadership whether it uses telemedicine services. **Document Review** ☐ If the hospital uses telemedicine services ask to see a copy of the written agreement(s) with the distant-site hospital(s) or telemedicine entity(ies). ○ Does each agreement include the required elements concerning credentialing and privileging of the telemedicine physicians and practitioners? ○ Does the hospital have documentation indicating that it granted privileges to each telemedicine physician and practitioner? ○ Does the documentation indicate that for each telemedicine physician and practitioner there is a medical staff recommendation, including an indication of whether the medical staff conducted its own review or relied upon the decisions of the distant-site hospital or telemedicine entity?

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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.		
LD.11.01.01, EP 5: For hospitals that use Joint Commission accreditation for deemed status purposes: The governing body consults directly with the individual assigned the responsibility for the organization and conduct of the hospital's medical staff, or with the individual's designee. At a minimum, this direct consultation occurs periodically throughout the fiscal or calendar year and includes a discussion of matters related to the quality of medical care provided to the hospital's patients. For a multi-hospital system using a single governing body, the single multihospital system governing body consults directly with the individual responsible for the organized medical staff (or the individual's designee) of each hospital within its system.	**§482.12(a)(10)** (The governing body must:) Consult directly with the individual assigned the responsibility for the organization and conduct of the hospital's medical staff, or his or her designee. At a minimum, this direct consultation must occur periodically throughout the fiscal or calendar year and include discussion of matters related to the quality of medical care provided to patients of the hospital. For a multi-hospital system using a single governing body, the single multi-hospital system governing body must consult directly with the individual responsible for the organized medical staff (or his or her designee) of each hospital within its system in addition to the other requirements of this paragraph (a).	**Interview** ☐ Ask the hospital's CEO how the hospital complies with the requirement for periodic consultations by the governing body with the leader of the hospital's medical staff, or the leader's designee. ○ Is there evidence that such consultations have occurred, for example, meeting agendas and lists of attendees, or meeting minutes. ○ Does the hospital track these consultations by the calendar year or its fiscal year; ask to see a copy of the policy that establishes the approach and the number and frequency of these consultations and the various factors they are based on specific to the hospital, or to each of the hospitals within a multihospital system. ○ Is there evidence that the consultations were "direct?" ○ Is there evidence that the governing body met with the medical staff leader or designee at least twice during the previous year? ○ Is there evidence that the discussion concerned matters related to the quality of medical care in the hospital? ☐ Ask the leader of the hospital's medical staff, or his/her designee, whether he or she has had

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		meetings with either the whole governing body or a subcommittee of it to discuss the quality of medical care in the hospital. ○ Has the leader/designee ever requested a meeting in addition to those regularly scheduled, to discuss a matter of urgent concern to the medical staff? If yes, did the governing body respond by setting up a meeting? *Note: If the hospital shares a unified medical staff with other separately certified hospitals in a multi-hospital system, the interview with the leader of the medical staff, or designee, may have to be conducted by telephone.* ○ Ask the leader/designee how he/she gathers information about the concerns/views of members of the medical staff practicing at the hospital being surveyed about the quality of medical care provided at that hospital. **Document Review** **General** ☐ Review governing body policies and procedures on the requirement for periodic, direct consultations with the leader of the medical staff or the designee.
LD.11.01.01, EP 6: The governing body appoints the chief executive officer responsible for managing the hospital.	**§482.12(b) Standard: Chief Executive Officer** The governing body must appoint a chief executive officer who is responsible for managing the hospital.	**Document Review** ☐ Review board meeting minutes to ○ Verify that the hospital has only one chief executive officer for the entire hospital. ○ Verify that the governing body has appointed the chief executive officer. ○ Verify that the chief executive officer is responsible for managing the entire hospital.

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	§482.12(c) Standard: Care of Patients In accordance with hospital policy, the governing body must ensure that the following requirements are met:	
LD.11.01.01, EP 7: The governing body makes certain that patients are under the care of the appropriate licensed practitioners. **MS.16.01.03, EP 4:** For hospitals that use Joint Commission accreditation for deemed status purposes: Every Medicare patient is under the care of at least one of the following: - A doctor of medicine or osteopathy (This requirement does not limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified health care staff to the extent recognized under state law or a state's regulatory mechanism.) - A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the state and who is acting within the scope of their license - A doctor of podiatric medicine, but only with respect to functions which they are legally authorized by the state to perform - A doctor of optometry who is legally authorized to practice optometry by the state in which they practice - A chiropractor who is licensed by the state or legally authorized to perform the services of a chiropractor, but only with respect to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by x-ray to exist - A clinical psychologist as defined in 42 CFR	**§482.12(c)(1)** Every Medicare patient is under the care of: (i) A doctor of medicine or osteopathy. (This provision is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified health care personnel to the extent recognized under State law or a State's regulatory mechanism.); (ii) A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State and who is acting within the scope of his or her license; (iii)A doctor of podiatric medicine, but only with respect to functions which he or she is legally authorized by the State to perform; (iv) A doctor of optometry who is legally authorized to practice optometry by the State in which he or she practices; (v) A chiropractor who is licensed by the State or legally authorized to perform the services of a chiropractor, but only with respect to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by x-ray to exist; and (vi) A clinical psychologist as defined in §410.71 of this chapter, but only with respect to clinical psychologist services as defined in §410.71 of this chapter and only to the extent permitted by State law.	**Document Review** **Personnel/Credential File** ☐ Verify that Medicare patients are under the care of a licensed practitioner as follows: ○ Doctor of medicine or osteopathy ○ Doctor of dental surgery or dental medicine ○ Doctor of podiatric medicine ○ Doctor of optometry ○ Chiropractor ○ Clinical psychologist

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410.71, but only with respect to clinical psychologist services as defined in 42 CFR 410.71 and only to the extent permitted by state		
LD.11.01.01, EP 7: The governing body makes certain that patients are under the care of the appropriate licensed practitioners. **MS.16.01.03, EP 1:** Patients are admitted to the hospital only on the recommendation of a licensed practitioner permitted by the state to admit patients to a hospital. For hospitals that use Joint Commission accreditation for deemed status purposes: If a Medicare patient is admitted by a practitioner not specified in MS.16.01.03, EP 4, that patient is under the care of a doctor of medicine or osteopathy.	**§482.12(c)(2)** Patients are admitted to the hospital only on the recommendation of a licensed practitioner permitted by the State to admit patients to a hospital. If a Medicare patient is admitted by a practitioner not specified in paragraph (c)(1) of this section, that patient is under the care of a doctor of medicine or osteopathy.	**Document Review** **Personnel/Credential File** ☐ Verify that admitting privileges are limited to those categories of practitioners as allowed by State law. ☐ Verify that patients are admitted only by those practitioners who are currently licensed and have been granted admitting privileges by the governing body in accordance with State laws and medical staff bylaws. **Patient Health Record** If the hospital grants admitting privileges to practitioners, for example nurse practitioners and midwives, ☐ Select Medicare and Medicaid patients (select only Medicare patients admitted by midwives) that are admitted to the hospital by these practitioners to determine if they are/were under the care of an MD/DO.
LD.11.01.01, EP 7: The governing body makes certain that patients are under the care of the appropriate licensed practitioners. **MS.16.01.03, EP 2:** A doctor of medicine or osteopathy is on duty or on call at all times.	**§482.12(c)(3)** A doctor of medicine or osteopathy is on duty or on call at all times.	**Interview** ☐ Ask nursing staff: o How they know who is on call? o If they are able to call the on-call MD/DO and speak with him/her at all times? o When appropriate, if on-call MD/DOs come to the hospital to provide needed care. ☐ Ask hospital leaders how they monitor and ensure that an MD/DO is on duty or on call at all times to provide medical care and on-site supervision when necessary. **Document Review**

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		General ☐ Review the "call" register or other available documentation that leaders and staff would consult to determine who the doctor of medicine or osteopathy is on duty or on call at all times.
LD.11.01.01, EP 7: The governing body makes certain that patients are under the care of the appropriate licensed practitioners. **MS.16.01.03, EP 3:** A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization and is not specifically within the scope of practice, as defined by the medical staff and in accordance with state law, of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor, as limited under 42 CFR 12(c)(1)(v); or clinical psychologist.	**§482.12(c)(4)** A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that— (i) is present on admission or develops during hospitalization; and (ii) Is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor; or clinical psychologist, as that scope is— (A) Defined by the medical staff; (B) Permitted by State law; and (C) Limited, under paragraph (c)(1)(v) of this section, with respect to chiropractors.	**Document Review** **Patient Health Record** ☐ Verify that an assigned MD or DO is responsible for and is monitoring the care of each Medicare or Medicaid patient with respect to all medical or psychiatric problems during the hospitalization. ☐ If non-MD/DOs admit patients, verify that every Medicare/Medicaid patient is being monitored by an MD/DO who is responsible for any medical or psychiatric problem outside the scope of practice of the admitting practitioners.
LD.13.01.05, EP 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has an overall institutional plan that meets the following conditions: - The plan includes an annual operating budget that is prepared according to generally accepted accounting principles and that has all anticipated income and expenses. This provision does not require that the budget identify item by item the components of each anticipated income or expense. - The plan must provide for capital	**§482.12(d) Standard: Institutional Plan and Budget** The institution must have an overall institutional plan that meets the following conditions: (1) The plan must include an annual operating budget that is prepared according to generally accepted accounting principles. (2) The budget must include all anticipated income and expenses. This provision does not require that the budget identify item by item the components of each anticipated income or expense.	**Document Review** **General** ☐ Verify that an institutional plan and budget exist, and include: o An annual operating budget that is prepared according to generally accepted accounting principles. o All anticipated income and expenses. o A plan that provides for capital expenditures for at least a 3-year period, including the year in which the operating budget specified in paragraph (d)(2) of this section is applicable. o A plan that includes and identifies in detail the objective of, and the anticipated sources of

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expenditures for at least a 3-year period, including the year in which the operating budget is applicable. **LD.13.01.05, EP 2:** For hospitals that use Joint Commission accreditation for deemed status purposes: The institutional plan includes and identifies in detail the objective of, and the anticipated sources of financing for, each anticipated capital expenditure in excess of $600,000 (or a lesser amount that is established, in accordance with section 1122(g)(1) of the Social Security Act [42 U.S.C. 1320a–1(g)(1)], by the state in which the hospital is located) that relates to any of the following: - Acquisition of land - Improvement of land, buildings, and equipment - The replacement, modernization, and expansion of buildings and equipment	(3) The plan must provide for capital expenditures for at least a 3-year period, including the year in which the operating budget specified in paragraph (d)(2) of this section is applicable. (4) The plan must include and identify in detail the objective of, and the anticipated sources of financing for, each anticipated capital expenditure in excess of $600,000 (or a lesser amount that is established, in accordance with section 1122(g)(1) of the Act, by the State in which the hospital is located) that relates to any of the following: (i) Acquisition of land; (ii) Improvement of land, buildings, and equipment; or (iii) The replacement, modernization, and expansion of buildings and equipment.	financing for, each anticipated capital expenditure in excess of $600,000 (or a lesser amount that is established, in accordance with section 1122(g)(1) of the Act, by the State in which the hospital is located) that relates to any of the following: (i) (ii) Acquisition of land; Improvement of land, buildings, and equipment; or (iii)The replacement, modernization, and expansion of buildings and equipment. *Note: Do not review the specifics or format in the institutional plan or the budget.*
LD.13.01.05, EP 4: For hospitals that use Joint Commission accreditation for deemed status purposes: The institutional plan is submitted for review to the planning agency designated in accordance with section 1122(b) of the Social Security Act [42 U.S.C. 1320a–1(b)], or if an agency is not designated, to the appropriate health planning agency in the state. A capital expenditure is not subject to section 1122 review if 75 percent of the health care facility's patients who are expected to use the service for which the capital expenditure is made are individuals enrolled in a health	**§482.12(d)(5)** The plan must be submitted for review to the planning agency designated in accordance with section 1122(b) of the Act, or if an agency is not designated, to the appropriate health planning agency in the State. (See part 100 of this title.) A capital expenditure is not subject to section 1122 review if 75 percent of the health care facility's patients who are expected to use the service for which the capital expenditure is made are individuals enrolled in a health maintenance organization (HMO) or competitive medical plan (CMP) that meets the requirements of section 1876(b) of the Act, and if the Department determines that	**Document Review** **General** ☐ Determine that the hospital's plan for capital expenditures has been submitted to the planning agency designated to review capital expenditures. In certain cases facilities used by HMO and CMP patients are exempt from the review process.

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maintenance organization (HMO) or competitive medical plan (CMP) that meets the requirements of section 1876(b) of the Social Security Act (42 U.S.C. 1395mm(b)), and if the US Department of Health and Human Services determines that the capital expenditure is for services and facilities that are needed by the HMO or CMP in order to operate efficiently and economically and that are not otherwise readily accessible to the HMO or CMP because of one of the following: - The facilities do not provide common services at the same site. - The facilities are not available under a contract of reasonable duration. - Full and equal medical staff privileges in the facilities are not available. - Arrangements with these facilities are not administratively feasible. - The purchase of these services is more costly than if the HMO or CMP provided the services directly.	the capital expenditure is for services and facilities that are needed by the HMO or CMP in order to operate efficiently and economically and that are not otherwise readily accessible to the HMO or CMP because— (i) The facilities do not provide common services at the same site; (ii) The facilities are not available under a contract of reasonable duration; (iii) Full and equal medical staff privileges in the facilities are not available; (iv) Arrangements with these facilities are not administratively feasible; or (v) The purchase of these services is more costly than if the HMO or CMP provided the services directly.	
LD.13.01.05, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The institutional plan is prepared by representatives of the hospital's governing body, the administrative staff, and the medical staff under the direction of the governing body. The institutional plan is reviewed and updated annually.	**§482.12(d)(6)** The plan must be reviewed and updated annually	**Document Review** **General** ☐ Verify that the plan and budget are reviewed and updated annually.
LD.13.01.05, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The institutional plan is prepared by representatives of the hospital's	**§482.12(d)(7)** The plan must be prepared-- (i) Under the direction of the governing body; and (ii) By a committee consisting of representatives of the governing body, the	**Document Review** **General** ☐ Verify that the governing body, administrative staff, and medical staff have participated in the development of the institutional plan and budget.

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governing body, the administrative staff, and the medical staff under the direction of the governing body. The institutional plan is reviewed and updated annually.	administrative staff, and the medical staff of the institution.	
LD.13.03.03, EP 1: The hospital maintains a list of all contracted services, including the scope and nature of the services provided. **LD.13.03.03, EP 2:** The governing body is responsible for all services provided in the hospital, including contracted services. The governing body assesses that services are provided in a safe and effective manner and takes action to address issues pertaining to quality and performance. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The governing body makes certain that a contractor of services (including one for shared services and joint ventures) provides services that permit the hospital to that comply with applicable Centers for Medicare & Medicaid Services (CMS) Conditions of Participation and standards for contract services.	**§482.12(e) Standard: Contracted Services** The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services. **§482.12(e)(1)** The governing body must ensure that the services performed under a contract are provided in a safe and effective manner. **§482.12(e)(2)** The hospital must maintain a list of all contracted services, including the scope and nature of the services provided.	**Interview** ☐ Ask leaders and staff about procedures for monitoring care, treatment, and services furnished under contracts. ☐ Who is responsible for assessing contracted services to determine they are provided in compliance with the Medicare Conditions of Participation? ☐ Does the assessment process follow QAPI principles (identify problems, implement corrections/improvements, and monitor effect of corrections/improvement and for sustainability) and is it part of the QAPI program activities and reporting? ☐ Is the governing body kept apprised of the performance of contracted services? **Document Review** **General** ☐ Current list of services being furnished under contract including scope and nature of the services being provided. ☐ Procedures for assessing quality and effectiveness of contracted services. ☐ Current QAPI plan to ensure that every contracted service is evaluated.
LD.11.01.01, EP 2: The governing body does the following:	**§482.12(f) Standard: Emergency services.**	**Interview** ☐ Interview hospital staff at various locations. Can they state their duties and what they are to do if

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- 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 - 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 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 hospital, or are provided at the hospital but not at one or	(1) If emergency services are provided at the hospital, the hospital must comply with the requirements of § 482.55. (2) If emergency services are not provided at the hospital, the governing body must assure that the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate. (3) If emergency services are provided at the hospital but are not provided at one or more off-campus departments of the hospital, the governing body of the hospital must assure that the medical staff has written policies and procedures in effect with respect to the off-campus department(s) for appraisal of emergencies and referral when appropriate.	an individual seeks or needs emergency care at their location? ☐ Interview off-campus hospital department staff. Can they state their duties and what they are to do if an individual seeks emergency care? ☐ Verify that the medical staff has adopted written policies and procedures for the management of medical emergencies 24 hours per day and 7 days per week. **Document Review** ☐ Review emergency care policies and procedures to determine they address the following: o Conducting appraisals of persons with emergencies. o Immediately available RN, as needed, to provide bedside care to any patient o Among such RN(s) who are immediately available at all times, there must be an RN(s) who is/are qualified, through a combination of education, licensure, and training, to conduct an assessment that enables them to recognize the fact that a person has a need for emergency care. o MD/DO (on-site or on-call) to directly provide appraisals of emergencies or provide medical direction of on-site staff conducting appraisals. o Providing the initial treatment needed by persons with emergency conditions. o Availability of an RN(s) who are qualified, through a combination of education, licensure, and training, to provide initial treatment to a person experiencing a medical emergency.

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more off-campus locations **LD.13.03.01, EP 8:** For hospitals that use the Joint Commission for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55.		○ Identifying situations in which a person's emergency needs may exceed the hospital's capabilities and require transfer. ○ Patient transportation ○ Emergency procedures for all on-campus and off-campus locations.

Hospital Patient Rights Evaluation Module (482.13)

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RI.11.01.01, EP 1: The hospital develops and implements written policies to protect and promote patient rights.	**§482.13 Condition of Participation: Patient's Rights** A hospital must protect and promote each patient's rights.	
	§482.13(a) Standard: Notice of Rights	
RI.11.01.01, EP 2: The 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 patient care whenever possible.	**§482.13(a)(1)** A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.	**Interview** ☐ Ask staff how the hospital communicates information about patient rights to diverse patients, including individuals who need assistive devices or translation services. o Does the hospital have alternative means, such as written materials, signs, or interpreters (when necessary), to communicate patients' rights? ☐ Ask staff and patients or patients' representatives (as appropriate) to examine how the hospital determines whether the patient has a representative, who that representative is, and whether notice of patient rights is provided as required to patients' representatives. o Ask patients to describe what the hospital has told them about their rights. ☐ Does staff know what steps to take to inform a patient about their rights, including those patients with special communication needs? **Document Review** **General** ☐ Verify that the hospital has a policy for notifying all patients, both inpatient and outpatient, of their rights.

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		Note: *Whenever possible, this notice must be provided before providing or stopping care.* ☐ Determine that the hospital's policy identifies when a patient has a representative and who that representative is, consistent with this guidance and state law. **Patient Health Record** ☐ Review a sample of patient health records to assess how the hospital communicates information about patient rights to diverse patients, including individuals who need assistive devices or translation services. ☐ Review records to examine how the hospital determines whether the patient has a representative, who that representative is, and whether notice of patient rights is provided as required to the patient's representative. ☐ Review a sample of inpatient medical records for Medicare beneficiaries to determine whether the records contain a signed and dated IM provided within 2 days of the admission of the patient. For patients whose discharge occurred more than 2 days after the initial "Important Message from Medicare" (IM) was issued, determine whether the hospital provided another copy of the IM to the patient prior to discharge in a timely manner.

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LD.11.01.01, EP 2: The governing body does the following: - Approves and is responsible for the effective operation of the grievance process - Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee - 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 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	**§482.13(a)(2)** The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's governing body must approve and be responsible for the effective operation of the grievance process and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. At a minimum:	**Interview** ☐ Ask Medicare patients if they are aware of their right to appeal premature discharge. ☐ Ask a sample of patients or their legal representative if they know how to file a complaint (grievance) and who to contact if they have a complaint (grievance). ☐ Confirm that patients or their representative know they have the right to file a complaint with the state agency as well as or instead of using the hospital's grievance process. ☐ Confirm that the hospital provided the telephone number for the state agency to patients or their patient representatives. ☐ Ask if beneficiaries are aware of their right to seek review by the QIO for quality of care issues and coverage decisions and to appeal a premature discharge. **Document Review** **General** ☐ Confirm that the hospital has a process for prompt resolution of patient grievances and informs each patient whom to contact to file a grievance. ☐ Confirm that the grievance process includes a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate utilization and quality control quality improvement organization (QIO). ☐ Verify that the hospital's governing body approved the grievance process. ☐ Verify that the governing body is responsible for the effective operation of the grievance process and reviews and resolves grievances unless delegated in writing to a grievance committee. ☐ Review patient discharge materials.

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the hospital, or are provided at the hospital but not at one or more off-campus locations **RI.14.01.01, EP 1**: For hospitals that use Joint Commission accreditation for deemed status purposes: The process for resolving grievances includes a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. **RI.14.01.01, EP 2:** The 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.		○ Is the hospital in compliance with 42 CFR §489.27 (beneficiary notice of discharge rights)? ○ Does the hospital grievance process include a mechanism for timely referral of Medicare patient concerns to the QIO? What time frames are established? ☐ Determine how effectively the grievance process works. ○ Are patient's or the patient representative's concerns addressed in a timely manner? ○ Are patients informed of any resolution to their grievances? ○ Does the hospital apply what it learns from the grievance as part of its continuous quality improvement activities? ☐ Verify that the grievance process is reviewed and analyzed through the hospital's quality assurance/performance improvement or some other mechanism that provides oversight of the grievance process ☐ Review the hospital's policies and procedures to confirm that its grievance process encourages all personnel to alert appropriate staff concerning any patient grievance. **Note:** *A "patient grievance" is a formal or informal written or verbal complaint that is made to the hospital by the patient or the patient's representative about the patient's care (when the complaint is not resolved at the time of the complaint by staff present), abuse or neglect, issues related to the hospital's compliance with the CMS Hospital Conditions of Participation, or a Medicare beneficiary billing issue related to rights and limitations provided by 42 CFR §489.* ☐ Confirm that the hospital adheres to its policy or procedure established for grievances.

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		☐ Verify that the hospital's process assures that grievances involving situations or practices that place the patient in immediate danger are resolved in a timely manner.
RI.14.01.01, EP 2: The 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.	**§482.13(a)(2)(i)** *[At a minimum:]* The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital.	**Interview** ☐ Ask a sample of patients or their representatives (if they are incapacitated) if they know about the grievance process and how to submit a grievance. **Document Review** **General** ☐ Confirm that the information provided to patients about the hospital's grievance procedures clearly explains how they submit either a verbal or written grievance.
RI.14.01.01, EP 2: The 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.	**§482.13(a)(2)(ii)** *[At a minimum:]* The grievance process must specify time frames for review of the grievance and the provision of a response.	**Document Review** **General** ☐ Confirm that the time frames established to review and respond to patient grievances are clearly explained in the information provided to patients explaining the hospital's grievance process. ☐ Verify that, on average, the hospital provides a written response to most of its grievances within the time frame specified in its policy. **Note:** *On average, a time frame of 7 days for the provision of the response would be considered appropriate. Not every grievance must be resolved*

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		during the specified time frame, although most should be resolved.
RI.14.01.01, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: In its resolution of grievances, the hospital provides the patient with a written notice of its decision, which contains the following: - Name of the 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	**§482.13(a)(2)(iii)** *[At a minimum:]* In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.	**Document Review** **General** ☐ Review the hospital's copies of written notices of its decision (responses to grievances) to patients to confirm that all patients are provided a written notice and that the notices comply with the requirements of §482.13(a)(2)(iii). **Note:** *The written notice of the hospital's determination regarding a grievance must be communicated to the patient or their representative in a language and manner the patient or their legal representative understands.*
	§482.13(b) Standard: Exercise of Rights	
PC.11.03.01, EP 2: The hospital involves the patient in the development and implementation of their plan of care. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to be informed, in advance, of changes to their plan of care.	**§482.13(b)(1)** The patient has the right to participate in the development and implementation of his or her plan of care.	**Interview** ☐ Ask staff and patients or patients' representatives (as appropriate) if the hospital involves the patient or their representative (as appropriate) in the development and implementation of the plan of care. ☐ Verify that revisions in the plan of care were explained to the patient and/or their representative (when appropriate). **Document Review** **General** ☐ Confirm that the hospital has policies and procedures to involve the patient or their representative (as appropriate) in the development and implementation of their inpatient treatment/care plan, outpatient treatment/care plan, discharge plan, and pain management plan. ☐ Verify that the hospital's policies and procedures provide for determining when a patient has a

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		representative who may exercise the patient's right to participate in developing and implementing their plan of care, as well as who that representative is, consistent with this guidance and state law. **Patient Health Record** ☐ Review a sample of patient health records to determine how the hospital involves the patient or their representative (as appropriate) in the development and implementation of their plan of care. ☐ Confirm that there is evidence that the patient or their representative was included or proactively involved in the development and implementation of their plan of care.
RI.12.01.01, EP 1: The patient or their representative (as allowed, in accordance with state law) has the right to make informed decisions regarding their care. The patient's rights include being informed of their health status, being involved in care planning and treatment, and being able to request or refuse treatment. This does not mean the patient has the right to demand the provision of treatment or services deemed medically unnecessary or inappropriate.	**§482.13(b)(2)** The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her 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.	**Interview** ☐ Ask current patients and/or hospital personnel to determine their understanding of the hospital's informed decision-making policies and how they are implemented. ☐ Determine whether patients or their representatives are provided adequate information about the patient's medical status, diagnosis, and prognosis and then are allowed to make informed decisions about their care planning and treatment. **Document Review** **General** ☐ Confirm that there is a hospital policy addressing the patient's or the patient representative's (as appropriate) right to make informed decisions. ☐ Verify that the hospital's policy provides for determining when a patient has a representative who may exercise the patient's right to make informed decisions, as well as who that representative is, consistent with this guidance and state law.

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		Note: *Hospitals are expected to take reasonable steps to determine the patient's wishes concerning designation of a representative.* ☐ Confirm that there is a hospital policy addressing the patient's right to have information on their medical status, diagnosis, and prognosis that articulates the hospital's process for ensuring that patients have this information. ☐ Review the hospital policy addressing how the patient will be involved in their care planning and treatment. **Patient Health Record** ☐ Review a sample of patient health records to determine whether patients or their representatives are provided adequate information about the patient's medical status, diagnosis, and prognosis and then are allowed to make informed decisions about their care planning and treatment. **Assessing Required Disclosures: Physician Ownership** **Interview** ☐ Ask staff whether the hospital furnishes its list of physician owners and investors at the time a patient or patient's representative requests it. ☐ Ask staff whether a physician-owned hospital's medical staff membership and admitting privileging requirements include a requirement that, as a condition of continued membership or admitting privileges, physician owners who refer patients to the hospital agree to provide written disclosure of their own or any immediate family member's ownership or investment interest to all patients at the time of the referral to the hospital. **Document Review** **General**

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		☐ *If the hospital is physician owned but not exempt from the physician ownership disclosure requirements:* ○ Verify that appropriate policies and procedures are in place to ensure that necessary written notices are provided to all patients at the beginning of an inpatient or outpatient stay. ○ Review the notice the hospital issues to each patient to verify that it discloses, in a manner reasonably designed to be understood by all patients, that the hospital meets the federal definition of "physician owned," that a list of owners and investors who are physicians or immediate family members of physicians is available upon request, and that such a list is provided to the patient at the time the request is made by or on behalf of the patient. ○ Review policies, procedures, and staff records to determine whether a physician-owned hospital's medical staff membership and admitting privileging requirements include a requirement that, as a condition of continued membership or admitting privileges, physician owners who refer patients to the hospital agree to provide written disclosure of their own or any immediate family member's ownership or investment interest to all patients at the time of the referral to the hospital. **Observation** ☐ Observe whether the hospital furnishes its list of physician owners and investors at the time a patient or patient's representative requests it. **MD/DO 24/7 On-Site Presence**

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		Interview *For each required location where an MD/DO is not present:* ☐ Ask a sample of inpatients and affected outpatients whether they were provided notice about an MD/DO not being present at all times in the hospital. **Document Review** **General** ☐ *For each required location where a doctor of medicine or osteopathy (MD/DO) is not present:* o Verify that the hospital has policies and procedures to ensure that a written notice stating an MD/DO is not present at all times is provided at the beginning of an inpatient stay or outpatient stay to all inpatients and all outpatients receiving observation services, surgery, or another procedure requiring anesthesia. o Review the written notice to verify that it indicates how the hospital will meet the medical needs of any patient who develops an emergency medical condition at a time when no physician is present at that hospital, including any remote location or satellite. **Patient Health Record** ☐ Verify that there is signed acknowledgment by patients of receiving the written notice obtained by the hospital prior to the patient's admission or before applicable outpatient services were provided. **Observation** ☐ Observe whether an MD/DO is present in the hospital at each campus or satellite location providing inpatient services 24 hours a day, seven days a week.

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		☐ *For each required location where an MD/DO is not present:* o Verify that the hospital's emergency department has signage with the appropriate disclosure information about an MD/DO not being present at all times in the hospital.
RI.12.01.01, EP 5: Staff and licensed practitioners who provide care, treatment, or services in the hospital honor the patient's right to formulate advance directives and staff comply with these directives, in accordance with law and regulation. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Law and regulation includes, at a minimum, 42 CFR 489.100, 489.102, and 489.104.	**§482.13(b)(3)** The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with §489.100 of this part (Definition), §489.102 of this part (Requirements for providers), and §489.104 of this part (Effective dates).	**Interview** ☐ Ask staff about their knowledge of the advance directives of the patients in their care. ☐ Ask patients about the hospital's process to allow them to formulate an advance directive or to update their current advance directive. ☐ Confirm that the hospital is promoting and protecting each patient's right to formulate an advance directive. **Document Review** **General** ☐ Review the hospital's advance directive notice to confirm that it advises inpatients or applicable outpatients, or their representatives, of the patient's right to formulate an advance directive and to have hospital staff comply with the advance directive (in accordance with state law). ☐ Confirm that the notice includes a clear, precise, and valid statement of limitation if the hospital cannot implement an advance directive on the basis of conscience. At a minimum, a statement of limitation should do the following: • Clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians or other practitioners. • Identify the state legal authority permitting such an objection.

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		• Describe the range of medical conditions or procedures affected by the conscience objection. ☐ Review the hospital's process to allow patients to formulate an advance directive or update their current advance directive. ☐ Confirm that the hospital is promoting and protecting each patient's right to formulate an advance directive. ☐ Determine to what extent the hospital complies, as permitted under state law, with patient advance directives that delegate decisions about the patient's care to a designated individual. **Patient Health Record** ☐ Review a sample of patient health records for evidence of hospital compliance with advance directive notice requirements. ☐ Verify that every inpatient or applicable outpatient record contains documentation that notice of the hospital's advance directives policy was provided at the time of admission or registration and there is documentation of whether or not each patient has an advance directive. ☐ For those patients who have reported an advance directive, verify that a copy of the patient's advance directive been placed in the medical record.
RI.12.01.01, EP 2: The hospital asks the patient whether they want a family member, representative, or physician or other licensed practitioner notified of their admission to the hospital. The hospital promptly notifies the identified individual(s). Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient is informed, prior to the notification occurring, of any process to	**§482.13(b)(4)** The patient has the right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital.	**Interview** ☐ Interview staff who is responsible for providing notification of a patient's family or representative and physician when the patient is admitted as an inpatient. ☐ Ask them how they identify the persons to be notified and the means of notification and what they do in the case of an incapacitated person to identify a family member or representative and the patient's physician.

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automatically notify the patient's established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well as all applicable post–acute care services providers and suppliers. The 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.		**Document Review** **General** ☐ Verify that the hospital has policies that address notification of a patient's family or representative and physician when the patient is admitted as an inpatient. **Patient Health Record** ☐ Review a sample of inpatient medical records to confirm the following: 1. Evidence that the patient was asked about notifying a family member or representative and their physician 2. Record of when and how notice was provided 3. Evidence that the notice was provided promptly 4. Record of the patient declining to have notice provided to a family member or representative and their physician 5. Documentation of whether the patient was incapacitated at the time of admission and, if so, what steps were taken to identify a family member or representative and the patient's physician
	§482.13(c) Standard: Privacy and Safety	
RI.11.01.01, EP 5: The 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 hospitals that use Joint Commission accreditation for deemed status	**§482.13(c)(1)** The patient has the right to personal privacy.	**Interview** ☐ Ask patients or their representatives if they are provided reasonable privacy during examinations or treatments, personal hygiene activities and discussions about their health status or care, and other appropriate situations. ☐ Ask staff about their understanding of the use of patient information in the facility directory. ☐ Confirm with staff that the policy addresses the opportunity for the patient or patient's

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purposes and have swing beds: 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.		representative to restrict or prohibit use of patient information in emergent and nonemergent situations. ☐ Ask staff if reasonable safeguards are used to reduce incidental disclosures of patient information. **Document Review** **General** ☐ Review hospital policy about the use of patient information in the facility directory. o Confirm that the policy addresses the opportunity for the patient or patient's representative to restrict or prohibit use of patient information in emergent and nonemergent situations. ☐ Determine if reasonable safeguards are used to reduce incidental disclosures of patient information. **Observation** ☐ Observe whether patients are provided reasonable privacy during examinations or treatments, personal hygiene activities and discussions about their health status or care, and other appropriate situations. o Observe whether reasonable safeguards are used to reduce incidental disclosures of patient information. o If audio and/or visual monitoring is used in the medical-surgical or intensive care unit setting, observe whether monitor screens and/or speakers are not readily visible or audible to visitors or the public. **Note:** *Audio/video monitoring (not include recording) of patients in medical-surgical or intensive care type units would not be considered violating the patient's privacy, as long as a clinical need exists, the patient or patient's representative is aware of the monitoring, and the monitors or speakers are located so that the monitor screens are not readily visible and speakers are not*

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		readily audible to visitors or the public. Video recording of patients undergoing medical treatment requires the consent of the patient or their representative.
NPG.08.01.01, EP 1: For psychiatric hospitals and psychiatric units in general hospitals: The hospital conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the hospital takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging). For nonpsychiatric units in hospitals: The organization implements procedures to mitigate the risk of suicide for patients at high risk for suicide, such as one-to-one monitoring, removing objects that pose a risk for self-harm if they can be removed without adversely affecting the patient's medical care, assessing objects brought into a room by visitors, and using safe transportation procedures when moving patients to other parts of the hospital. Note: Nonpsychiatric units in hospitals do not need to be ligature resistant. Nevertheless, these facilities should routinely assess clinical areas to identify objects that could be used for self-harm and remove those objects, when possible, from the area around a patient who has been identified as high risk for suicide. This information can be used for training staff who monitor high-risk patients (for example, developing checklists to help staff remember which equipment should be removed when possible).	**§482.13(c)(2)** The patient has the right to receive care in a safe setting.	**Interview** ☐ Ask staff in patient care areas about their training to identify risks in the care environment. If risks are found, how does staff report those findings? ☐ Ask staff how the hospital defines continuous visual observation or 1:1 observation in which a staff member is assigned to observe only one patient at all times. ☐ In units where infants and children are inpatients, ask staff whether there are appropriate security protections (such as alarms, arm banding systems) in place, and confirm that they are functioning. **Document Review** **General** ☐ Review and analyze patient and staff incident and accident reports to identify any incidents or patterns of incidents concerning a safe environment. Expand the review if a problem with safe environment in the hospitals is suspected. ☐ Verify that the hospital has a policy or procedure for defining continuous visual observation or 1:1 observation in which a staff member is assigned to observe only one patient at all times. ☐ Verify that the hospital has a policy or procedure for curtailing unwanted visitors, contaminated materials, or unsafe items that pose a safety risk to patients and staff. ☐ Access the hospital's security efforts to protect vulnerable patients, including newborns, children, and patients at risk of suicide or intentional harm to self or others. - Confirm that the hospital is providing appropriate security to protect patients and

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NPG.08.01.01, EP 2: The hospital screens all patients for suicidal ideation who are being evaluated or treated for behavioral health conditions as their primary reason for care using a validated screening tool. Note: The Joint Commission requires screening for suicidal ideation using a validated tool starting at age 12 and above. **NPG.08.01.01, EP 3:** The hospital uses an evidence-based process to conduct a suicide assessment of patients who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens patients for suicidal ideation and assesses the severity of suicidal ideation. **NPG.08.01.01, EP 4:** The hospital documents patients' overall level of risk for suicide and the plan to mitigate the risk for suicide. **NPG.08.01.01, EP 5:** The hospital follows written policies and procedures addressing the care of patients identified as at risk for suicide. At a minimum, these should include the following: - Training and competence assessment of staff who care for patients at risk for suicide - Guidelines for reassessment		that appropriate security mechanisms are in place and being followed to protect patients. - Confirm that security mechanisms are based on nationally recognized standards of practice. **Observation** ☐ Observe patient care environments for unattended items, such as utility or housekeeping carts, that contain hazardous items that may pose a safety risk to patients, visitors, and staff. ☐ Observe units where infants and children are inpatients to determine whether appropriate security protections (such as alarms, arm banding systems) are in place and functioning. **Note:** *Examples of hazardous items include cleaning agents, disinfectant solutions, mops, brooms, and tools.*

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- Monitoring patients who are at high risk for suicide **NPG.08.01.01, EP 7:** The hospital monitors implementation and effectiveness of policies and procedures for screening, assessment, and management of patients at risk for suicide and takes action as needed to improve compliance. **RI.11.01.01, EP 3:** The patient has the right to receive care in a safe setting.		
RI.13.01.01, EP 1: The 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 hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital also protects the resident from misappropriation of property.	§482.13(c)(3) The patient has the right to be free from all forms of abuse or harassment.	**Interview** ☐ Ask staff to identify various forms of abuse or neglect. ☐ Ask staff if they know what to do if they witness abuse or neglect. **Document Review** **General** ☐ Verify that the hospital has a system in place to protect patients from abuse, neglect, and harassment of all forms, whether from staff, other patients, visitors, or other persons. In particular, determine the extent to which the hospital does the following: o Staffing levels across all shifts are sufficient to care for individual patient's needs. o The hospital has a written procedure for investigating allegations of abuse and neglect, including methods to protect patients from abuse during investigations of allegations. o How does the hospital substantiate allegations of abuse and neglect? o Incidents of substantiated abuse and neglect result in appropriate action.

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		○ The hospital has implemented an abuse protection program that it is effective and complies with federal, state, and local law and regulation. ○ Appropriate agencies are notified in accordance with state and federal laws regarding incidents of substantiated abuse and neglect. ○ - Allegations of abuse and neglect are thoroughly investigated. ○ The hospital conducts criminal background checks as allowed by state law for all potential new hires. ○ The hospital does not employ people with a history of abuse, neglect, or harassment.
	§482.13(d) Standard: Confidentiality of Patient Records	
IM.12.01.01, EP 1: The hospital develops and implements policies and procedures addressing the privacy and confidentiality of health information. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Policies and procedures also address the resident's personal records.	**§482.13(d)(1)** The patient has the right to the confidentiality of his or her clinical records.	**Interview** □ Ask staff to about their understanding of and compliance with the hospital's policies and procedures for protecting medical record information. **Document Review** **General** □ Verify that the hospital has policies and procedures addressing the protection of information in patients' medical records from unauthorized disclosures. **Observation** □ Observe locations where medical records are stored to determine whether appropriate safeguards are in place to protect medical record information.

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RI.11.01.01, EP 6: The hospital provides the patient, upon an oral or written request, with access to medical records, including past and current records, in the form and format requested (including in electronic form or format when available). If electronic is unavailable, the medical record is provided in hard copy form or another form agreed to by the hospital and patient. The 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).	**§482.13(d)(2)** The patient has the right to access their medical records, including current medical records, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such medical records are maintained electronically); or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, and within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits.	**Document Review** **General** ☐ Confirm that the hospital promotes and protects the patient's right to access information contained in their clinical record. ☐ Confirm that the hospital has a procedure for providing records to patients within a reasonable time frame. ☐ Determine whether the hospital's system frustrates the legitimate efforts of individuals to gain access to their own medical record. ☐ Verify that the procedure for providing records to patients includes a method to identify what documents were not provided and the reason.
RI.13.01.01, EP 1: The 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 hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital also protects the resident from misappropriation of property. **PC.13.02.01, EP 1:** The 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	**§482.13(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.	**Interview** ☐ Ask staff who work directly with patients to determine their understanding of the restraint and seclusion policies. If any patients are currently in restraint or seclusion, determine the rationale for use and when the patient was last monitored and assessed. ☐ Confirm that the actual use of restraints or seclusion was consistent with hospital restraint and seclusion policies and procedures, as well as CMS requirements. ☐ Interview a sample of patients who were restrained to manage nonviolent, non-self-destructive behavior to determine whether the reasons for the use of a restraint to manage such behavior were explained to the patient in understandable terms. ☐ Confirm that the patient could articulate their understanding of the reasons for the use of restraint.

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restrictive interventions have been ineffective and is discontinued at the earliest possible time, regardless of the length of time specified in the order.		**Document Review** **General** ☐ Review the restraint and seclusion policies and procedures to determine if they address, at a minimum the following: o Who has the authority to discontinue the use of restraint or seclusion (based on state law and hospital policies) o Circumstances under which restraint or seclusion should be discontinued. *Also see §482.13(e)(3)*. ☐ Review incident and accident reports to determine whether patient injuries occurred proximal to or during a restraint or seclusion intervention. Are incidents and accidents occurring more frequently with restrained or secluded patients? ☐ If record review indicates that restrained or secluded patients sustained injuries, determine what the hospital did to prevent additional injury. Did the hospital investigate possible changes to its restraint or seclusion policies? ☐ Review data on the use of restraint and seclusion for a specified time period (for example, 3 months) to determine any patterns in their use for specific units, shifts, days of the week, and so on. Did the number of patients who were restrained or secluded increase on weekends, on holidays, at night, on certain shifts, where contract nurses were used, or in one unit more than other units? **Note:** *Such patterns of restraint or seclusion use may suggest that the intervention is not based on the patient's need but on issues such as convenience, inadequate staffing, or lack of staff training. Obtain nursing staffing schedules during the time periods in question to determine if staffing levels impact the use of restraint or seclusion.* **Patient Health Record**

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		☐ Review a sample of medical records of patients for whom restraints were used to manage nonviolent, non-self-destructive behavior, as well as a sample of medical records of patients for whom restraint or seclusion was used to manage violent or self-destructive behavior. ☐ Include in the review patients who are currently in restraint or seclusion, as well as those who have been in restraint or seclusion during their hospital stay (include both violent or self-destructive patients and nonviolent, non-self-destructive patients). ☐ Determine if there is evidence that hospital staff identified the reason for the restraint or seclusion and that other less restrictive measures would not be effective before applying the restraint.
	§482.13(e)(1) **Definitions.**	
	§482.13(e)(1)(i) **A restraint is—**	
PC.13.02.01, EP 4: The 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	**§482.13(e)(1)(i)(A)** *[A restraint is -]* 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 **§482.13(e)(1)(i)(B)** *[A restraint is -]* 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.	**Interview** ☐ Ask hospital staff whether they know the definition of a restraint. ☐ Ask hospital staff if they can identify when the use of a drug or medication is considered a chemical restraint. ☐ Ask hospital staff if they know the definition of a restraint, particularly with respect to use of bedside rails. **Document Review** **General** ☐ Determine whether the hospital's policy and procedures employ a definition or description of what constitutes a restraint that is consistent with the CMS regulation.

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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).	§482.13(e)(1)(i)(C) *[A restraint is -]* 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).	☐ Verify that the hospital's policies and procedures include a definition or description of what constitutes the use of drugs or medications as a restraint that is consistent with the CMS regulation. ☐ Verify that the hospital's policies and procedures include a definition or description of what constitutes a restraint that is consistent with the regulation. **Observation** ☐ While touring hospital units, look for restraints in use. Where a restraint is in use, check the medical record for appropriate documentation. ☐ While touring hospital units, look for bedside rail use to determine whether it is consistent with the definition of a restraint. Where bed side rails are being used as a restraint, check the medical record for appropriate documentation.
PC.13.02.01, EP 5: The 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.	§482.13(e)(1)(ii) Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.	**Interview** ☐ Ask hospital staff if they know the definition of seclusion. **Document Review** **General** ☐ Verify that the hospital's policy and procedures include a definition or description of what constitutes seclusion that is consistent with the CMS regulation. **Observation** ☐ While touring hospital units, look for cases where a patient is in seclusion.
PC.13.02.01, EP 1: The 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	§482.13(e)(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.	**Document Review** **Patient Health Record** ☐ Review a sample of health records for patients for whom restraint or seclusion was used.

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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.		○ Confirm that the physician's or other practitioner's orders specify the reason for restraint or seclusion, the type of restraint, and the duration of restraint or seclusion. ○ Verify that the severity of the patient's behavior justifies seclusion or restraint usage by identifying an immediate and serious danger to the physical safety of the patient or others. ○ Confirm that the hospital considers factors other than the individual patient in determining causes for the need for restraints or seclusion (that is, environmental factors). ○ Review the medical record for documentation of an individual patient assessment and a revision of the plan of care. ○ Confirm that the medical record reflects changes in behavior and staff concerns regarding safety risks to the patient, staff, or others, prompting use of seclusion or restraints. ○ Verify that the patient's behavior placed the patient or others at risk for harm and that the patient's behavior was violent or self-destructive. ○ Determine if other, less restrictive interventions were tried and documented. Or is there evidence that alternatives were considered and determined to be insufficient?
PC.13.02.01, EP 2: The hospital uses the least restrictive form of restraint or seclusion	**§482.13(e)(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	**Document Review** **General** ☐ Review a sample of health records for patients for whom restraint or seclusion was used.

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that will be effective to protect the patient, a staff member, or others from harm.	staff member, or others from harm.	○ Is there documentation in the record describing the steps or interventions used prior to the use of the needed restraint or seclusion? That is, what documentation is in the record to explain the rationale for the use of restraint or seclusion? ○ Confirm that there is documentation in the record showing that less restrictive measures were tried or considered. ○ Verify that the restraint or seclusion intervention was the least restrictive intervention to meet the patient's clinical needs and protect the safety of the patient, staff, or others. ○ Confirm that staff determined that less restrictive alternatives would not meet the patient's clinical needs or protect the patient's safety or the safety of others. ○ Verify that ongoing documented assessments demonstrate that the restraint or seclusion intervention was needed at that time (or at a time in the past) and that the restraint or seclusion intervention remained the least restrictive way to protect the patient's safety. ○ If the time of restraint or seclusion use was lengthy, look for evidence that the symptoms necessitating the use of restraint or seclusion persisted. Look for evidence indicating that staff evaluated whether the restraint or seclusion could be safely discontinued.
	§482.13(e)(4) The use of restraint or seclusion must be –	

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PC.13.02.03, EP 1: The 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 hospital's policies and procedures in accordance with law and regulation	**§482.13(e)(4)(i)** *[The use of restraint or seclusion must be --]* in accordance with a written modification to the patient's plan of care. **§482.13(e)(4)(ii)** *[The use of restraint or seclusion must be --]* implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law.	**Document Review** **General** ☐ Verify that the hospital's procedures are consistent with the requirements of §482.13(e)(4)(i). ☐ Review the hospital's policies and procedures to determine if they reflect current standards of practice regarding safe and appropriate restraint and seclusion techniques. Are there any references to state law statutes or any indication state laws were reviewed and incorporated? **Patient Health Record** ☐ Review a sample of health records for patients for whom restraint or seclusion was used. ○ Does the plan of care or treatment reflect a process of assessment, intervention, and evaluation when restraint or seclusion was used? ○ Confirm that there is evidence of the assessment of the identified problem or of an individual patient assessment. ○ Verify that the patient's plan of care reflects that assessment. ○ Identify the goal of the intervention. ○ Identify the described intervention. ○ Confirm who is responsible for implementation. ○ Verify that the patient was informed of the changes in their treatment plan or plan of care. ○ Confirm that the physician or other practitioner wrote orders that included a time limit and that these orders were incorporated into the plan of care. ○ After the discontinuation of the restraint or seclusion intervention, confirm that this

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		information was documented in an update of the plan of care or treatment plan. **Patient Health Record** ☐ Review a sample of health records for patients who required the use of restraint or seclusion for the management of both violent, self-destructive behaviors and non-violent, non-self-destructive behaviors. o Were restraints properly and safely applied? o After restraints were applied, was an assessment immediately made to ensure that the hospital's policies and procedures were followed? o Was the use of restraint or seclusion effective in achieving the purpose for which it was ordered? If not, were timely changes made? Was there any evidence of injury to the patient?
PC.13.02.05, EP 1: The hospital uses restraint or seclusion as ordered by a physician or other authorized licensed practitioner responsible for the patient's care in accordance with hospital policy and state law and regulation.	**§482.13(e)(5)** The use of restraint or seclusion must be in accordance with the order of a physician or other licensed practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with State law.	**Document Review** **General** ☐ Review hospital policies and medical staff bylaws to ensure that they include clinical practice guidelines describing the responsibilities of medical staff and clinicians who are privileged to order restraint and seclusion. ☐ Confirm that the hospital's written policies identify what categories of practitioners the state recognizes as a licensed practitioner or as having the authority to order restraint and seclusion. ☐ Verify that the hospital has written policies indicating which practitioners are permitted to order restraint or seclusion in the facility. ☐ Confirm that the hospital's written policies conform to state law. ☐ Determine whether the hospital has established policies for who can initiate restraint or seclusion.

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		☐ Confirm that the hospital uses protocols for the use of restraint or seclusion. If so, verify that the use of protocols is consistent with the requirements of the regulation. **Patient Health Record** ☐ Review a sample of health records for patients for whom restraint or seclusion was used. o Do records identify the physician or licensed practitioner who ordered each use of restraint or seclusion? o Was the order from the physician or licensed practitioner obtained prior to the initiation of restraint or seclusion? o When emergency application of restraint or seclusion was necessary, verify that the order from the physician or licensed practitioner was obtained immediately (within a few minutes) after application of the restraint or seclusion.
PC.13.02.05, EP 2: The hospital does not use standing orders or PRN (also known as "as needed") orders for restraint or seclusion.	**§482.13(e)(6)** Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).	**Document Review** **Patient Health Record** ☐ Review a sample of medical records for patients from whom restraint or seclusion as used. Review orders, progress notes, flow sheets, and nursing notes to do the following: o Verify that there is an order from a physician or other licensed practitioner for each episode of restraint or seclusion. o Evaluate patterns of use and verify that orders were obtained when necessary. o Verify that documentation specifically addresses the patients' behaviors or symptoms. o Determine if restraint or seclusion is being improperly implemented on a PRN basis. *Note: The use of standing or PRN orders for the use of restraint or seclusion is prohibited. The ongoing*

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		authorization of restraint or seclusion is not permitted. Each episode of restraint or seclusion must be initiated in accordance with the order of a physician or other licensed practitioner.
PC.13.02.05, EP 3: The attending physician is consulted as soon as possible, in accordance with hospital policy, if they did not order the restraint or seclusion. Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).	§482.13(e)(7) The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion.	**Interview** ☐ Ask staff if actual practice is consistent with the hospital's policies and procedures for consulting with the attending physician if the attending physician did not order the restraint or seclusion. **Document Review** **Patient Health Record** ☐ Review a sample of health records for patients for whom restraint or seclusion was used. o Is there documentation showing that the attending physician was notified if they did not order the restraint or seclusion and that the attending physician was notified "as soon as possible?" **General** ☐ Review the hospital's policies and procedures for consulting with the attending physician if the attending physician did not order the restraint or seclusion. ☐ Verify that hospital policies and procedures address the definition of "as soon as possible" based on the needs of their particular patient population(s). However, any established time frames must be consistent with "as soon as possible."
	§482.13(e)(8) **Unless superseded by State law that is more restrictive –**	
PC.13.02.05, EP 4: Unless state law is more restrictive, orders for the use of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient,	§482.13(e)(8)(i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance	**Document Review** **Patient Health Record** ☐ Review a sample of health records for patients for whom restraint or seclusion was used. o When restraint or seclusion is used to manage violent or self-destructive

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staff, or others may be renewed within the following limits: - 4 hours for adults 18 years of age or older - 2 hours for children and adolescents 9 to 17 years of age - 1 hour for children under 9 years of age Orders may be renewed according to the time limits for a maximum of 24 consecutive hours.	with the following limits for up to a total of 24 hours: (A) 4 hours for adults 18 years of age or older; (B) 2 hours for children and adolescents 9 to 17 years of age; or (C) 1 hour for children under 9 years of age; and	behavior, confirm that the order for restraint or seclusion contains the appropriate time frames based on the patient's age and that the total number of hours covered by an order or its renewal does not exceed 24 hours. ○ If more restrictive state laws apply, verify that they are being followed in the order. ○ Each order may only be renewed in accordance with the following limits: ▪ 4 hours for adults 18 years of age or older ▪ 2 hours for children and adolescents 9 to 17 years of age ▪ 1 hour for children under 9 years of age ▪ If more restrictive state laws apply, verify that they are being followed in the order. ○ Confirm that a renewal order for restraint or seclusion is based on a comprehensive individual patient assessment. ○ Verify that there is evidence in the record that the symptoms necessitating the continued use of restraint or seclusion have persisted.
PC.13.02.05, EP 5: Unless state law is more restrictive, every 24 hours, a physician or other authorized licensed practitioner responsible for the patient's care sees and evaluates the patient before writing a new order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others	**§482.13(e)(8)(ii)** *[Unless superseded by State law that is more restrictive --]* After 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior, a physician or other licensed practitioner who is responsible for the care of the patient and authorized to order restraint or	**Document Review** **Patient Health Record** ☐ Review a sample of health records for patients for whom restraint or seclusion was used. ○ If restraint or seclusion was used to manage violent or self-destructive behavior for longer than 24 hours, confirm that there is documentation of a new written order, patient assessments,

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in accordance with hospital policy and law and regulation.	seclusion by hospital policy in accordance with State law must see and assess the patient.	and a reevaluation by a physician or other licensed practitioner in the record. ○ Confirm that the documentation provides sufficient evidence to support the need to continue the use of restraint or seclusion and there is evidence in the record that the symptoms necessitating the continued use of restraint or seclusion have persisted. ○ Verify that the patient's plan of care or treatment plan addresses the use of restraint or seclusion. ○ Review the patient's documented clinical response to the continued need for restraint or seclusion.
PC.13.02.05, EP 6: Orders for restraint used to protect the physical safety of a nonviolent or non-self-destructive patient are renewed in accordance with hospital policy.	**§482.13(e)(8)(iii)** *[Unless superseded by State law that is more restrictive --]* Each order for restraint used to ensure the physical safety of the non-violent or non-self-destructive patient may be renewed as authorized by hospital policy.	**Interview** ☐ Ask staff to confirm that actual practice is consistent with the policy on renewal of restraint orders for the management of nonviolent, non-self-destructive patient behavior. **Document Review** **General** ☐ Review the hospital's policy on renewal of restraint orders for the management of nonviolent, non-self-destructive patient behavior. **Patient Health Record** ☐ Review a sample of patient health records for documentation showing that actual practice is consistent with the policy on renewal of restraint orders for the management of nonviolent, non-self-destructive patient behavior.
PC.13.02.01, EP 1: The 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	**§482.13(e)(9)** Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.	**Interview** ☐ Ask staff whether they are aware that use of a restraint or seclusion must be discontinued as soon as is safely possible. **Document Review** **General**

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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.		☐ Confirm that the hospital has policies and procedures for ending restraint or seclusion and that the policies include a requirement to end the restraint or seclusion as soon as is safely possible. **Patient Health Record** ☐ Review a sample of health records for patients for whom restraint or seclusion was used. Verify that the record contains evidence that the decision to continue or discontinue the use of restraint or seclusion was based on an assessment and a reevaluation of the patient's condition.
PC.13.02.07, EP 1: Physicians, other licensed practitioners, or staff who have been trained in accordance with 42 CFR 482.13(f) monitor the condition of patients in restraint or seclusion.	**§482.13(e)(10)** The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy.	**Document Review** **General** ☐ Review the hospital's policies on assessment and monitoring of a patient in restraint or seclusion. o Verify that the hospital's monitoring policies are put into practice for all restrained or secluded patients. o Confirm that the policies identify which categories of staff are responsible for assessing and monitoring patients. o Verify that the policies include time frames for offering fluids and nourishment, toileting or elimination, range of motion, exercise of limbs, and systematic release of restrained limbs and that the time frames are documented in the patient's medical record. **Patient Health Record** ☐ Review a sample of health records for patients for whom restraint or seclusion was used. o Confirm that there was a valid rationale for the decision on the frequency of assessment and monitoring of a patient in restraint or seclusion documented in the medical record.

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		○ Verify that the documentation was consistent, relevant, and reflective of the patient's condition. ○ Verify the time frames for how often a patient is monitored for vital signs, respiratory and cardiac status, and skin integrity checks are documented. ○ Confirm that there is documentation of ongoing patient monitoring and assessment (for example, skin integrity, circulation, respiration, intake and output, hygiene, injury). ○ Determine whether the patient's mental status was assessed and that this was documented in the medical record. ○ Confirm that the patient was assessed for the continued need for the use of seclusion or restraint. ○ Verify that there was adequate justification for continued use of restraint or seclusion and that this is documented. ○ Determine whether the level of supervision was appropriate to meet the safety needs of patients who are at a higher risk for injury (for example, self-injurious, suicidal).
PC.13.02.09, EP 1: The hospital's policies and procedures regarding the use of restraint or seclusion 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	**§482.13(e)(11)** Physician and other licensed practitioner training requirements must be specified in hospital policy. At a minimum, physicians and other licensed practitioners authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint or seclusion.	**Document Review** **General** ☐ Review the hospital's policy on restraint and seclusion training requirements for physicians and other licensed practitioners. Confirm that the hospital's minimum training requirements are addressed. **Personnel/Credential File** ☐ Review a sample of medical staff credentialing and privileging files to determine if physicians or other licensed practitioners involved in restraint and

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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 **PC.13.02.09, EP 2:** Physicians and other licensed practitioners authorized to order restraint or seclusion (through hospital policy in accordance with law and regulation) have a working knowledge of the hospital policy regarding the use of restraint or seclusion.		seclusion activities have completed the required training.
PC.13.02.11, EP 1: A physician or other licensed practitioner responsible for the patient's care evaluates the patient in-person within one hour of the initiation of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. A registered nurse may conduct the in-person evaluation within one hour of the initiation of restraint or seclusion; if they are trained in accordance with the requirements in PC.13.02.17, EP 3. Note: The hospital also follows any state statute or regulation that may be more	**§482.13(e)(12) (i) (A) (B)** When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1 hour after the initiation of the intervention— **(i)** By a— **(A)** Physician or other licensed practitioner.	**Interview** ☐ Ask staff if actual practice is consistent with the hospital's policy on the 1-hour face-to-face evaluation. **Document Review** **General** ☐ Review the hospital's policy on the 1-hour face-to-face evaluation. Identify which categories of practitioners the policy authorizes to conduct the evaluation. **Note:** *The 1-hour face-to-face patient evaluation must be conducted in person by a physician or other licensed practitioner or a trained registered nurse*

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stringent than the requirements in this element of performance.	**(B)** Registered nurse who has been trained in accordance with the requirements specified in paragraph (f) of this section.	*(RN) or physician assistant. A telephone call or telemedicine methodology is not permitted.*
PC.13.02.11, EP 2: The in-person evaluation is conducted within one hour of the initiation of restraint or seclusion for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. The evaluation includes the following: - An evaluation of the patient's immediate situation - The patient's reaction to the intervention - The patient's medical and behavioral condition - The need to continue or terminate the restraint or seclusion	**§482.13(e)(12)(ii)(A) (B) (C) (D)** When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1 hour after the initiation of the intervention— **(ii)** To evaluate— **(A)** The patient's immediate situation; **(B)** The patient's reaction to the intervention; **(C)** The patient's medical and behavioral **condition; and** **(D)** The need to continue or terminate the restraint or seclusion.	**Document Review** **Patient Health Record** ☐ Review a sample of health records for patients for whom restraint or seclusion was used. Confirm that the 1-hour face-to-face evaluation was conducted by a practitioner authorized by hospital policy in accordance with state law to conduct this evaluation. o If the 1-hour face-to-face evaluations were conducted by RNs who are not advanced practice nurses (APNs), verify that those RNs have documented training that demonstrates they are qualified to conduct a physical and behavioral assessment of the patient that addresses the following: 1. Patient's immediate situation 2. Patient's reaction to the intervention 3. Patient's medical and behavioral condition 4. Need to continue or terminate the restraint or seclusion ☐ Verify that documentation of the 1-hour face-to-face evaluation in the patient's medical record includes all the listed elements of this requirement. ☐ Determine whether the evaluation indicated that changes in the patient's care were required and, if so, the changes were made. **Observation** Confirm that actual practice is consistent with the hospital's policy on restraint and seclusion and state law.

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PC.13.02.11, EP 1: A physician or other licensed practitioner responsible for the patient's care evaluates the patient in-person within one hour of the initiation of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. A registered nurse may conduct the in-person evaluation within one hour of the initiation of restraint or seclusion; if they are trained in accordance with the requirements in PC.13.02.17, EP 3. Note: The hospital also follows any state statute or regulation that may be more stringent than the requirements in this element of performance.	**§482.13(e)(13)** States are free to have requirements by statute or regulation that are more restrictive than those contained in paragraph (e)(12)(i) of this section.	**Document Review** **General** ☐ When preparing for the hospital survey, determine whether there are state provisions governing the use of restraint or seclusion that are more restrictive than those found in §482.13(e)(12)(i). ☐ When state requirements are more restrictive, apply those requirements instead of those found in §482.13(e)(12)(i).
PC.13.02.11, EP 3: When the in-person evaluation (performed within one hour of the initiation of restraint or seclusion) is done by a trained registered nurse, they consult with the attending physician or other licensed practitioner responsible for the care of the patient as soon as possible after the evaluation, as determined by hospital policy.	**§482.13(e)(14)** If the face-to-face evaluation specified in paragraph (e)(12) of this section is conducted by a trained registered nurse, the trained registered nurse must consult the attending physician or other licensed practitioner who is responsible for the care of the patient as soon as possible after the completion of the 1-hour face-to-face evaluation.	**Document Review** **General** ☐ Review the hospital's restraint and seclusion policy to confirm that it clarifies expectations regarding the "as soon as possible" requirement. **Patient Health Record** ☐ Review a sample of health records for patients for whom restraint or seclusion was used. Verify that documentation in the records indicate consultation with the attending physician or other licensed practitioner when the 1-hour face-to-face evaluation was conducted by a trained RN or PA. **Observation** ☐ Confirm that actual practice is consistent with the hospital's restraint and seclusion policy.
PC.13.02.13, EP 1: The patient who is simultaneously restrained and secluded is	**§482.13(e)(15)(i) (ii)** All requirements specified under this paragraph	**Interview**

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continually monitored by trained staff, either in person or through the use of both video and audio equipment that is in close proximity to the patient. Note: In this element of performance continually means ongoing without interruption.	are applicable to the simultaneous use of restraint and seclusion. Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored— (i) Face-to-face by an assigned, trained staff member; or (ii) By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.	☐ Ask staff if actual practice is consistent with the hospital's policy on simultaneous use of restraint and seclusion and if uninterrupted audio/visual monitoring is provided as required. ☐ Ask whether the staff member monitoring the patient with audio/video equipment was trained in such monitoring. **Document Review** **General** ☐ Review the hospital's policy on simultaneous use of restraint and seclusion to determine whether it provides for continual monitoring and otherwise complies with all requirements of §482.13. ☐ Review documents to determine if actual practice is consistent with the hospital's policy and if uninterrupted audio/visual monitoring is provided as required. **Observation** ☐ Determine if actual practice is consistent with the hospital's policy and if uninterrupted audio/visual monitoring is provided as required. ☐ Confirm that audio/visual monitoring equipment is appropriately maintained and in working condition. ☐ Observe whether the staff member monitoring the patient with audio/video equipment was trained in such monitoring and is in close proximity to ensure prompt emergency intervention if a problem arises. ☐ Ensure that the video equipment covers all areas of the room or location where the patient is restrained or secluded. ☐ Observe whether the audio/video equipment is located in an area that ensures patient privacy.
PC.13.02.15, EP 1: Documentation of restraint or seclusion in the medical record includes the following:	**§482.13(e)(16)(i) (ii) (iii) (iv) (v)**	**Document Review** **Patient Health Record**

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- The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior - Description of the patient's behavior and the intervention used - Alternatives or other less restrictive interventions attempted (as applicable) - Patient's condition or symptom(s) that warranted the use of the restraint or seclusion - Patient's response to the intervention(s) used, including the rationale for continued use of the intervention	When restraint or seclusion is used, there must be documentation in the patient's medical record of the following: (i) The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior; (ii) A description of the patient's behavior and the intervention used; (iii) Alternatives or other less restrictive interventions attempted (as applicable); (iv) The patient's condition or symptom(s) that warranted the use of the restraint or seclusion; and (v) The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.	□ Review a sample of health records for patients for whom restraint or seclusion was used. ○ Confirm that records include documentation of the1-hour face-to-face medical and behavioral evaluation when restraint or seclusion is used to manage violent or self-destructive behavior. ○ Confirm that the records include a clear description of patient behaviors that warranted the use of restraint or seclusion. ○ Verify that the intervention employed was appropriate for the identified behavior. ○ Identify the patient's clinical response to the intervention(s). ○ Review a sample of health records for patients for whom restraint or seclusion was used. Confirm that the records document any alternatives or less restrictive interventions attempted by staff, if appropriate. ○ Review the effect of less restrictive interventions, if attempted by staff. ○ Determine whether the interventions selected were appropriate to the targeted patient behaviors. ○ When an immediate and serious danger to the patient or others occurred, determine whether the more restrictive intervention(s) was effective. ○ Assess whether a less restrictive intervention could have been used to ensure the safety of the patient, staff, or others. ○ Confirm that the records include descriptions of the patient's condition or symptom(s) that warranted the use of restraint or seclusion. ○ Confirm that the records include descriptions of the impact of the intervention on the patient behavior that resulted in the use of restraint or seclusion.

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		○ Verify that the records include a detailed assessment of the patient's response to the intervention and a well-reasoned plan for the continued use of restraint or seclusion.
PC.13.02.03, EP 1: The 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 hospital's policies and procedures in accordance with law and regulation	**§482.13(f) Standard: Restraint or seclusion: Staff training requirements.** The patient has the right to safe implementation of restraint or seclusion by trained staff.	**Document Review** **General** ☐ Verify that the hospital has a staff training and education program that protects the patient's right to safe implementation of restraint or seclusion. **Observation** ☐ Observe patients in restraint or seclusion to verify safe application of the restraint or seclusion.
PC.13.02.17, EP 1: The hospital trains staff on the use of restraint and seclusion, and assesses their competence, at the following intervals: - At orientation - Before participating in the use of restraint or seclusion - On a periodic basis thereafter, as determined by hospital policy	**§482.13(f)(1) (i) (ii) (iii)** **(1)** ***Training intervals.*** Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion— **(i)** Before performing any of the actions specified in this paragraph; **(ii)** As part of orientation; and **(iii)** Subsequently on a periodic basis consistent with hospital policy.	**Document Review** **General** ☐ Confirm that the hospital has a documented training program for the use of restraint and seclusion interventions employed by staff at the hospital. ☐ Verify that the hospital has documented evidence that all levels of staff, including agency or contract staff, who have direct patient care responsibilities and any other individuals who may be involved in the application of restraints (for example, security guards) have been trained and can demonstrate competency in the safe use of seclusion and the safe application and use of restraints. **Personnel/Credential File** ☐ Review a sample of personnel files to verify restraint and seclusion education staff training documentation for all new employees and contract staff. ☐ Confirm that the training included demonstration of required competencies.

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		☐ Identify the topic areas that were included in this training program. ***Note:*** *Verify that staff competency was demonstrated initially as part of orientation and subsequently on a periodic basis consistent with hospital policy. Hospitals have the flexibility to identify a timeframe for ongoing training based on the level of staff competency, and the needs of the patient population(s) served.*
PC.13.02.17, EP 3: Based on the population served, staff education, training, and demonstrated knowledge focus on the following: - Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion - Use of nonphysical intervention skills - Methods for choosing the least restrictive intervention based on an assessment of the patient's medical or behavioral status or condition - Safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia) - Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary - Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including, but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special	**§482.13(f)(2) (i) (ii) (iii) (iv) (v) (vi) (vii)** (2) ***Training content.*** The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following: **(i)** Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion. **(ii)** The use of nonphysical intervention skills. **(iii)** Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition. **(iv)** The safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia);	**Interview** ☐ Ask staff about their knowledge of the restraint and seclusion techniques addressed in §482.13(f)(2)(i). ☐ Ask staff about their nonphysical intervention skills. ☐ Ask staff if they are able to assess the patient to determine the least restrictive intervention as described in §482.13(f)(2)(iii). ☐ Verify that staff are able to identify signs of physical and psychological distress in a timely manner. ☐ Confirm that staff are able to respond to and appropriately treat signs of physical and psychological distress. ☐ Ask staff if they are able to identify specific behavioral changes that indicate that restraint or seclusion is no longer necessary as described in §482.13(f)(2)(v). ☐ Ask staff if they are able to demonstrate the competencies addressed in §482.13(f)(2)(vi). **Document Review** **General** ☐ Confirm that the hospital's educational program on restraint and seclusion includes techniques related to the specific patient populations being served. ☐ Determine whether the program provides more in-depth training for restraint and seclusion for staff members who routinely provide care to patients who

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requirements specified by hospital policy associated with the in-person evaluation conducted within one hour of initiation of restraint or seclusion - Use of first aid techniques and certification in the use of cardiopulmonary resuscitation (CPR), including required periodic recertification	**(v)** Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary. **(vi)** Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation. **(vii)** The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.	exhibit violent or self-destructive behavior (for example, staff who work in the emergency department or psychiatric unit). ☐ Verify that the program includes techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion. ☐ Verify that the hospital's educational program on restraint and seclusion addresses the use of nonphysical intervention skills. • Confirm that the program complies with §482.13(f)(2)(ii). ☐ Confirm that the hospital's educational program on restraint and seclusion addresses choosing the least restrictive intervention based on an individualized assessment of the patient's medical or behavioral status or condition. • Verify that the program addresses how to conduct an assessment of a patient's medical and behavioral conditions. • Determine whether the program addresses types of interventions appropriate to the specific needs of the patient population(s) served and ranging from less to more restrictive. ☐ Confirm that the hospital's educational program on restraint and seclusion addresses recognition and response to patient signs of physical and psychological distress. ☐ Review hospital data (that is, incident reports, patient injury or death reports) to identify any patterns of patient injuries or death that may indicate that staff are not adequately trained to recognize and respond to patient signs of physical and psychological distress. ☐ Confirm that the hospital's educational program on restraint and seclusion addresses identification of

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		specific behavioral changes that may indicate that restraint or seclusion is no longer necessary. ☐ Confirm that the hospital's educational program on restraint and seclusion addresses monitoring the physical and psychological needs of patients who are restrained or secluded, including but not limited to respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation. ☐ Verify that the program addresses the specific requirements for the training of RNs and PAs that the hospital authorizes to conduct the 1-hour face-to-face evaluation. ☐ Confirm that the hospital's educational program on restraint and seclusion addresses first aid techniques. ☐ Determine whether the program includes, or provides for, staff training and certification in cardiopulmonary resuscitation (including provisions for recertification). ***Note:*** *The hospital is expected to provide education and training at the appropriate level to the appropriate staff based upon the specific needs of the patient population being served. For example, staff routinely providing care for patients who exhibit violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others (such as in an emergency department or on a psychiatric unit) generally require more in-depth training about restraint and seclusion than staff routinely providing medical/surgical care.* **Personnel/Credential File** ☐ Determine if all staff, including contract or agency personnel, identified by the hospital as direct

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		caregivers are trained and able to demonstrate competency in the safe use of all types of restraints or seclusion used in the hospital. ☐ Verify that appropriate staff are certified in cardiopulmonary resuscitation.
PC.13.02.17, EP 4: Individuals providing staff training in restraint or seclusion are qualified as evidenced by education, training, and experience in the techniques used to address patient behaviors that necessitate the use of restraint or seclusion.	**§482.13(f)(3) Trainer Requirements.** Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors.	**Document Review** **Personnel/Credential File** ☐ Review personnel files of individuals responsible for providing staff education and training to determine whether the individuals providing the education and training possess education, training, and experience to teach the staff. ☐ Are they qualified to identify and meet the needs of the patient population(s) being served? ☐ Does the hospital have a system for documenting and ensuring that the individuals providing education and training have the appropriate qualifications required by §482.13(f)(3)?
PC.13.02.17, EP 5: The hospital documents in staff records that they have completed restraint and seclusion training and demonstrated competence.	**§482.13(f)(4) Training Documentation.** The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.	**Document Review** **Personnel/Credential File** ☐ Review a sample of staff personnel records, including contract or agency staff, to determine if the training and demonstration of competency for restraint and seclusion have been completed during orientation and on a periodic basis consistent with hospital policy.
PC.13.02.19, EP 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The 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	**§482.13(g) Standard: Death Reporting Requirements:** Hospitals must report deaths associated with the use of seclusion or restraint.	☐ **Interview** Ask staff about their knowledge of the hospital's death reporting policy. **Document Review** **General** ☐ Confirm that the hospital has a death reporting policy that addresses the requirements of §482.13(g).

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or seclusion - Each death known to the 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.		☐ Review data related to patient deaths while the patients were in restraint or seclusion to determine if the hospital followed the requirements related to death reporting for the following: o Each death that occurred while the patient was in restraints (whether physical or drugs used as a restraint) or seclusion o Each death that occurred within 24 hours after the patient had been removed from restraint or seclusion o Each death that occurred within one week after restraint or seclusion where it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to a patient's death **Patient Health Record** ☐ Review medical records of patients who died associated with the use of restraint or seclusion to determine if the deaths were reported to CMS. Does documentation include the date and time the death was reported to CMS?
PC.13.02.19, EP 2: For hospitals that use Joint Commission accreditation for deemed status purposes: 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.	**§482.13(g)(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:	**Interview** ☐ Ask staff in various types of inpatient units, including a psychiatric unit if applicable, if they are aware of any patients who died while in restraints or seclusion or within one day of restraint or seclusion discontinuation, excluding cases involving only the use of two-point soft wrist restraints and no seclusion. If yes, determine whether the hospital has any evidence that these cases were reported to CMS. **Document Review**

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		General ☐ Confirm that the hospital has restraint and seclusion death reporting policies and procedures that address responsibilities and systems for identifying restraint- or seclusion-associated deaths reportable to CMS and for implementing the reporting and recordkeeping requirements. ☐ Can the hospital provide examples of restraint- or seclusion-associated deaths that were reported to CMS? o If yes, review the report and medical records to determine whether the following occurred: • The reports met the criteria for reporting to CMS. • The reports were submitted in a timely fashion to CMS. • The reports were complete. • The date and time the death reported to CMS was entered into the patient's medical record. o If no, do the following: • Ask how the hospital ensures that there were no reportable restraint- or seclusion-associated deaths. • If the hospital's system relies on staff identification of reportable deaths, interview several applicable staff members to determine if they are aware of the hospital's policy and know when and where to internally report a restraint- or seclusion-associated death. Ask if there have been any patient deaths that met the reporting requirements.
PC.13.02.19, EP 1: For hospitals that use Joint Commission accreditation for deemed	**§482.13(g)(1)(i) (ii) (iii)**	**Interview**

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status purposes: The 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 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.	*(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:)* **(i)** Each death that occurs while a patient is in restraint or seclusion. **(ii)** Each death that occurs within 24 hours after the patient has been removed from 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.	☐ Ask staff about their knowledge of the hospital's death reporting policy. **Document Review** **General** ☐ Confirm that the hospital has a death reporting policy that addresses the requirements of §482.13(g). ☐ Review data related to patient deaths while the patients were in restraint or seclusion to determine if the hospital followed the requirements related to death reporting for the following: o Each death that occurred while the patient was in restraints (whether physical or drugs used as a restraint) or seclusion o Each death that occurred within 24 hours after the patient had been removed from restraint or seclusion o Each death that occurred within one week after restraint or seclusion where it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to a patient's death **Patient Health Record** ☐ Review medical records of patients who died associated with the use of restraint or seclusion to determine if the deaths were report to CMS. Does documentation include the date and time the death was reported to CMS?
PC.13.02.19, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed	**§482.13(g)(2) (i) (ii)** **(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	**Interview** ☐ Ask inpatient unit staff if they have had patients die while 2-point soft wrist restraints are being used without seclusion or within 24 hours of their

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solely of soft, nonrigid, cloth-like material, the hospital does the following: - Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. - Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. - Documents in the patient record the date and time that the death was recorded in the log or other system - Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the care of the patient, medical record number, and primary diagnosis(es) - Makes the information in the log or other system available to the Centers for Medicare and Medicaid Services, either electronically or in writing, immediately upon request	must record in an internal log or other system, the following information: (i) Any death that occurs while a patient is in such restraints. (ii)Any death that occurs within 24 hours after a patient has been removed from such restraints.	discontinuance. If yes, ask the hospital to demonstrate that it has recorded such deaths. ☐ If the hospital's log or tracking system relies on staff identification of reportable deaths, interview several applicable staff members to determine if they are aware of the hospital's policy and know when and where to report internally a restraint- or seclusion-associated death. **Document Review** **General** ☐ Confirm that the hospital has restraint and seclusion death reporting policies and procedures that address responsibilities and systems for identifying restraint- or seclusion-associated deaths that must be recorded in an internal hospital log or tracking system and for implementing the reporting and recordkeeping requirements. ☐ Verify how the hospital ensures that each death that must be captured in the log or tracking system is identified and entered. ☐ Review the log/tracking system for patient deaths associated with use of only 2-point soft wrist restraints to determine if the following requirements were met o Each entry was made within 7 days of the patient's death o Each entry contains all the information required under the regulation. ☐ Confirm that the hospital is able to make the log or tracking system available immediately on request. **Patient Health Record** ☐ Review a sample of medical records of patients whose deaths were entered in the log or tracking system.

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		○ Confirm that the medical record indicates that only soft, 2-point wrist restraints were used. ☐ Verify that there is documentation in the medical record of the entry into the log or tracking system.
PC.13.02.19, EP 2: For hospitals that use Joint Commission accreditation for deemed status purposes: 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.	**§482.13(g)(3)(i)** **(3)** The staff must document in the patient's medical record the date and time the death was: **(i)**Reported to CMS for deaths described in paragraph (g)(1) of this section; or	**Interview** ☐ Ask staff about their knowledge of the hospital's death reporting policy. **Document Review** **General** ☐ Confirm that the hospital has a death reporting policy that addresses the requirements of §482.13(g). ☐ Review data related to patient deaths while the patients were in restraint or seclusion to determine if the hospital followed the requirements related to death reporting for the following: ○ Each death that occurred while the patient was in restraints (whether physical or drugs used as a restraint) or seclusion ○ Each death that occurred within 24 hours after the patient had been removed from restraint or seclusion ○ Each death that occurred within one week after restraint or seclusion where it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to a patient's death **Patient Health Record** ☐ Review medical records of patients who died associated with the use of restraint or seclusion to determine if the deaths were reported to CMS. Does

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		documentation include the date and time the death was reported to CMS?
PC.13.02.19, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: 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 hospital does the following: - Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. - Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. - Documents in the patient record the date and time that the death was recorded in the log or other system - Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the care of the patient, medical record number, and primary diagnosis(es) - Makes the information in the log or other system available to the Centers for Medicare and Medicaid Services, either electronically or in writing, immediately upon request	**§482.13(g)(3)(ii)** Recorded in the internal log or other system for deaths described in paragraph (g)(2) of this section.	**Interview** ☐ Ask inpatient unit staff to determine whether they have had patients die while 2-point soft wrist restraints are being used without seclusion or within 24 hours of their discontinuance. If yes, ask the hospital to demonstrate that it has recorded such deaths. ☐ If the hospital's log or tracking system relies on staff identification of reportable deaths, interview several applicable staff members to determine whether they are aware of the hospital's policy and know when and where to report internally a restraint- or seclusion-associated death. **Document Review** **General** ☐ Confirm that the hospital has restraint and seclusion death reporting policies and procedures that address responsibilities and systems for identifying restraint- or seclusion-associated deaths that must be recorded in an internal hospital log or tracking system and for implementing the reporting and recordkeeping requirements. ☐ Determine how the hospital ensures that each death that must be captured in the log or tracking system is identified and entered. ☐ Review the log or tracking system for patient deaths associated with use of only 2-point soft wrist restraints to determine if the following requirements were met: o Each entry was made within 7 days of the patient's death.

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		○ Each entry contains all the information required under §482.13(g). ☐ Confirm that the hospital is able to make the log or tracking system available immediately on request. **Patient Health Record** ☐ Review a sample of medical records of patients whose deaths were entered in the log or tracking system. ○ Confirm that the medical record indicates that only 2-point soft wrist restraints were used. ○ Determine whether there is documentation in the medical record of the entry into the log or tracking system.
PC.13.02.19, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: 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 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,	**§482.13(g)(4)(i) (ii) (iii)** (4) For deaths described in paragraph (g)(2) of this section, entries into the internal log or other system must be documented as follows: (i) Each entry must be made not later than seven days after the date of death of the patient. (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). (iii) The information must be made available in either written or electronic form to CMS immediately upon request..	**Interview** ☐ Ask inpatient unit staff whether they have had patients die while 2-point soft wrist restraints are being used without seclusion or within 24 hours of their discontinuance. If yes, ask the hospital to demonstrate that it has recorded such deaths. ☐ If the hospital's log or tracking system relies on staff identification of reportable deaths, interview several applicable staff members to determine whether they are aware of the hospital's policy and know when and where to report internally a restraint- or seclusion-associated death. **Document Review** **General** ☐ Confirm that the hospital has restraint and seclusion death reporting policies and procedures that address responsibilities and systems for identifying restraint- or seclusion-associated deaths that must be recorded in an internal hospital log or tracking system and for implementing the reporting and recordkeeping requirements.

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name of attending physician or other licensed practitioner responsible for the care of the patient, medical record number, and primary diagnosis(es) - Makes the information in the log or other system available to the Centers for Medicare and Medicaid Services, either electronically or in writing, immediately upon request		☐ Verify that the hospital ensures that each death that must be captured in the log or tracking system is identified and entered. ☐ • Review the log or tracking system for patient deaths associated with use of only 2-point soft wrist restraints to determine if the following requirements were met: o Each entry was made within 7 days of the patient's death. o Each entry contains all the information required under the regulation. ☐ Confirm that the hospital is able to make the log or tracking system available immediately on request. **Patient Health Record** ☐ Review a sample of medical records of patients whose deaths were entered in the log or tracking system. ☐ Confirm that the medical record indicates that only 2-point soft wrist restraints were used. ☐ Determine whether there is documentation in the medical record of the entry into the log or tracking system. ☐ Confirm that each entry in the patient's medical record related to any death that occurs while a patient in is restraints or any death that occurs within 24 hours after a patient has been removed from such restraints was made no later than 7 days after the date of death of the patient. ☐ Confirm that each entry in the patient's medical record related to any death that occurs while a patient in is restraints or any death that occurs within 24 hours after a patient has been removed from such restraints documents the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner who is

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		responsible for the care of the patient, medical record number, and primary diagnosis(es). ☐ Verify that information about any death that occurs while a patient in is restraints or any death that occurs within 24 hours after a patient has been removed from such restraints is made available in either written or electronic form to CMS immediately upon request.
RI.11.01.01, EP 7: The hospital develops and implements policies and procedures for patient visitation rights. Visitation rights include the right to receive the visitors designated by the patient, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. The patient also has the right to withdraw or deny such consent at any time. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The 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: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital informs the patient (or support person, where appropriate) of the patient's visitation rights, including any clinical restriction or limitation on such rights.	**§482.13(h) Standard: Patient visitation rights.** A hospital 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 hospital may need to place on such rights and the reasons for the clinical restriction or limitation. A hospital must meet the following requirements: **§482.13(h)(1)** (1) Inform each patient (or support person, where appropriate) of his or her visitation rights, including any clinical restriction or limitation on such rights, when he or she is informed of his or her other rights under this section **§482.13(h)(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.	**Interview** ☐ Determine whether hospital staff are aware of the hospital's visitation policies and procedures and confirm that staff on a given unit can correctly describe the policies for that unit. ☐ Ask staff responsible for providing the required notice of the patient's visitation rights how they accomplish this. Ask staff if they are familiar with the concept of a patient's "support person" and what it means. ☐ Ask a sample of current hospital patients or patients' support persons (where appropriate) whether they were provided notice of their right to have visitors. Ask if they were able to have visitors when they wanted to. If not, verify that the restriction or limitation on visitors was addressed in the hospital's visitation policies and notice and does not violate the regulations at §482.13(h)(3&(4). (See interpretive guidelines for the latter provisions.) ☐ Ask a sample of current hospital patients or patients' support persons (where appropriate) if the hospital failed to limit some or all visitors, contrary to the patient's wishes. **Document Review** **General** ☐ Verify that the hospital has written policies and procedures that address the right of patients to have visitors.

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		☐ Review the policy to determine if there are limitations or restrictions on visitation. If so, confirm that the policy explains the clinical rationale for the restrictions or limitations and that the rationale is clear and reasonably related to clinical concerns. ☐ Confirm that there is documentation of how the hospital identifies and trains staff who play a role in facilitating or controlling access of visitors to patients. ☐ Determine whether the hospital's visitation policies and procedures require providing notice of the patient's visitation rights to each patient or, if appropriate, to the patient's support person and/or, as applicable, the patient's representative. **Note:** *A patient's "support person" does not necessarily have to be the same person as the patient's representative who is legally responsible for making medical decisions on the patient's behalf. A support person could be a family member, a friend, or another individual who supports the patient during the course of the hospital stay. Hospitals must accept a patient's designation, orally or in writing, of an individual as the patient's support person.* ☐ Review the hospital's standard notice of visitation rights to confirm that it clearly explains the following: o Hospital's visitation policy, including any limitations or restrictions, such as visiting hours, numbers of visitors, or unit-specific restrictions, and the clinical rationale for such limitations or restrictions o Right of the patient to have designated visitors, including but not limited to a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and the right to withdraw or deny consent to visitation **Patient Health Record**

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		☐ Review a sample of medical records to determine if there is documentation that the required notice of the patient's visitation rights was provided. How was the notice provided?
RI.11.01.01, EP 4: The 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 hospital allows all visitors to have full and equal visitation privileges consistent with patient preferences.	§482.13(h)(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. §482.13(h)(4) Ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences.	**Interview** ☐ Ask the hospital how it educates staff to ensure that visitation policies are implemented in a nondiscriminatory manner. ☐ Ask staff how about the education they received to ensure that visitation policies are implemented in a nondiscriminatory manner. ☐ Ask hospital staff who play a role in facilitating or controlling visitors to discuss their understanding of the circumstances under which visitors may be subject to restrictions or limitations and whether the restrictions or limitations are appropriately based on the hospital's clinically based policies. ☐ Ask hospital patients (or patients' support persons, where appropriate) whether the hospital has restricted or limited visitors against their wishes. If yes, verify whether the restriction or limitation on visitors was addressed in the hospital's visitation policies and in the patient notice and whether it was appropriately based on a clinical rationale rather than impermissible discrimination. **Document Review** **General** ☐ Review the hospital's visitation policies and procedures to determine whether they restrict, limit, or otherwise deny visitation to individuals on a prohibited basis.

Hospital Quality Assessment and Performance Improvement Evaluation Module (482.21)

Surveyors are not expected to judge the performance and quality measures used by a hospital. Instead, surveyors will evaluate the hospital's success in its efforts to improve performance and quality. ***The focus of the QAPI CoP assessment is to determine whether a hospital has an effective, ongoing system in place for identifying problematic events, policies, or practices, and is taking actions to remedy them and then following up on these remedial actions to determine if they were effective in improving performance and quality. The survey focus will also include whether improvements are sustained over time.***

There may also be an evaluation of the QAPI program when surveyors identify non-compliance with other regulatory requirements. For example, a surveyor may observe deficiencies in infection control or medication administration practices. Citations should be made under the applicable portions of the infection control, nursing, or pharmacy CoPs. However, surveyors should also investigate the tracking of medical errors and adverse events related to healthcare-associated infections or medication errors, what type of analyses and actions have been taken to reduce future errors, and what follow-up evaluations are underway. If, during the course of the survey, such lapses in care and safety are found to be very serious or widespread, surveyors should investigate the effectiveness of the QAPI program related to the handling of medical errors and adverse events. If there is evidence that the hospital is taking effective actions through its QAPI program to correct such deficiencies, then a citation of QAPI CoP deficiencies generally would not be appropriate, despite the individual lapses surveyors might have observed for other regulatory requirements.

Surveyors should avoid using the hospital's own QAPI program data and analyses as evidence of violations of other CoPs unless there is evidence of current non-compliance with the regulatory requirements. However, surveyors may review additional records pertaining to the operation of the hospital, including medical error reports and peer review information when these documents are necessary to determine compliance with statutory and regulatory requirements. With rare exceptions, surveyors must not use the information they have gathered from QAPI program records as the basis for a deficiency citation under other CoPs. There may be cases where it might be appropriate to use QAPI program information as evidence of a deficiency, but these cases would be the exception rather than the rule. For example, a review of the QAPI program documents might show that a hospital identified three incidents of wrong-site surgery over twelve months, and another five near misses, but that no subsequent action was taken to analyze these incidents and implement any changes to its pre-surgical verification procedures. Here, the QAPI documents would suggest there is current noncompliance with the QAPI CoP since the hospital's QAPI program did not take any action to address the problems it had identified. In this circumstance, it would also be appropriate for surveyors to review the medical records for the incidents identified in the QAPI system to assess compliance with the surgical services CoP.

Surveyors should be aware of the sensitivity of the documents when reviewing QAPI program materials furnished by a hospital that relate to peer review or other analyses of adverse events. Surveyors must:

- *Avoid making copies of such information unless absolutely necessary to support a deficiency citation; and*
- *Avoid making notes that could identify particular events--e.g., do not write: "root cause analysis of an adverse event in August, 20XX related to inadvertent disposal of an organ recovered from a living donor showed that primary causes were Y and Z and that the process for handling a recovered organ should be modified in XX manner. In December 20XX hospital made the following changes to its process…." Instead write: "confirmed that hospital conducted a root cause analysis of an adverse event related to the hospital's transplant program; reviewed analysis, which was systematic, detailed, and resulted in recommendations; confirmed the hospital implemented recommendations and is monitoring for effectiveness." Ensure that the recommendations resulted in improvements to processes, outcomes, etc., resulting in positive patient outcomes.*

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LD.11.01.01, EP 8: The governing body is responsible for making sure that performance improvement activities reflect the complexity of the hospital's organization and services; involve all departments and services including services provided under contract or arrangement; and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. (For more information on contracted services, see Standard LD.13.03.03) Note: For hospitals that do not use Joint Commission accreditation for deemed status purposes: If the hospital does not have a governing body, it identifies the leadership structure that is responsible for these activities. **LD.12.01.01, EP 1:** The hospital develops, implements, maintains, and documents an effective, ongoing, data-driven, hospitalwide quality assessment and performance improvement program. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital maintains and demonstrates evidence of its QAPI program for review by CMS.	**§482.21 Condition of Participation: Quality Assessment and Performance Improvement Program** The hospital must develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. (A-0308) The hospital's governing body must ensure that: the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.	**Document Review** □ Quality assurance/performance improvement (QAPI) program documents to verify the program meets the following requirements: ○ Includes processes for systematically examining the quality of care delivered and implementing specific improvement projects on an ongoing basis ○ Facilitates the continuous study and improvement of processes and service delivery ○ Takes a proactive approach to improve their performance ○ Is based on, and reflects, the size and complexity of the organization and services ○ Is hospitalwide (including services under contract or arrangement)[3] ▪ All hospital departments and services are included in the QAPI program ▪ Documentation shows participation by all contracted services ▪ Written contracts include QAPI requirements and roles and responsibilities of the contractor ○ Is data driven ▪ Documentation indicates which data are used to make QAPI program decisions

[3] While it is not expected that all departments and services be continuously engaged in large scale or resource-intensive QAPI projects, all departments and services (including those provided under arrangement or contract) should provide evidence that there is continuous monitoring of the quality and safety of the services provided and take corrective actions as necessary to ensure patient safety and to improve the quality of care provided.

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PI.14.01.01, EP 1: The hospital acts on improvement priorities.		○ Focuses on quality indicators or measures related to improved health outcomes, as well as the prevention and reduction of medical errors ▪ Does the program focus on nonclinical measures, such as employee satisfaction data, as opposed to clinical measures, such as infection control incidence rates and/or nationally recognized quality indicators? □ Evidence of continuous data collection, data analysis (with identified areas for improvement), and implementation of changes, including ongoing monitoring of changes for effectiveness. □ Evidence that the governing body is engaged in oversight of QAPI program □ Evidence of services provided under an arrangement or contract are included in its QAPI program.
LD.12.01.01, EP 2: As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities related to 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	**Data Collection & Analysis** **§482.21(a) Standard: Program Scope** (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes…. (2) The hospital must measure, analyze, and track quality indicators…and other aspects of performance that assess processes of care, hospital service and operations. **§482.21(b) Standard: Program Data.** (1) The program must incorporate quality indicator data including patient care data, and other relevant data *such as data submitted to or received from Medicare*	**Interview** □ Ask QAPI staff to provide a list of the quality indicators they are currently tracking. Verify that the ○ List includes the tracking of adverse events. ○ Quality indicator data include patient care data and other relevant data, such as that received from Medicare quality reporting (hospital readmissions and hospital-acquired conditions) and performance programs. ○ Quality indicators are reflective of the hospital's patient population. □ Ask QAPI staff to provide evidence (measurement data) of measurable improvements in the quality indicators it has selected for its program.

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PI.11.01.01, EP 2: The 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 hospitals that use Joint Commission accreditation for deemed status purposes: 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.12.01.01, EP 3:** The hospital measures, analyzes, and tracks quality indicators, including adverse patient events, and other aspects of performance that assess	*quality reporting and quality performance programs, including but not limited to data related to hospital readmissions and hospital-acquired conditions.* (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of services and quality of care; and… (3) The frequency and detail of data collection must be specified by the hospital's governing body.	○ Verify that improvements are ongoing (several data analyses showing improvement over time) and not just one-time events. ○ If the evaluation did not show improvements or sustained improvements, is there evidence that the hospital implemented a revised or new solution? □ Ask to see evidence that the governing body has specified the frequency and detail of QAPI program data collection.[4] ○ Look at governing body meeting minutes. ○ Do QAPI program reviews include this information? □ Verify that the hospital is using the data being collected to monitor the safety and quality of care. ○ Select a sample of data being collected and ask the governing body or other appropriate leaders to explain how the collection of the particular data is used to monitor quality and safety. □ Verify that the hospital is using the data being collected to identify opportunities for improvement. ○ Select a sample of data being collected and ask the governing body or other appropriate leaders to

[4] ***Governing body responsibility for frequency and detail of data collection*** *The governing body is responsible for specifying the frequency and the detail of the data collection, which may include, but is not limited to, what data will be collected, what the data is intended to measure, in what areas of the hospital the data will be collected, and how frequently the various types of data will be collected. This does not mean that the governing body is expected to have a high degree of technical expertise in the area of quality data collection. However, the governing body must have information that describes the hospital's QAPI data collection program in sufficient detail so that the governing body is able to determine what program data requirements to approve. There must be evidence that the governing body has had an active role in the development and ongoing planning of the frequency and detail of QAPI data collection. Such evidence may be documentation in the governing body meeting minutes that it has reviewed and approved the frequency and detail of the QAPI data collection program.*

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processes of care, hospital service and operations.		give examples of how the specific data has identified opportunities for improvement. ○ Ask to see documented evidence of the opportunities the hospital has identified for improvement based on the collection of data.
LD.12.01.01, EP 2: As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities related to 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 **PI.12.01.01, EP 4:** The hospital takes action to improve its performance. After implementing changes, the hospital measures its success, and tracks performance to ensure that improvements are sustained. **PI.14.01.01, EP 1:** The hospital acts on improvement priorities.	**Quality Improvement Activities** **§482.21(b)(2) Standard: Program Data** The hospital must use the data collected to-- … (ii) Identify opportunities for improvement and changes that will lead to improvement. **§482.21(c) Standard: Program Activities** (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.	**Interview** Ask QAPI leaders or staff to see □ A list of current or recent performance improvement activities. ○ Ask about the actions taken, post action measurement to determine improvement, and measurement to determine sustained improvement. □ Evidence that the hospital tracks data for the identified indicators, which may include but are not limited to blood product transfusion reactions, drug reactions, errors in medication administration, and infection control–related errors and events. Ask the governing body or the leaders who oversee the QAPI program to provide evidence □ That its improvement activities are focused on high-risk, high-volume, or problem-prone areas. ○ Does it have any data (either derived from its own QAPI data collection or public data) on incidence, prevalence, or severity to support its choices? ○ Does it have evidence that the activities affect health outcomes through improving quality of care or patient safety?

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		□ QAPI activities that were initiated based on data reported through the medical error/adverse event tracking system.
PI.11.01.01, EP 2: The 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 hospitals that use Joint Commission accreditation for deemed status purposes: 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.12.01.01, EP 1:** The hospital tracks medical errors and adverse patient events,	**Patient Safety, Medical Errors & Adverse Events** **§482.21(a) Standard: Program Scope.** (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will … identify and reduce medical errors.[5] (2) The hospital must measure, analyze, and track…adverse patient events…. **§482.21(c) Standard: Program Activities…** (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. **§482.21(e) Standard: Executive Responsibilities.**	**Interview** □ Interview staff in various units to assess their understanding of identifying and reporting medical errors and adverse events. **Document Review** **General** □ Verify that the hospital has a medical error and adverse patient event reporting policy. □ Select a sample of several **(at least three)** adverse events or errors the hospital has tracked and ask to see written evidence showing that it has used a systematic approach (for example, root cause analysis) to ○ Analyze the cause of the events and errors, ○ Implement changes based on the identified causes to prevent further events or errors, ○ Conduct periodic data collection to verify if the changes resulted in improvements, and ○ Analyze the post-implementation data to assess whether the improvement (if there was an improvement) was sustained over time.

[5] CMS has adopted the following definition of an error from the Quality Interagency Coordination Task Force (QuIC) (68 FR 3435, 3436, January 24, 2003): "An **error** is defined as 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."

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analyzes their causes, and implements preventive actions and mechanisms that include feedback and learning throughout the hospital. Medical errors and adverse patient events include but are not limited to the following: - Medication administration errors - Surgical errors - Equipment failure - Infection control errors - Blood transfusion-related errors - Diagnostic errors **PI.12.01.01, EP 3:** The hospital measures, analyzes, and tracks quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital service and operations. **LD.12.01.01, EP 3:** The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for the following: - An ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained - The hospitalwide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety; and that all improvement actions are evaluated	The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following:... (3) That clear expectations for safety are established.	**Observation** □ Look for evidence of the medical error/adverse event reporting system. □ Ask QAPI staff for a demonstration of the system and explain how the system is able to organize the reported data for meaningful analysis. o Can the system organize the data by type of error or adverse event, and by actual or near misses? o Can the system organize the data by dates to show trends over time? o Can the system organize the data by shift, by unit where the error occurred, and so on? □ Look for evidence of hospitalwide staff education and training regarding what errors and adverse events must be reported and how to report them. Review the materials used for education and training. o Are there records to show staff received the training? **Prospective hospitals applying for initial certification in Medicare** A facility seeking Medicare program initial certification as a hospital may not have been in operation long enough to demonstrate extensive internal data collection for the identification of opportunities for improvement based on the monitoring data. However, it □ Must be able to show that it has an active data collection and analysis infrastructure in place, and indicate when it expects to have sufficient data to begin analysis.

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- Clear expectations for safety are established - Adequate resources are allocated for measuring, assessing, improving, and sustaining the hospital's performance and reducing risk to patients - The determination of the number of distinct improvement projects is conducted annually		In addition, because hospitals may utilize quality indicators from outside sources to prioritize QAPI program activities, □ An initial applicant would still be expected to provide evidence of implementing improvement actions based on selected indicators from outside sources.
PI.11.01.01, EP 3: The hospital conducts performance improvement projects as part of its quality assessment and performance improvement program. The number and scope of distinct improvement projects conducted annually is proportional to the scope and complexity of the hospital's services and operations. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital may, as one of its projects, develop and implement an information technology system explicitly designed to improve patient safety and quality of care. In the initial stage of development, this project, does not need to demonstrate measurable improvement in indicators related to health outcomes. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital is not	**Performance Improvement Projects §482.21(d) Standard: Performance Improvement Projects.** As part of its quality assessment and performance improvement program, the hospital must conduct performance improvement projects.[6] (1) The number and scope of distinct improvement projects conducted annually must be proportional to the scope and complexity of the hospital's services and operations. (2) A hospital may, as one of its projects, develop and implement an information technology system explicitly designed to improve patient safety and quality of care. This project, in its initial stage of development, does not need to demonstrate	**Document Review** **General** □ Ask QAPI leader and staff to provide a list of distinct performance improvement projects it is currently conducting and has conducted within the last three years to verify that the hospital is conducting annual QAPI projects. □ Ask to see documentation showing why each project was conducted and evidence to support the progress being made on each project. **Interview** □ Ask the governing body or responsible leaders to explain how the selection (number and scope) of the specific projects is in alignment with the hospital's complexity and the scope of services it provides. o Consider the size of the facility and the intensity of its services, such as critical care services/units, complex surgeries, transplant services,

[6] Performance improvement **projects** are differentiated from performance improvement **activities** under 482.21(b)(2) in that ***performance improvement projects require a significant amount of up-front planning, include project objectives, and have a definitive beginning and end date (time-limited).*** Whereas ***performance improvement activities make up the continuous, ongoing functions of a hospital QAPI program, such as ongoing tracking of medical errors and adverse events, analysis of data, implementation of changes with associated education and training, continuous monitoring of quality and safety in all hospital departments and service areas, etc.***

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required to participate in a quality improvement organization cooperative project, but its own projects are required to be of comparable effort. **PI.12.01.01, EP 2:** The hospital documents what quality improvement projects it is conducting, the reasons for conducting these projects, and the measurable progress achieved on these projects. **PI.14.01.01, EP 1:** The hospital acts on improvement priorities.	measurable improvement in indicators related to health outcomes. (3) The hospital must document what quality improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects. (4) A hospital is not required to participate in a QIO cooperative project, but its own projects are required to be of comparable effort.	maternal/child health services, and oncology services, including radiation and chemotherapy.
LD.12.01.01, EP 3: The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for the following: - An ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained - The hospitalwide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated - Clear expectations for safety are established - Adequate resources are allocated for measuring, assessing, improving, and sustaining the hospital's performance and reducing risk to patients - The determination of the number of	**Executive Responsibilities** **§482.21(e) Standard: Executive Responsibilities** The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: (1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained. (2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety and that all improvement actions are evaluated… (5) That the determination of the number of distinct improvement projects is conducted annually.	**Interview** □ Ask staff if they are aware of the hospital's expectations for safety and how they learned about these. o Do they know their roles and responsibilities in quality assessment and performance improvement? **Document Review** **General** □ Ask to see **evidence** that the governing body, hospital CEO, medical staff (or its executive committee), and other administrative officials are **providing oversight** for the QAPI program. o Are there QAPI **meeting minutes** that document their attendance? o Do the governing body **meeting agendas** provide evidence that the QAPI program has been addressed?

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distinct improvement projects is conducted annually **PI.14.01.01, EP 1:** The hospital acts on improvement priorities.		○ Do the governing body meeting minutes include evidence of QAPI discussions? ○ Are there documents such as annual QAPI program reviews that include signatures from the governing body? □ Ask to see **evidence** that the governing body, medical staff (or its executive committee), and administrative officials do the following: ○ Approve the number of distinct QAPI projects to be conducted annually. ○ Review the results of QAPI data collection, analyses, activities, and projects and make decisions based on such review. □ For those services the hospital provides under arrangement or contract, ask to see **evidence that the contractor is actively involved in the QAPI program.** ○ Do the governing body, medical staff, and administrative officials periodically receive and review **quality data from the contractor**? ○ Is the contracted service involved in any current or past hospital QAPI projects? ○ Does the contract or agreement include the hospital's expectations regarding the **contractor's roles and responsibilities for QAPI**? ○ Does the data from the contractor demonstrate positive outcomes related to the services provided?

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		Observation □ Look for evidence of communications and reminders to staff about safety expectations.
LD.12.01.01, EP 3: The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for the following: - An ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained - The hospitalwide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated - Clear expectations for safety are established - Adequate resources are allocated for measuring, assessing, improving, and sustaining the hospital's performance and reducing risk to patients - The determination of the number of distinct improvement projects is conducted annually	**Providing Adequate Resources** **§482.21(e) Standard: Executive Responsibilities** [§482.21(e) The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following:] (4) That adequate resources are allocated for measuring, assessing, improving, and sustaining the hospital's performance and reducing risk to patients.	**Document Review** **General** □ Ask QAPI leader and staff to see detailed evidence of the resources (for example, staff, staff time, education, information systems) that are provided to support required QAPI functions. □ For QAPI services provided under contract, ask to see evidence that contracted services have been incorporated into the QAPI program and that there is governing body oversight of these services and the QAPI program. **Personnel/Credential File** □ Ask to see evidence that staff are qualified to engage in their respective QAPI responsibilities. o Have all staff been educated and trained on how to report errors and adverse events? o Have staff who are required to conduct data collection and analysis received training or possess experience in these functions?
LD.11.01.01, EP 9: For hospitals that use Joint Commission accreditation for deemed status purposes: If a hospital is part of a system consisting of multiple separately certified hospitals using a system governing body that is legally responsible for the conduct of two or	**§482.21(f) Standard: Unified and integrated QAPI program for multi-hospital systems.** If a hospital is part of a hospital system consisting of multiple separately certified hospitals using a system governing body that is legally responsible for the conduct of two	**Document Review** **General** *If the hospital is part of a multihospital system:* □ Ask if there are any descriptions of the unified and integrated QAPI program.

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
more hospitals, the system governing body can elect to have a unified and integrated quality assessment and performance improvement program for all of its member hospitals after determining that such decision is in accordance with all applicable state and local laws. Each separately certified 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 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 hospitals are duly considered and addressed Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The system governing body is responsible and accountable for making certain that each of its separately certified hospitals meets the requirements for quality assessment and performance improvement at 42 CFR 482.21.	or more hospitals, the system governing body can elect to have a unified and integrated QAPI program for all of its member hospitals 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 hospitals meets all of the requirements of this section. Each separately certified hospital subject to the system governing body must demonstrate that: §482.21(f)(1) The unified and integrated QAPI program is established in a manner that takes into account each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital; and §482.21(f)(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 hospitals, 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 hospitals are duly considered and addressed.	○ Does the program include governing body expectations for each certified hospital? ○ Does it take into account each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital? □ Ask to see policies and procedures that guide the unified and integrated QAPI program to ensure that the following requirements are met: ○ The needs and concerns of each separately certified hospital, regardless of practice or location, are given due consideration. ○ The unified and integrated QAPI program has procedures in place to ensure that issues localized to particular hospitals are duly considered and addressed. □ Ask to see reports provided to the governing body about QAPI performance. ○ Do such reports reveal the performance of each certified hospital? Interview *If the hospital is part of a multihospital system:* □ Ask staff if their system governing body has elected to have a unified and integrated QAPI program. ○ Did the system check state and local laws to determine if a unified program was acceptable? □ Ask leaders and QAPI staff at each individual hospital how they participate in the unified and integrated program and if it addresses their unique circumstances.

Hospital Medical Staff Evaluation Module (482.22) including Psychiatric Special Staff Requirements (482.62) (b)

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
MS.16.01.01, EP 1: The hospital has an organized medical staff that operates under bylaws approved by the governing body and that is responsible for the quality of medical care provided by the hospital.	**§482.22 Condition of participation: Medical Staff.** The hospital has an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital.	**Interview** Leaders (senior leaders and medical staff leader(s)) to confirm there is one medical staff for the entire hospital (including all campuses, provider-based locations, satellites, remote locations, etc.) The organized medical staff is responsible for the quality of medical care provided to patients by the hospital. **Note:** If this is a hospital system, it can have a unified and integrated medical staff ("unified medical staff") for multiple, separately certified hospitals. The medical staff is organized and integrated as one body that operates under one set of bylaws approved by the governing body. These medical staff bylaws apply equally to all practitioners within each category of practitioners at all locations of the hospital and to the care provided at all locations of the hospital.
MS.14.01.01, EP 2: The medical staff bylaws include the qualifications for appointment and reappointment to the medical staff. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff is composed of doctors of medicine or osteopathy. In accordance with state law, including scope of practice laws, the medical staff may also include other categories of physicians as listed at 42 CFR 482.12(c)(1) and other licensed practitioners who the governing body determines are eligible for appointment. Note 2: Gender, race, creed, and national origin are not used in making decisions	**§482.22(a) Standard: Eligibility and process for appointment to medical staff.** The medical staff must be composed of Doctors of Medicine or osteopathy. In accordance with State law, including scope-of-practice laws, the medical staff may also include other categories of physicians (as listed at § 482.12(c)(1)) and non-physician practitioners who are determined to be eligible for appointment by the governing body.	**Interview** ☐ Who can be members of the medical staff or who may be granted medical staff privileges (MDs, DOs, other licensed practitioners such as CRNA, APPs?). ☐ Does state law include other licensed practitioners such as PT/OT/SLT ☐ If the hospital grants medical staff privileges and/or membership to physicians who are not MDs/DOs, ask about the process the used to ensure that any privileges granted are consistent with state law. ☐ What is the oversight process for non-physician practitioners? **Document Review** **General** ☐ Determine whether the documentation of the categories of practitioners who are members of

regarding the granting or denying of medical staff membership.		the medical staff supports the description of categories of practitioners who are members of the medical staff or who may be granted medical staff privileges. - Determine if documentation supports the process described to ensure that any privileges granted are consistent with state law.
MS.18.02.03, EP 1: The medical staff's ongoing professional practice evaluation includes a clearly defined process that facilitates the periodic evaluation of each physician's or other licensed practitioner's professional practice. Note: Privileges are granted for a period not to exceed three years or for the period required by law and regulation if shorter.	**§482.22(a)(1)** The medical staff must periodically conduct appraisals of its members.	**Interview** The medical staff appraises the qualifications of all practitioners appointed to the medical staff/who have medical staff privileges at regular intervals. If there are no timeframes established by State Law, CMS recommends an appraisal is conducted for each practitioner at least every 24 months to determine the suitability of continuing medical staff membership or continuation of privileges. **Note: The Joint Commission requirements are every 3 years.**
MS.17.01.03, EP 4: The medical staff examines the credentials of all candidates eligible for medical staff membership and makes recommendations to the governing body on the appointment of these candidates in accordance with state law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations. A candidate who has been recommended by the medical staff and who has been appointed by the governing body is subject to all medical staff bylaws, rules, and regulations. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: A candidate who has been recommended by the medical staff and who	**§482.22(a)(2)** The medical staff must examine the credentials of all eligible candidates for medical staff membership and make recommendations to the governing body on the appointment of these candidates in accordance with State law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations. A candidate who has been recommended by the medical staff and who has been appointed by the governing body is subject to all medical staff bylaws, rules, and regulations, in addition to the requirements contained in this section.	**Interview** - The medical staff leaders about methods used to ensure that all medical staff members and nonmember practitioners who hold privileges adhere to the medical staff bylaws, rules, and regulations and are afforded the protections and due process rights provided for under the bylaws, rules, and regulations. Ask for specific examples of actions taken. - The practitioners how they are made aware of their rights and responsibilities with respect to medical staff bylaws, rules, and regulations. How are they informed that they've been granted (or denied) privileges - Ask medical staff how they conduct periodic appraisals of any current member of the medical staff who has not provided patient care at the hospital or who has not provided care for which they are privileged to patients at the hospital

has been appointed by the governing body is also subject to 42 CFR 482.22(a).		during the appropriate evaluation time frames. Is this method in accordance with state law and the hospital's written criteria for medical staff membership and granting privileges? - How are constraints such as limitations or revoking privileges reported to appropriate state and federal authorities, registries, and/or databases (such as NPDB)? **Document Review** **General:** - Verify that the medical staff bylaws identify the process and criteria to be used for the periodic appraisal and how often reappraisals occur. - Determine what criteria is used to reappraise each of the current medical staff members and their qualifications – do they comply with CoPs, state law, bylaws, rules and regulations? - Determine whether the medical staff has a system to ensure that practitioners seek approval to expand their privileges for tasks, activities, or procedures that go beyond the specified list of privileges for their category of practitioner. - Does each medical staff member have their own file? - Review meeting minutes - are recommendations for privileging decisions taken to the governing body? **General** - The medical staff bylaws identify the process and criteria to be used for the evaluation of candidates for medical staff membership/privileges. The criteria complies with CoPs, state law, bylaws, rules, and regulations - Determine there is a process to examine the following credentials when appointing/reappointing medical staff members:

		○ Request for clinical privileges ○ Evidence of current licensure ○ Evidence of training and professional education ○ Documented experience ○ Supporting references of competence ☐ There is a system to ensure that practitioners seek approval to expand their privileges for tasks/ activities/procedures that go beyond the specified list of privileges for their category of practitioner
MS.20.01.01, EP 1: When telemedicine services are furnished to the hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating 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 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 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	**§482.22(a)(3)** When telemedicine services are furnished to the hospital's patients through an agreement with a distant-site hospital, the governing body of the hospital whose patients are receiving the telemedicine services may choose, in lieu of the requirements in paragraphs (a)(1) and (a)(2) of this section, to have its medical staff rely upon the credentialing and privileging decisions made by the distant-site hospital when making recommendations on privileges for the individual distant-site physicians and practitioners providing such services, if the hospital's governing body ensures, through its written agreement with the distant-site hospital, that all of the following provisions are met: **§482.22(a)(3)(i)** The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. **§482.22(a)(3)(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	**Document Review** **General** If the hospital provides telemedicine services to its patients under an agreement with a distant-site hospital and has exercised the option to have medical staff rely on the credentialing and privileging decisions of the distant-site hospital in making privileging recommendations on telemedicine physicians and other licensed practitioners**:** ☐ Review the written agreement with the distant-site hospital. Does the agreement address the following? ○ Does the distant-site participate in the Medicare program? ○ Does the distant-site hospital provide a list of all physicians and practitioners covered under the agreement? Is the list current? ○ Does each physician or other licensed practitioner hold a license recognized by the state where originating hospital is located? Are they privileged for the services they are providing? ○ Does the originating hospital review the telemedicine services provided to its patients and provide feedback to the distant-site hospital for use in the provider's appraisal?

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 hospital whose patients are receiving the telemedicine services is located. - For distant-site physicians or other licensed practitioners privileged by the originating hospital, the originating 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 hospital's patients and complaints the hospital has received about the distant-site physician or other licensed practitioner. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: 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).	practitioner's privileges at the distant-site hospital. **§482.22(a)(3)(iii)** The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the hospital whose patients are receiving the telemedicine services is located. **§482.22(a)(3)(iv)** With respect to a distant-site physician or practitioner, who holds current privileges at the hospital whose patients are receiving the telemedicine services, the hospital 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 performance 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 hospital's patients and all complaints the hospital has received about the distant-site physician or practitioner.	
MS.20.01.01, EP 1: See above	**§482.22(a)(4)** When telemedicine services are furnished to the hospital's patients through an agreement with a distant-site telemedicine entity, the governing body of	**Interview** If the hospital has an agreement with one or more distant-site telemedicine entities to provide care to their patients via telemedicine:

	the hospital whose patients are receiving the telemedicine services may choose, in lieu of the requirements in paragraphs (a)(1) and (a)(2) of this section, to have its medical staff rely upon the credentialing and privileging decisions made by the distant-site telemedicine entity when making recommendations on privileges for the individual distant-site physicians and practitioners providing such services, if the hospital's governing body ensures, through its written agreement with the distant-site telemedicine entity, that the distant-site telemedicine entity furnishes services that, in accordance with § 482.12(e), permit the hospital to comply with all applicable conditions of participation for the contracted services. The hospital's governing body must also ensure, through its written agreement with the distant-site telemedicine entity, that all of the following provisions are met: **§482.22(a)(4)(i)** The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at § 482.12(a)(1) through (a)(7) and § 482.22(a)(1) through (a)(2). **§482.22(a)(4)(ii)** The individual distant-site physician or practitioner is privileged at the distant-site telemedicine entity providing the telemedicine services, which provides the hospital with a current list of the distant-site physician's or practitioner's privileges at the distant-site telemedicine entity. **§482.22(a)(4)(iii)** The individual distant-site physician or practitioner holds a license	☐ Has the hospital's governing body exercised the option to have the medical staff rely on the credentialing and privileging decisions of the distant-site telemedicine entity in making privileging recommendations on telemedicine physicians and practitioners? ○ If it has, how has the governing body verified that the telemedicine entity employs a credentialing and privileging process that meets or exceeds what is required for hospitals under the Medicare Conditions of Participation? **Note:** *Surveyors: Do not attempt to independently verify whether the distant-site telemedicine entity's credentialing and privileging process fulfills the regulatory requirements. Focus only on whether the hospital takes steps to ensure that the distant-site telemedicine entity complies with the terms of the written agreement.* **Document Review** **General** **If medical staff relies on the credentialing and privileging decisions of the distant-site entity:** ☐ Review the written agreement(s) with the distant-site telemedicine entity(ies). Does each agreement address the following? ○ Required elements concerning the distant-site telemedicine entity's use of a medical staff credentialing and privileging process that meets the requirements of the hospital's Conditions of Participation ○ Appropriate licensure of telemedicine physicians and practitioners ○ Current list of telemedicine physicians and practitioners specifying their privileges

	issued or recognized by the State in which the hospital whose patients are receiving such telemedicine services is located. **§482.22(a)(4)(iv)** With respect to a distant-site physician or practitioner, who holds current privileges at the hospital whose patients are receiving the telemedicine services, the hospital 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 performance 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 hospital's patients, and all complaints the hospital has received about the distant-site physician or practitioner.	○ Written hospital review of the telemedicine physicians' and practitioners' services and provision of information based on its review to the distant-site hospital ☐ Review the list provided by the distant-site telemedicine entity of the telemedicine physicians and practitioners covered by the agreement, including their current privileges and pertinent licensure information. ☐ Ensure that the hospital reviews the services provided by the telemedicine physicians and practitioners, including any adverse events and complaints, and provides written feedback to the distant-site telemedicine entity.
LD.11.02.01, EP 1: The hospital has an organized medical staff that is accountable to the governing body for the quality of care provided to patients. **LD.11.02.01, EP 2:** The governing body approves the structure of the organized medical staff. **MS.15.01.01, EP 3:** The majority of voting medical staff executive committee members are fully licensed doctors of medicine or osteopathy actively practicing in the hospital. Note: All members of the organized medical staff, of any discipline or specialty, are	**§482.22(b) Standard: Medical staff organization and accountability.** The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to patients. **§482.22(b)(1)** The medical staff must be organized in a manner approved by the governing body. **§482.22(b)(2)** If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy.	**Document Review** **General** ☐ Verify that the medical staff has a formal, organized structure reflected in the medical staff bylaws, rules, and regulations and that the functions and responsibilities of the medical staff and the governing body are reflected. ☐ Is the individual who leads the medical staff and is responsible for the organization and conduct of the medical staff a doctor of medicine or osteopathy (or if permitted by state law where the hospital is located, a doctor of dental surgery, dental medicine, or podiatric medicine)? ☐ If there is a medical staff executive committee, are the majority of the members doctors of medicine or osteopathy?

eligible for membership on the medical staff executive committee.		
LD.11.02.01, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy, or, if permitted by state law, a doctor of dental surgery or dental medicine, or a doctor of podiatric medicine is responsible for the organization and conduct of the medical staff.	**§482.22(b)(3)** The responsibility for organization and conduct of the medical staff must be assigned only to one of the following: **§482.22(b)(3)(i)** An individual doctor of medicine or osteopathy. **§482.22(b)(3)(ii)** A doctor of dental surgery or dental medicine, when permitted by State law of the State in which the hospital is located. **§482.22(b)(3)(iii)** A doctor of podiatric medicine, when permitted by State law of the State in which the hospital is located.	**Interview** ☐ The CEO and medical staff leaders to describe the mechanisms by which the medical staff fulfills its responsibility to be accountable for the quality of medical care in the hospital. ☐ Interview several members of the medical staff, including both practitioners who hold leadership or executive committee positions and ones who do not. Ask what their medical staff duties and responsibilities are and how they perform them. Ask them to describe how the medical staff is accountable for the quality of medical care provided to patients.
MS.14.03.01, EP 1: For hospitals that use Joint Commission accreditation for deemed status purposes: If a multihospital system with separately accredited hospitals chooses to establish a unified and integrated medical staff, in accordance with state and local laws, the following occurs: Each separately accredited hospital within a multihospital system that elects to have a unified and integrated medical staff demonstrates that the medical staff members of each hospital (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	**§482.22(b)(4)** If a hospital is part of a hospital system consisting of multiple separately certified hospitals and the system elects to have a unified and integrated medical staff for its member hospitals, after determining that such a decision is in accordance with all applicable State and local laws, each separately certified hospital must demonstrate that: **§482.22(b)(4)(i)** The medical staff members of each separately certified hospital in the system (that is, all medical staff members who hold specific privileges to practice at that hospital) have voted by majority, in	**Interview** ☐ Ask hospital and medical staff leaders if the hospital is part of a multihospital system of separately certified hospitals. ☐ If yes, ask if the hospital also shares its governing body and medical staff with one or more other separately certified hospitals in the system. ☐ If the hospital shares its governing body and medical staff with one or more separately certified hospitals in the system, ask the following questions: ☐ Does the use of the unified medical staff predate July 11, 2014? If yes, ask for

unified and integrated medical staff structure or to opt out of such a structure and maintain a separate and distinct medical staff for their hospital.	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 hospital;	documentation of the governing body's determination that use of a unified medical staff does not conflict with state or local law. - Did the use of the unified medical staff start after July 11, 2014? **Interview** - Ask the hospital and members of the medical staff whether there has ever been a vote on the question of opting out of using a unified medical staff. If yes, ask them to produce evidence that a majority of the practitioners holding privileges at the hospital voted against opting out. - Can the hospital readily identify the medical staff members who are eligible to vote on whether to accept or to opt out of a unified medical staff? **Document Review** **General** - If the unified medical staff started after July 11, 2014, verify that the hospital has documentation of the governing body's decision to elect use of a unified medical staff and of its determination that use of a unified medical staff does not conflict with state or local law. - If the hospital began using a unified medical staff after July 11, 2014, verify that there is documentation that, at the time of the vote, the majority of the medical staff holding privileges at the hospital voted in accordance with medical staff bylaws to accept using a unified medical staff. - Do the medical staff bylaws clearly describe a process by which a vote to opt out of using a unified medical staff may be requested and conducted? - Determine if there are restrictions or limitations on the rights of medical staff members to vote on whether to accept or opt out of a unified medical staff.

MS.14.03.01, EP 4: For hospitals that use Joint Commission accreditation for deemed status purposes: When a multihospital system has a unified and integrated medical staff, the medical staff bylaws include the following requirements: A 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 hospital.	**§482.22(b)(4)(ii)** 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 hospital (that is, all medical staff members who hold specific privileges to practice at that hospital) 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 hospital;	**Interview** ☐ Ask how the unified medical staff bylaws define a "majority" for the purpose of an opt-out vote of using a unified medical staff. If the bylaws require a supermajority, ask for evidence that this is consistent with the way "majority" is defined for other amendments to the bylaws. ☐ Interview several members of the medical staff to determine if they recall being notified of their right to vote by majority to opt out of using a unified medical staff. **Document Review** **General** ☐ Determine if the unified medical staff bylaws, rules, or requirements clearly describe how and when voting members holding privileges at the hospital are advised of their rights. **Personnel/Credential File** ☐ Review a sample of credentialing and privileging files of members of the medical staff for evidence of their being notified of their right to vote by majority to opt out of using a unified medical staff.
MS.14.03.01, EP 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If a multihospital system with separately accredited hospitals chooses to establish a unified and integrated medical staff, the following occurs: The unified and integrated medical staff takes into account each member hospital's unique circumstances and any significant	**§482.22(b)(4)(iii)** The unified and integrated medical staff is established in a manner that takes into account each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital; and	**Interview** ☐ Ask hospital and medical staff leaders to describe the other types of hospitals in the system with which it shares a unified medical staff. How are the hospital's unique circumstances addressed? ☐ Ask leaders how the unified medical staff ensures the following: o Standing orders it has approved are also approved by nursing and pharmacy leaders in each separately certified hospitals. o Policies and procedures developed by the medical staff to minimize drug errors, if not

differences in patient populations and services offered in each hospital.		delegated to the hospital's pharmaceutical service, take into account any unique hospital circumstances. ○ The formulary system established by the medical staff takes into account any unique hospital circumstances. ○ The medical staff's specification of procedures and treatments requiring a properly executed informed consent reflects any unique hospital circumstances. ○ The medical staff carries out its joint responsibility with the CEO and director of nursing for ensuring that hospital-specific infection control problems identified by the hospital's infection prevention and control officer(s) are addressed in the hospital's quality assurance/performance improvement (QAPI) and training programs. ○ The medical staff fulfills its joint executive responsibilities, along with the hospital's governing body and administrative officials, for ensuring that the hospital-specific QAPI program is ongoing, defined, implemented, and maintained; addresses hospital-specific priorities for improved quality of care and patient safety; establishes clear expectations for safety in the hospital; allocates adequate resources for the hospital-specific QAPI program; and determines annually the number of distinct improvement projects conducted in the hospital. ○ Medical staff policies governing the ordering of outpatient services address any unique hospital circumstances. ○ Medical staff policies and recommendations governing which practitioners may be authorized to write orders and be responsible for the care of the patient conform to state law,

		including scope of practice law, for the state in which the hospital is located.
MS.14.03.01, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: If a multihospital system with separately accredited hospitals chooses to establish a unified and integrated medical staff, the following occurs: The unified and integrated medical staff establishes and implements policies and procedures and mechanisms to make certain that the needs and concerns expressed by members of the medical staff at each of its separately accredited hospitals, regardless of practice or location, are duly considered and addressed.	**§482.22(b)(4)(iv)** 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, 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 are duly considered and addressed.	**Interview** ☐ Ask the hospital and medical staff leaders whether any members practicing at the hospital have raised concerns or needs. If yes, ask for documentation showing how the concern or need was considered and addressed by the unified medical staff. ☐ Ask members of the medical staff if they are aware that they can raise local concerns or needs with leaders of the unified medical staff. **Document Review** **General** ☐ Verify that the unified medical staff has policies and procedures addressing how members can raise local concerns and needs. Do the policies and procedures cover the following: ○ The process for raising their local concerns and needs with the unified medical staff's leadership; ○ How members are informed of the process by which they can raise their local concerns and needs; ○ The process for referring the concerns and needs raised to the appropriate committee or other group within the medical staff for due consideration; and ○ The process for documenting the outcome of the medical staff's review of the concerns and needs raised.
MS.14.01.01, EP 1: The organized medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following:	**§482.22(c) Standard: Medical staff bylaws.** The medical staff must adopt and enforce bylaws to carry out its responsibilities. The bylaws must:	**Document Review** **General** ☐ Verify that the medical staff has bylaws that comply with Conditions of Participation and state law.

- Statement of the duties and privileges of each category of medical staff (for example, active, courtesy) - Description of the organization of the medical staff, including those members who are eligible to vote - Description of the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body - Criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges, including the process for reprivileging physicians and other licensed practitioners - Process for credentialing and recredentialing physicians and other licensed practitioners - List of all the officer positions for the medical staff - Process by which the organized medical staff selects and/or elects and removes the medical staff officers - Process for adopting and amending the medical staff bylaws, medical staff rules and regulations, and policies - The qualifications and roles and responsibilities of the department chair, when applicable Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the hospital are also subject to the requirements in 42 CFR 482.12(a)(8) and (a)(9), and 42 CFR 482.22(a)(3) and (a)(4).	**§482.22(c)(1)** Be approved by the governing body. **§482.22(c)(2)** Include a statement of the duties and privileges of each category of medical staff (e.g., active, courtesy, etc.) **§482.22(c)(3)** Describe the organization of the medical staff. **§482.22(c)(4)** Describe the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body.	☐ Verify that the bylaws describe a mechanism for ensuring enforcement of its provisions along with rules and regulations of the hospital. ☐ Verify that the medical staff enforces the bylaws. ☐ Verify that medical staff bylaws have been approved by the medical staff and governing body. ☐ Determine whether the medical staff bylaws specify the duties and scope of medical staff privileges for each category of practitioner eligible for medical staff membership or privileges. ☐ Verify that the medical staff bylaws specify the organization and structure of the medical staff and a mechanism that delineates accountability to the governing body. ☐ Verify that the bylaws describe who is responsible for regularly scheduled review and evaluation of the clinical work of medical staff members and the formation of medical staff leadership. ○ Are the rules and regulations clear as to acceptable standards of patient care for all diagnostic, medical, surgical, and rehabilitative services? **Document Review** **General** ☐ Verify that the hospital has written criteria for appointments to the medical staff and granting of medical staff privileges. ☐ Verify that the granting of medical staff membership or privileges is based on an individual practitioner meeting the medical staff's membership or privileging criteria. ☐ Verify that, at a minimum, criteria for appointment to the medical staff or granting of medical staff privileges are individual character, competence, training, experience, and judgment. ☐ Verify that the written criteria for appointment to the medical staff and granting of medical staff privileges are not dependent solely on certification,

		fellowship, or membership in a specialty body or society.
MS.14.01.01, EP 3: The medical staff bylaws include requirements for the following: - Medical history and physical examination for each patient as described in PC.11.02.01, EP 2 - Updated examinations of patients as described in PC.11.02.01, EP 3 - Assessments in lieu of history and physician examinations of patients as described in PC.11.02.01, EP 4 Note: The medical history and physical examination are completed and documented by a physician (as defined in section 1861(r) of the Social Security Act), an oral and maxillofacial surgeon, or other qualified licensed practitioner in accordance with state law and hospital policy.	**§482.22(c)(5)** Include a requirement that— **§482.22(c)(5)(i)** A medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, and except as provided under paragraph (c)(5)(iii) of this section. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oral and maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.	**Document Review** **General** ☐ Review medical staff bylaws to determine whether they require that a physical examination and medical history (H&P) be done for each patient no more than 30 days before or 24 hours after admission or registration by a physician, an oral and maxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy. Verify that the bylaws require the H&P to be completed prior to surgery or a procedure requiring anesthesia services. ☐ Review the hospital's policy, if any, to determine if other qualified licensed individuals are permitted to conduct H&Ps to ensure that it is consistent with the state's scope of practice law or regulation. **Personnel/Credential File** ☐ Verify that nonphysicians who perform H&Ps within the hospital are qualified and have been credentialed and privileged in accordance with the hospital's policy. **Patient Health Record** ☐ Review a sample of inpatient and outpatient medical records that include a variety of patient populations undergoing both surgical and nonsurgical procedures to verify that the following: o There is an H&P that was completed no more than 30 days before or 24 hours after admission or registration but, in all cases, prior to surgery or a procedure requiring anesthesia services, except when an assessment is completed and documented pursuant to §482.22(c)(5)(iii). o The H&P was performed by a physician, an oral and maxillofacial surgeon, or other qualified licensed individual authorized in accordance with state law.

MS.14.01.01, EP 3: See above	**§482.22(c)(5)(ii)** An updated examination of the patient, including any changes in the patient's condition, be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration, and except as provided under paragraph (c)(5)(iii) of this section. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oral and maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.	**Document Review** **General** ☐ Review medical staff bylaws to ensure that they include provisions requiring that, when the H&P was completed within 30 days before admission or registration, an updated medical record entry documenting an examination for changes in the patient's condition was completed and documented in the patient's medical record within 24 hours after admission or registration. ☐ Determine whether the bylaws require that, in all cases involving surgery or a procedure requiring anesthesia services, the update to the H&P must be completed and documented prior to the surgery or procedure. **Document Review** **Patient Health Record** ☐ Review a sample of health records in which the H&P was completed within 30 days before admission or registration. Verify that an updated medical record entry documenting an examination for any changes in the patient's condition was completed and documented in the patient's health record within 24 hours after admission or registration. Verify that, in all cases involving surgery or a procedure requiring anesthesia services, the update was completed and documented prior to the surgery or procedure.
MS.14.01.01, EP 3: See above	**§482.22(c)(5)(iii)** An assessment of the patient (in lieu of the requirements of paragraphs (c)(5)(i) and (ii) of this section) be completed and documented after registration, but prior to surgery or a procedure requiring anesthesia services, when the patient is receiving specific outpatient surgical or procedural services and when the medical staff has chosen to	**Document Review** **General** ☐ Review medical staff bylaws to ensure that they include provisions requiring that allow for an assessment in lieu of an H&P being completed within 30 days before admission or registration, but prior to surgery or a procedure requiring anesthesia services when the patient is receiving specific outpatient surgical or procedural services.

	develop and maintain a policy that identifies, in accordance with the requirements at paragraph (c)(5)(v) of this section, specific patients as not requiring a comprehensive medical history and physical examination, or any update to it, prior to specific outpatient surgical or procedural services. The assessment must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oral and maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.	☐ Determine that there is a policy for the types of patients that do not require a comprehensive medical history and physical (or update to it) prior to specific outpatient surgical or procedural services. **Patient Health Record** ☐ Review a sample of health records in which an assessment was performed in lieu of an H&P. Verify that the type of surgery or procedure is one identified as meeting this criteria. ☐ Verify that the assessment was completed and documented by a physician, an oral and maxillofacial surgeon, or other qualified licensed practitioner in accordance with state law and hospital policy.
MS.16.01.01, EP 10: If the medical staff chooses to develop and maintain a policy for the identification of specific patients to whom the assessment requirements would apply, in lieu of a comprehensive medical history and physical examination, the policy is based on the following: - Patient age, diagnoses, the type and number of surgeries and procedures scheduled to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure - Nationally recognized guidelines and standards of practice for assessment of particular types of patients prior to specific outpatient surgeries and procedures - Applicable state and local health and safety laws The hospital demonstrates evidence that the policy applies only to those patients receiving specific outpatient surgical or procedural services.	**§482.22(c)(5)(iv)** The medical staff develop and maintain a policy that identifies those patients for whom the assessment requirements of paragraph (c)(5)(iii) of this section would apply. The provisions of paragraphs (c)(5)(iii), (iv), and (v) of this section do not apply to a medical staff that chooses to maintain a policy that adheres to the requirements of paragraphs of (c)(5)(i) and (ii) of this section for all patients. **§482.22(c)(5)(v)** The medical staff, if it chooses to develop and maintain a policy for the identification of specific patients to whom the assessment requirements in paragraph (c)(5)(iii) of this section would apply, must demonstrate evidence that the policy applies only to those patients receiving specific outpatient surgical or procedural services as well as evidence that the policy is based on:	**Document Review** **General** ☐ Determine that there is a policy for the types of patients that do not require a comprehensive medical history and physical (or update to it) prior to specific outpatient surgical or procedural services. ☐ Is this policy based on the following: ○ Patient age, diagnoses, the type and number of surgeries and procedures scheduled to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure; ○ Nationally recognized guidelines and standards of practice for assessment of specific types of patients prior to specific outpatient surgeries and procedures; and ○ Applicable state and local health and safety laws

Note: For hospitals that use Joint Commission accreditation for deemed status purposes: For law and regulation guidance pertaining to the medical history and physical examination at 482.22(c)(5)(iii), refer to https://www.ecfr.gov/.	**§482.22(c)(5)(v)(A)** Patient age, diagnoses, the type and number of surgeries and procedures scheduled to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure. **§482.22(c)(5)(v)(B)** Nationally recognized guidelines and standards of practice for assessment of specific types of patients prior to specific outpatient surgeries and procedures. **§482.22(c)(5)(v)(C)** Applicable state and local health and safety laws.	**Patient Health Record** ☐ Review a sample of health records in which an assessment was performed in lieu of an H&P. Verify that the type of surgery or procedure is one identified as meeting this criteria. ☐ Verify that the assessment was completed and documented by a physician, an oral and maxillofacial surgeon, or other qualified licensed practitioner in accordance with state law and hospital policy.
MS.14.01.01, EP 1: The organized medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following: - Statement of the duties and privileges of each category of medical staff (for example, active, courtesy) - Description of the organization of the medical staff, including those members who are eligible to vote - Description of the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body - Criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges, including the process for reprivileging physicians and other licensed practitioners - Process for credentialing and recredentialing physicians and other licensed practitioners	**§482.22(c)(6)** Include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges. For distant-site physicians and practitioners requesting privileges to furnish telemedicine services under an agreement with the hospital, the criteria for determining privileges and the procedure for applying the criteria are also subject to the requirements in § 482.12(a)(8) and (a)(9), and § 482.22(a)(3) and (a)(4).	**Document Review** **General** ☐ Review medical staff bylaws to ensure that they include criteria for determining the privileges to be granted to individual practitioners and the procedure for applying the criteria to individuals requesting privileges. ☐ What are the hospital's criteria for determining privileges for distant-site physicians and other licensed practitioners? If hospital's governing body has opted to have the medical staff rely on the credentialing and privileging decisions of the distant-site hospital or telemedicine entity, verify that the bylaws include a provision permitting such reliance. ☐ Verify that physicians and practitioners who provide care to patients are working within the scope of the privileges granted by the governing body.

- List of all the officer positions for the medical staff - Process by which the organized medical staff selects and/or elects and removes the medical staff officers - Process for adopting and amending the medical staff bylaws, medical staff rules and regulations, and policies - The qualifications and roles and responsibilities of the department chair, when applicable Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the hospital are also subject to the requirements in 42 CFR 482.12(a)(8) and (a)(9), and 42 CFR 482.22(a)(3) and (a)(4).		
Psychiatric Hospital	**Director of Inpatient Psychiatric Services**	
MS.17.01.03, EP 6: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: 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. The number and qualifications of doctors of medicine and osteopathy are adequate to provide essential psychiatric services.	**§482.62(b) Standard: 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.	**Interview** ☐ Just prior to the end of the survey, schedule a meeting with the clinical director. By the time of this meeting, you should already have conducted required observation, interviews, and document reviews for at least a majority of the patients in the sample. Collect any additional information necessary to consider in light of outcomes observed for patients, including the qualifications of the clinical director, the leadership exhibited for the scope of psychiatric/medical treatment programs needed by patients, and the rationale for medical staff coverage. If necessary, follow up on letters of complaint previously reported serious problems, discrepancies with Data Collection Medical Staff Coverage (CMS-729). **Interview:**

		☐ How many staff are board certified? Fully trained? How many full-time vs. part-time specialties are represented? Is this number adequate to provide services? ☐ How are medical staff deployed? To what programs or units are they assigned? Why? ☐ How much time do physicians spend on units? Based on observations, interviews, and medical record reviews, is coverage adequate to meet the needs of sampled patients? To meet the needs of other patients observed during the survey?
MS.17.01.03, EP 6: See above	§482.62(b)(1) 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.	**Document Review** **General** ☐ Determine if the clinical director has one of the following: ○ Certification of the American Board of Psychiatry and Neurology and/or certification of the American Osteopathic Board of Neurology and Psychiatry ○ If no certification, evidence that the person has the training and equivalency to be admitted to the board examination ○ If indicated, medical school and residency training ○ Length of time employed at the facility ○ Length of time at the position **Note:** *To be admitted to American Board Examinations, the following conditions must be met:* *1. License without restrictions* *2. Graduation from a medical school approved by either the Medical Osteopathic Association or the American Medical Association.* *3. A successful completion of an approved residency training program for at least 3 years before 1988 that the America Council on Graduate Medical Education (ACGME) approves. After 1988, it has to be a four-year accredited program.*

MS.16.01.01, EP 8: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: 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.	**§482.62(b)(2)** The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.	**Interview** ☐ The clinical director about mechanisms they use to monitor and evaluate the work of the medical staff (for example, personal interviews, quality improvement reports, incident reports). ○ When problems are discovered by the clinical director, how are they corrected? ○ Are services, notes, and reports timely? ○ Are medications used appropriately for the patient's diagnosis?

Hospital Nursing Services Evaluation Module (482.23)

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LD.13.03.01, EP 2: The hospital has an organized nursing service, with a plan of administrative authority and delineation of responsibility for patient care, that provides 24-hour nursing services. Note: For hospitals that use The Joint Commission for deemed-status purposes: Rural hospitals with a 24-hour nursing waiver granted under 42 CFR 488.54(c) are not required to have 24-hour nursing services. **NPG.12.02.01, EP 4:** A registered nurse directly provides or supervises the nursing services provided by other staff to patients 24 hours a day, 7 days a week. The hospital has a licensed practical nurse or registered nurse on duty at all times. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: A registered nurse is immediately available for the provision of care of any patient. Note 2: For hospitals that use The Joint Commission for deemed-status purposes: Rural hospitals with a 24-hour nursing waiver granted under 42 CFR 488.54(c) are not required to have 24-hour nursing services.	**§482.23 Condition of Participation: Nursing Services** The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.	**Interview** ☐ Interview patients about the delivery of nursing services. **Document Review** **General** ☐ Review quality assurance/performance improvement (QAPI) meeting minutes to determine if the nursing services are integrated into the hospitalwide QAPI program. ☐ Verify that the hospital has an organizational chart(s) for nursing services for all locations where the hospital provides nursing services. ☐ Verify that the hospital has job descriptions for all nursing personnel, including a description for the director. ☐ Review nursing care plans, medical records, accident and investigative reports, staffing schedules (to ensure that there is a registered nurse supervising the service 24 hours a day, 7 days a week), nursing policies and procedures, and QAPI activities and reports. **Observation** ☐ Select at least one patient from every inpatient care unit. Observe the nursing care in progress to determine the adequacy of staffing and assess the delivery of care.
LD.13.03.01, EP 2: The hospital has an organized nursing service, with a plan of administrative authority and delineation of responsibility for patient care, that provides 24-hour nursing services. Note: For hospitals that use The Joint Commission for deemed-status purposes:	**§482.23(a) Standard: Organization** The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service,	**Document Review** **General** ☐ Verify that the hospital's organizational chart or plan for nursing services displays lines of

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Rural hospitals with a 24-hour nursing waiver granted under 42 CFR 488.54(c) are not required to have 24-hour nursing services. **NPG.12.02.01, EP 1:** The nurse executive, who is a licensed registered nurse, is responsible for the operation of nursing services including determining the following: - Nursing policies and procedures - Types and numbers of nursing and other staff necessary to provide nursing care for all areas of the hospital.	including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital.	authority that delegate responsibility within the department. **Credential/Personnel File Review** ☐ Review the position description for the director of nursing (DON) to determine that it delegates to the DON specific duties and responsibilities for nursing service operations. ☐ Verify that the DON is currently licensed in accordance with state licensure requirements. ☐ Verify that the DON is involved with or approved the development of the nursing service staffing policies and procedures. ☐ Verify that the DON approves the nursing service patient care policies and procedures.
NPG.12.02.01, EP 5: There must be an adequate number of licensed registered nurses, licensed practical (vocational) nurses, and other staff to provide nursing care to all patients, as needed. Note: There are supervisors and staff for each department or nursing unit to make certain a registered nurse is immediate availability for the care of any patient.	**§482.23(b) Standard: Staffing and Delivery of Care** The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for the care of any patient.	**Document Review** **General** ☐ Verify that written staffing schedules correlate to the number and acuity of patients. **Patient Health Record** ☐ Review a sample of health records to determine if patient care that is to be provided by nurses is being provided as ordered. **Observation** ☐ Verify that there is an RN physically present on the premises and on duty at all times. ☐ Verify that there is supervision of personnel performance and nursing care for each department or nursing unit. To determine if there are adequate numbers of nurses to provide nursing care to all patients as needed, take into consideration the following: o Physical layout and size of the hospital o Number of patients o Intensity of illness and nursing needs o Availability of nurses' aides and orderlies and other resources for nurses (for

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		example, housekeeping services, ward clerks) o Training and experience of personnel
LD.13.03.01, EP 2: The hospital has an organized nursing service, with a plan of administrative authority and delineation of responsibility for patient care, that provides 24-hour nursing services. Note: For hospitals that use The Joint Commission for deemed-status purposes: Rural hospitals with a 24-hour nursing waiver granted under 42 CFR 488.54(c) are not required to have 24-hour nursing services. **NPG.12.02.01, EP 4:** A registered nurse directly provides or supervises the nursing services provided by other staff to patients 24 hours a day, 7 days a week. The hospital has a licensed practical nurse or registered nurse on duty at all times. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: A registered nurse is immediately available for the provision of care of any patient. Note 2: For hospitals that use The Joint Commission for deemed-status purposes: Rural hospitals with a 24-hour nursing waiver granted under 42 CFR 488.54(c) are not required to have 24-hour nursing services.	**§482.23(b)(1)** The hospital must provide 24-hour nursing services furnished or supervised by a registered nurse and have a licensed practical nurse or registered nurse on duty at all times, except for rural hospitals that have in effect a 24-hour nursing waiver granted under §488.54(c)of this chapter.	**Document Review** **General** ☐ Review the nurse staffing schedule for a one-week period. If there are concerns regarding insufficient RN coverage, review the staffing schedules for another one-week period to determine if there is a pattern of insufficient coverage. ☐ Determine daily RN coverage for every unit of the hospital. ☐ Verify that there is at least one RN for each unit on each tour of duty, 7 days a week, 24 hours a day. **Note:** If the hospital has a temporary waiver of the 24-hour RN requirement in effect, refer to the SOM to determine the required verification and documentation requirements.
HR.11.01.03, EP 3: The hospital develops and implements a procedure to verify and document the following:	**482.23(b)(2)** The nursing service must have a procedure to ensure that hospital nursing personnel for whom licensure is required have valid and current licensure.	**Document Review** **General** ☐ Review the nursing service licensure verification policies and procedures. Is licensure verified for

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- Credentials of staff using the primary source when licensure, certification, or registration is required by federal, state, or local law and regulation. This is done at the time of hire and at the time credentials are renewed. - Credentials of staff (primary source not required) when licensure, certification, or registration is not required by law and regulation. This is done at the time of hire and at the time credentials are renewed. Note 1: It is acceptable to verify current licensure, certification, or registration with the primary source via a secure electronic communication or by telephone, if this verification is documented. Note 2: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source. Note 3: An external organization (for example, a credentials verification organization [CVO]) may be used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary. Note 4: The hospital determines the required qualifications for staff based on job responsibilities.		each individual nursing services staff person for whom licensure is required? **Personnel/Credential File** ☐ Review hospital personnel records or records kept by the nursing service to determine that RNs, licensed practical nurses (LPNs), and other nursing personnel for whom licensure is required have current valid licenses.
NR.11.01.01, EP 4: A registered nurse supervises and evaluates the nursing care for each patient.	**§482.23(b)(3)** A registered nurse must supervise and evaluate the nursing care for each patient.	**Document Review** **General** ☐ Review staffing schedules and assignments to ensure that an RN is assigned to supervise and

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
		evaluate the nursing care furnished to each patient.
PC.11.03.01, EP 1: The 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 care plan, which may be a part of an interdisciplinary care plan, for each patient. Note 2: The hospital evaluates the patient's progress and revises the plan of care based on the patient's progress. Note 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The patient's goals include both short- and long-term goals.	**§482.23(b)(4)** The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient that reflects the patient's goals and the nursing care to be provided to meet the patient's needs. The nursing care plan may be part of an interdisciplinary care plan.	**Document Review** **Patient Health Record** ☐ Review a sample (approximately 6 to 12) of nursing or interdisciplinary care plans. For each plan reviewed, verify the following with respect to the nursing care component: ○ Was the plan initiated as soon as possible after admission for each patient? ○ Does the plan describe and reflect patient goals as part of the patient's nursing care assessment and, as appropriate, physiological and psychosocial factors and patient discharge planning? ○ Is the plan consistent with the medical care plan of the practitioner responsible for the care of the patient? ○ Is there evidence of reassessment of the patient's nursing care needs and response to nursing interventions and, as applicable, revisions to the plan? ○ Was the plan implemented in a timely manner?
NR.11.01.01, EP 1: A registered nurse assigns the nursing care for each patient to other nursing staff in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available.	**§482.23(b)(5)** A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available.	**Interview** ☐ Ask a charge nurse what considerations are necessary when making staff assignments. Answers should include but are not limited to the following: ○ Patient needs ○ Complexity of patients ○ Any special needs of individual patients ○ Competence of nursing personnel ○ Qualifications of nursing personnel ○ Education of nursing personnel

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		○ Experience of nursing personnel **Document Review** **General** ☐ Verify that an RN made the nursing assignments. Did the assignments take into consideration the complexity of patient care needs and the competence and specialized qualifications of the nursing staff?
NR.11.01.01, EP 2: All licensed nurses who provide services in the hospital adhere to its policies and procedures. Note: This applies to all nursing staff providing services (that is, hospital employee, contract, lease, other agreement, or volunteer). **NR.11.01.01, EP 3:** The nurse executive provides for the supervision and evaluation of the clinical activities of all nursing staff in accordance with nursing policies and procedures. Note: This applies to all nursing staff who are providing services (that is, hospital employee, contract, lease, other agreement, or volunteer).	**§482.23(b)(6)** All licensed nurses who provide services in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of all nursing personnel which occur within the responsibility of the nursing services, regardless of the mechanism through which those personnel are providing services (that is, hospital employee, contract, lease, other agreement, or volunteer).	**Document Review** **General** ☐ Review the hospital's method for orienting all licensed nurses to hospital policies and procedures. The orientation should include at least the following: ○ Information on the hospital and unit ○ Emergency procedures ○ Nursing services policies and procedures ○ Safety policies and procedures. **Personnel/Credential File** ☐ Review orientation documentation to ensure that all nursing personnel are appropriately oriented prior to providing care. ☐ Confirm with the DON that the performance of all nurses is evaluated by the hospital at least once a year. If the performance evaluation is not considered confidential, review two evaluations.
NPG.12.02.01, EP 7: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has policies and procedures that establish which outpatient departments, if any, are not required to have a registered nurse present. The policies and procedures meet the following requirements: - Establish criteria that such outpatient	**§482.23(b)(7)** The hospital must have policies and procedures in place establishing which outpatient departments, if any, are not required under hospital policy to have a registered nurse present. The policies and procedures must:	**Document Review** **General** ☐ Review staffing plan for outpatient departments. ☐ If an RN is not needed for that particular outpatient department, review the alternative staffing plan that has been approved by the director of nursing and confirm that the policy has been reviewed at least once every 3 years.

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departments need to meet, taking into account the types of services delivered, the general level of acuity of patients served by the department, and established standards of practice for the services delivered - Describe alternative staffing plans - Are approved by the director of nursing - Are reviewed at least once every three years		
NPG.12.02.01, EP 7: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has policies and procedures that establish which outpatient departments, if any, are not required to have a registered nurse present. The policies and procedures meet the following requirements: - Establish criteria that such outpatient departments need to meet, taking into account the types of services delivered, the general level of acuity of patients served by the department, and established standards of practice for the services delivered - Describe alternative staffing plans - Are approved by the director of nursing - Are reviewed at least once every three years	§482.23(b)(7)(i) Establish the criteria such outpatient departments must meet, taking into account the types of services delivered, the general level of acuity of patients served by the department, and the established standards of practice for the services delivered; **§482.23(b)(7)(ii) Establish alternative staffing plans;** **§482.23(b)(7)(iii) Be approved by the director of nursing;** **§482.23(b)(7)(iv) Be reviewed at least once every 3 years.**	**Document Review** ☐ Validate policy and procedures for outpatient departments that do not require the presence of a registered nurse as described in **§482.23(b)(7)(i) – (iv).**
	§482.23(c) Standard: Preparation and administration of drugs.	
MM.16.01.01, EP 1: Drugs and biologicals are prepared and administered in accordance with federal and state laws, the orders of the licensed practitioner or practitioners responsible for the patient's care, and accepted standards of practice.	§482.23(c)(1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care, and accepted standards of practice.	**Interview** ☐ Are staff knowledgeable about intervention protocols when patients experience adverse medication-related events? ☐ Interview personnel who administer medication to verify their understanding of the hospital's

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For hospitals that use Joint Commission Accreditation for deemed status purposes: Drugs and biologicals may be prepared and administered as follows: - On the orders of other practitioners not specified under 42 CFR 482.12(c) only if such practitioners are acting in accordance with state law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. - On the orders contained within preprinted and electronic standing orders, order sets, and protocols for patient orders only if such orders meet the requirements of 42 CFR 482.24(c)(3).		policies regarding timeliness of medication administration. ☐ Can staff identify time-critical and non-time-critical scheduled medications? Can they identify medications not eligible for scheduled dosing times? ☐ Can staff describe requirements for the timing of administration of time-critical and non-time-critical medications in accordance with the hospital's policies? **Document Review** **General** ☐ Verify that the hospital has policies and procedures approved by the medical staff and governing body concerning ordering of drugs and biologicals by practitioners. ☐ Verify that the hospital has policies and procedures approved by the medical staff addressing who is authorized to administer medications and that the policies and procedures are followed. ☐ Verify that nursing staff authorized to administer drugs and biologicals are practicing within their state-permitted scope of practice. ☐ Are personnel other than nursing personnel administering drugs or biologicals? If yes, determine if those personnel are administering drugs or biologicals in accordance with federal and state law and regulation, including scope of practice laws, hospital policy, and medical staff bylaws, rules, and regulations. Use the above procedures to determine compliance. ☐ Verify that the hospital has policies and procedures approved by medical staff addressing the timing of medication administration.

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		☐ Consistent with its policies, verify that the hospital has identified medications that meet the following criteria: o Are not eligible for scheduled dosing times o Are eligible for scheduled dosing times and are time critical o Are eligible for scheduled dosing times and are not time critical ☐ Verify that the hospital has established total windows of time that do not exceed the following: o 1 hour for time-critical scheduled medications o 2 hours for medications prescribed more frequently than daily but not more frequently than every 4 hours o 4 hours for medications prescribed for daily or longer administration intervals ☐ Verify that the hospital has a policy describing requirements for the administration of identified time-critical medications. Is it clear whether time-critical medications or medication types are identified as such for the entire hospital or are they specific to the unit, patient diagnosis, or clinical situation? **Patient Health Record** ☐ Review a sample of patient health records to determine if medication administration conformed to an authorized practitioner's order (that is, there is an order from an authorized practitioner, or an applicable standing order, and that the correct medication was administered to the right patient at the right dose via the correct route) and if the timing of administration complied with the hospital's policies and procedures. **Observation**

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		☐ Verify that procedures for the preparation of drugs and their administration to patients (medication pass) are being followed. ○ Is the patient's identity confirmed prior to medication administration? ○ Are procedures to ensure the correct medication, dose, and route followed? ○ Are drugs administered in accordance with the hospital's established policies and procedures for safe and timely medication administration? ○ Does the nurse remain with the patient until oral medication is taken? ○ Are patients assessed by nursing and/or other staff, per hospital policy, for their risk to their prescribed medications? ○ Are patients who are at higher risk and/or receiving high-alert medications monitored for adverse effects?
MM.16.01.01, EP 1: Drugs and biologicals are prepared and administered in accordance with federal and state laws, the orders of the licensed practitioner or practitioners responsible for the patient's care, and accepted standards of practice. For hospitals that use Joint Commission Accreditation for deemed status purposes: Drugs and biologicals may be prepared and administered as follows: - On the orders of other practitioners not specified under 42 CFR 482.12(c) only if such practitioners are acting in accordance with state law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.	**§482.23(c)(1)(i)** Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. **§482.23(c)(1)(ii)** Drugs and biologicals may be prepared and administered on the orders contained within pre-printed and electronic standing orders, order sets, and protocols for patient orders only if such orders meet the requirements of §482.24(c)(3).	**Interview** ☐ Ask nursing staff if they initiate medications in accordance with standing orders. ○ Are they familiar with the hospital's policies and procedures for using standing orders? ○ Are they following the policies and procedures? ☐ Request the protocol for a standing order used by nursing staff. Ask nursing staff how their practice conforms to the protocol. **Document Review** **General** ☐ Review the hospital's policy for drug and biological orders. Does it require that all administration of drugs or biologicals be based on either an applicable standing order or the order of

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- On the orders contained within preprinted and electronic standing orders, order sets, and protocols for patient orders only if such orders meet the requirements of 42 CFR 482.24(c)(3).		a practitioner who is responsible for the care of the patient or otherwise authorized by hospital and medical staff policy and in accordance with state law to write orders? **Patient Health Record** □ Review a sample of open and closed patient medical records to verify that all orders for drugs and biologicals, with the exception of influenza and pneumococcal vaccines, are included in the patient's medical record and authenticated by a practitioner who is authorized to write orders by hospital and medical staff policy and in accordance with state law and who is responsible for the care of the patient. o Determine if there was an assessment of contraindications prior to administration of the vaccine(s). □ Ensure that all standing orders initiated by a nurse were authenticated by an authorized practitioner. □ Verify that all orders for drugs and biologicals contain the required elements according to **§482.23(c)(1) (ii), (c)(3) and (c)(3)(iii).** **Note:** *Although the regulation applies to both inpatient and outpatient medical records, the sample should be weighted to include more inpatient records.*
MM.16.01.01, EP 2: 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.	**§482.23(c)(2)** All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures.	**See Survey Procedures for §§482.23(c)(1)**

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MM.14.01.01, EP 1: Orders for drugs and biologicals are documented and signed by any practitioner who is authorized to write orders in accordance with state law and hospital policy, medical staff bylaws, rules, and regulations. Note: Influenza and pneumococcal vaccines may be administered per physician-approved hospital policy after an assessment of contraindications.	**§482.23(c)(3)** With the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders in accordance with State law and hospital policy, and who is responsible for the care of the patient.	**See Survey Procedures for §482.23(c)(1)**
MM.14.01.01, EP 2: The hospital minimizes the use of verbal medication orders.	**§482.23(c)(3)(i)** If verbal orders are used, they are to be used infrequently.	**Interview** ☐ Ask direct care staff if actual practice is consistent with verbal order policies and procedures. **Document Review** **General** ☐ Verify that the hospital has a policy or procedure to minimize the use of verbal orders. Does the policy include a requirement for read-back verification for every verbal order? **Patient Health Record** ☐ Review a sample of both open and closed patient medical records containing of verbal orders. o Were the hospital's policies and procedures for the use of verbal orders followed? o Does the number of verbal orders found in the sampled records suggest routine use, which the regulations do not permit? The number of verbal orders is not in itself evidence of noncompliance but should result in more focused analysis. For example, assess the following: ▪ Is there a pattern to the use of verbal orders?

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		▪ Are verbal orders used frequently for certain types of situations, and, if so, is it reasonable to assume that it is impossible or impractical for the prescribing practitioners to write/enter the orders in such situations? ▪ Do certain practitioners use verbal orders frequently?
RC.12.02.01, EP 1: Only staff authorized by hospital policies and procedures consistent with federal and state law accept and record verbal orders.	**§482.23(c)(3)(ii)** When verbal orders are used, they must only be accepted by persons who are authorized to do so by hospital policy and procedures consistent with Federal and State law.	**Interview** ☐ Interview several direct care staff to determine if they are permitted to take verbal orders for drugs and biologicals and if they have been authorized to do so in accordance with hospital policy. **Document Review** **General** ☐ Determine whether the hospital has policies and procedures, consistent with federal and state law governing who is authorized to accept verbal orders. **Patient Health Record** ☐ Review open and closed patient medical records containing verbal orders for drugs and biologicals. o Verify that the orders were accepted and documented by authorized hospital personnel.
MM.14.01.01, EP 1: Orders for drugs and biologicals are documented and signed by any practitioner who is authorized to write orders in accordance with state law and hospital policy, medical staff bylaws, rules, and regulations. Note: Influenza and pneumococcal vaccines may be administered per physician-approved hospital policy after an assessment of contraindications.	**§482.23(c)(3)(iii)** Orders for drugs and biologicals may be documented and signed by other practitioners only if such practitioners are acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.	**See Survey Procedures for §482.23(c)(1)**

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PC.12.01.01, EP 3: The hospital administers blood transfusions and intravenous medications in accordance with state law and approved medical staff policies and procedures.	§482.23(c)(4) Blood transfusions and intravenous medications must be administered in accordance with State law and approved medical staff policies and procedures.	**Interview** ☐ Interview nursing staff on different units who administer IV medications and blood transfusions. Verify that they are knowledgeable about the following: o Venipuncture techniques o Safe medication administration practices, including general practices applying to all types of medications and practices concerning IV tubing and infusion pumps o Maintaining fluid and electrolyte balance o Patient assessment for risk related to IV medications and appropriate monitoring o Early detection and intervention for IV opioid-induced respiratory depression in postoperative patients o Blood transfusions, including the following: ▪ Blood components ▪ Process for verification of the right blood product for the right patient ▪ Transfusion reactions, including identification, treatment, and reporting requirements **Document Review** **Personnel/Credential File** ☐ Review the files for a sample of staff who administer blood products and IV medications for evidence that competency was assessed, and training was provided as appropriate. **Patient Health Record** ☐ Review a sample of medical records of patients who received blood transfusions or IV medications. o Are blood transfusions and IV medications administered in accordance with state law

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		and approved medical staff policies and procedures? o Are blood transfusions and IV medications administered by personnel who are working within their scope of practice in accordance with state law and approved medical staff policies? **Observation** ☐ If able, observe blood transfusion and IV medication administration to assess staff adherence to accepted standards of practice. o Were safe medication administration practices used? o Was the transfused patient correctly identified and matched to review policies and procedures for IV medication administration and blood transfusion to the correct blood product prior to administration? o Was the appropriate access used for IV medications? o Were appropriate steps taken with regard to IV tubing and infusion pumps? o Are patients being monitored postinfusion for adverse reactions? ☐ If staff appear to not be following accepted standards of practice for patient risk assessment related to IV medications, particularly opioids, and appropriate monitoring of patients receiving IV medications and/or blood transfusions, determine if the staff address safe practices considerations.
MM.17.01.01, EP 1: The hospital develops and implements policies and procedures for reporting transfusion reactions, adverse drug reactions, and errors in administration of drugs.	**§482.23(c)(5)** There must be a hospital procedure for reporting transfusion reactions, adverse drug reactions, and errors in administration of drugs.	For adverse drug events and medication administration errors, follow the survey procedures for **§482.25(b)(6)**. Deficiencies are to be cited under both **§482.23(c)(5)** and **§482.25(b)(6)** when the drug or transfusion related to an adverse drug reaction, transfusion reaction, or

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Note: This element of performance is also applicable to sample medications.		medication administration error relates to a drug or transfusion administered by a nurse. **Interview** ☐ Interview nursing staff responsible for administering blood transfusions to verify that they are familiar with and comply with the hospital's policies. **Document Review** **General** ☐ Verify that the hospital has a policy or procedure for internal reporting of transfusion reactions. ☐ Request any transfusion-related incident reports. o Is there evidence that the transfusion reaction was reported immediately to the practitioner responsible for the patient's care? o Was it reported to the hospital's quality assurance/performance improvement program?
MM.16.01.01, EP 3: The hospital develops and implements policies and procedures that guide the safe and accurate self-administration of medications by the patient or their caregiver or support person, where appropriate. Note 1: This applies to hospital-issued medications and the patient's own medications brought into the hospital. Note 2: The term "self-administered medication(s)" may refer to medications administered by a family member.	**§482.23(c)(6)** The hospital may allow a patient (or his or her caregiver/support person where appropriate) to self-administer both hospital-issued medications and the patient's own medications brought into the hospital, as defined and specified in the hospital's policies and procedures.	
MM.16.01.01, EP 4: If the hospital allows a patient to self-administer specific hospital-	**§482.23(c)(6)(i)** If the hospital allows a patient to self-administer specific hospital-	**Interview**

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issued medications, the hospital has policies and procedures in place that address the following: - Making certain that an order is issued by a practitioner responsible for the patient's care and that it is consistent with the hospital's self-administration policy - Determining that the patient or the patient's caregiver or support person is capable of administering the specified medication(s) - Instructing the patient or the patient's caregiver or support person, where appropriate, in the safe and accurate administration of the specified medication(s) - Addressing the security of the medications for each patient Note: The term "self-administered medication(s)" may refer to medications administered by a family member. **MM.16.01.01, EP 5:** If the hospital allows a patient to self-administer medications not issued by the hospital, the hospital has policies and procedures in place that address the following: - Making certain that an order is issued by a practitioner responsible for the patient's care and that it is consistent with the hospital's self-administration policy - Determining that the patient or the patient's caregiver or support person is capable of administering the specified medication(s) - Instructing the patient or the patient's caregiver or support person, where	issued medications, then the hospital must have policies and procedures in place to: **§482.23(c)(6)(i)**(A) Ensure that a practitioner responsible for the care of the patient has issued an order, consistent with hospital policy, permitting self-administration. **§482.23(c)(6)(i)(B)** Assess the capacity of the patient (or the patient's caregiver/support person where appropriate) to self-administer the specified medication(s). **§482.23(c)(6)(i)(C)** Instruct the patient (or the patient's caregiver/support person where appropriate) in the safe and accurate administration of the specified medication(s). **§482.23(c)(6)(i)(D)** Address the security of the medication(s) for each patient. **§482.23(c)(6)(i)(E)** Document the administration of each medication, as reported by the patient (or the patient's caregiver/support person where appropriate), in the patient's medical record. **§482.23(c)(6)(ii)** If the hospital allows a patient to self-administer his or her own specific medications brought into the hospital, then the hospital must have policies and procedures in place to: **§482.23(c)(6)(ii)(A)** Ensure that a practitioner responsible for the care of the patient has issued an order, consistent with hospital policy, permitting self-administration of	*For hospitals that permit self-administration of hospital-issued medications:* ☐ Ask the hospital to identify current inpatients for whom self-administration of hospital-issued medications is permitted. ☐ Interview several of these patients (or their caregivers/support persons when applicable) to verify that they received instruction on how to administer their medications ☐ Interview nurses caring for the selected patients. Ask them the following questions: o What are the applicable hospital policies and procedures for supervision of self-medication? o How do they assess a patient's (or patient's caregiver/support person's) capacity to self-administer medication. If they have concerns, how do they communicate them to the responsible practitioner? o Does the hospital permit nurses to return to nurse administration of medications in response to temporary reduction in patient capacity or absence of the patient's caregiver/support person? If so, how do the nurses make this assessment? o How do they instruct a patient (or patient's caregiver/support person's) in medication self-administration? o How are self-administered medications? o How do they document self-administration of medications? **Document Review** **Policy/Procedure**

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appropriate, in the safe and accurate administration of the specified medication(s) - Addressing the security of the medications for each patient - Identifying the specified medication(s) and visually evaluating the medication(s) for integrity Note: The term "self-administered medication(s)" may refer to medications administered by a family member. **RC.12.01.01, EP 2:** The medical record contains the following clinical information: - Admitting diagnosis - Any emergency care, treatment, and services provided to the patient before their arrival - Any allergies to food and medications - Any findings of assessments and reassessments - 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	medications the patient brought into the hospital. **§482.23(c)(6)(ii)(B)** Assess the capacity of the patient (or the patient's caregiver/support person where appropriate) to self-administer the specified medication(s), and also determine if the patient (or the patient's caregiver/support person where appropriate) needs instruction in the safe and accurate administration of the specified medication(s). **§482.23(c)(6)(ii)(C)** Identify the specified medication(s) and visually evaluate the medication(s) for integrity. **§482.23(c)(6)(ii)(D)** Address the security of the medication(s) for each patient. **§482.23(c)(6)(ii)(E)** Document the administration of each medication, as reported by the patient (or the patient's caregiver/support person where appropriate), in the patient's medical record.	☐ Verify that the hospital has policies and procedures for self-administration of hospital-issued medications. ○ Are the staff following the policies and procedures? ☐ Verify that the policies and procedures address the following: ○ Limitations on medications not eligible for self-administration or patient conditions that exclude self-administration ○ Orders for self-administration of medication ○ Requirements, if any, for supervision of self-administration ○ Assessment of self-medication capacity ○ Instruction in self-medication ○ Security of self-administered medications ○ Documentation of self-administration **Patient Health Record** ☐ Review a sample of medical records for patients who self-administer medication. Verify that the records contain documentation of the following: ○ Order for self-administration of specific medication(s) ○ Nurse assessment of the patient's (or patient's caregiver/support person's) capacity to self-administer medication ○ Documentation of nurse instruction to the patient (or patient's caregiver/support person) in safe and appropriate techniques for self-administration of medication. ○ Documentation of self-administration times and doses, as reported by the patient (or patient's caregiver/support person) or directly observed by a nurse.

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administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the 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.		

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NPG.12.03.01, EP 4: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: 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. **HR.11.02.01, EP 2:** For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a director of psychiatric nursing that 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.	**§482.62(d) Standard: Nursing services.** The hospital 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 patient's active treatment program and to maintain progress notes on each patient. **§482.62(d)(1)** 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. **§482.62(d)(1)** 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.	**Interview** ☐ Ask patients and staff if necessary treatment modalities and other services were provided in a timely manner. **Document Review** **Patient Health Record** ☐ Review a sample of patient medical records to ascertain if necessary active treatment assessments, treatments, evaluations, and activities have been conducted and documented. ☐ Review a sample of patient medical records to determine the following: o Are nursing assessments completed on all patients? o Do multidisciplinary treatment plans reflect nursing input, including specific nursing interventions for nursing problems (for example, violence toward self/others, physical/medical crises)? o Is nursing care evaluated by a registered nurse, with changes in care based on the patient's progress or lack thereof? ☐ Are intrusive techniques (for example, seclusion, restraint, electroconvulsive therapy, medical procedures) and patient incidents (for example, medication errors, patient falls, patient-to-patient and patient-to-staff injuries) monitored in accordance with hospital policy, state statutes, and safe nursing practice? ☐ **General** ☐ Review other records, such as the following, to determine the extent to which staffing levels or deployment contributed to negative patient outcomes:

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		○ Restraint and seclusion records ○ Incident reports ○ Medication error reports ○ Reports of patient/staff injuries ☐ Evaluate all outcome data in light of the success or failure observed during the survey relevant to each patient receiving active treatment and achieving desired outcomes of care. **Personnel/Credential File** ☐ Review the educational background and psychiatric nursing and leadership skills of the director of psychiatric nursing services. If the director has less than a master's degree in psychiatric nursing, ask to see evidence of experience and ongoing training in psychiatric nursing. **Note:** *Documented consultation from a nurse with a master's degree in psychiatric nursing constitutes ongoing training* **Observation** ☐ Observe sampled patients and others during structured sessions and in unstructured settings. Do you see behavioral evidence of a rational organization of resources? ☐ Are nursing personnel observed relating to patients in a therapeutic manner?
NPG.12.03.01, EP 4: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: 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	**§482.62(d)(2)** The staffing pattern must insure the availability of a registered professional nurse 24 hours each day. **§482.62(d)(2)** There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each patient's active treatment program.	**Document Review** **General** ☐ Review the staffing plans for a sample of approximately 25% of the certified wards. **Note:** Staffing levels, including levels of nursing personnel, should be reviewed for the day(s) of the survey and evaluated based on the level of needs presented by the patients. ☐ If a problem or concern emerges, assess additional staffing patterns.

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- 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. **NPG.12.03.01, EP 2:** The hospital makes certain a registered professional nurse is available 24 hours a day.		**Note:** *Decisions regarding the extent of additional data (number of wards and dates) to be reviewed should be based on the degree of the problem/concern. Patient needs assessment/patient acuity should be reviewed for any wards deemed necessary based on problems/concerns found in the sampling review.*

Hospital Medical Record Services Evaluation Module (482.24)

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LD.13.03.01, EP 1: The 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 **RC.11.01.01, EP 1:** The hospital maintains a medical record for every inpatient and outpatient in the hospital.	**§482.24** The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.	**Document Review** **General** □ Review the hospital's organizational structure and policy statements and interview the person responsible for the medical records service to determine if the service is structured appropriately to meet the needs of the hospital and its patients. **Patient Health Record** □ Review a sample of active and closed patient health records for completeness and accuracy in accordance with federal and state law, and regulation and hospital policy. **Note:** The sample should be 10 percent of the average daily census and no less than 30 records. □ Review a sample of outpatient records to determine compliance in outpatient departments, services, and locations.
LD.14.03.01, EP 1: The 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	**§482.24(a) Standard: Organization and Staffing** The organization of the medical record service must be appropriate to the scope and complexity of the services performed. The hospital must employ adequate personnel to ensure prompt completion, filing, and retrieval of records.	**Document Review** **Patient Health Record** □ Verify that health records are promptly completed in accordance with state law and hospital policy. □ Request a sample of health records of past patients (inpatient and/or outpatient). Can the hospital promptly retrieve those records? **General**

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the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic **NPG.12.01.01, EP 6:** The hospital has a medical record service that has administrative responsibility for medical records. The hospital employs adequate staff to support the prompt completion, filing, and retrieval of records.		□ Review written job descriptions and staffing schedules to determine if staff is carrying out all designated responsibilities. **Observation** □ Verify that there is an established system that addresses at least the following activities of the medical records service: o Timely processing of records o Coding/indexing of records o Retrieval of records o Compiling and retrieving quality assurance activity data □ Verify that the system is reviewed and revised as needed. □ Verify that the hospital employs adequate medical record personnel who are qualified to ensure the hospital's medical records system complies with applicable law and regulation.
RC.11.01.01, EP 1: The hospital maintains a medical record for every inpatient and outpatient in the hospital. **RC.11.01.01, EP 4:** The 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. The medical records are	**§482.24(b) Standard: Form and Retention of Record** The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.	**Document Review** **Patient Health Record** □ Verify that a health record is maintained for each person treated or receiving care. [7] □ Verify that health records are accurate, completed promptly, easily retrieved, and readily accessible, as needed, in all locations where health records are maintained. **Observation**

[7] The hospital may have a separate record for both inpatients and outpatients. However, when two different systems are used, they must be appropriately cross-referenced and accessible.

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promptly completed, properly filed and retained, and readily accessible. **RC.11.02.01, EP 2:** The hospital uses a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.		□ Determine the location(s) where health records are stored and maintained and verify that they are secure and protected from damage, flood, fire, and so on; and that access is limited to only authorized individuals □ Verify that the hospital's procedures ensure the integrity of authentication and protect the security of patient records.
RC.11.03.01, EP 1: The retention time of the original or legally reproduced medical record is determined by its use and hospital policy, in accordance with law and regulation. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Medical records are retained in their original or legally reproduced form for at least five years. This includes nuclear medicine reports; radiological reports, printouts, films, and scans; and other applicable image records.	**§482.24(b)(1)** - Medical records must be retained in their original or legally reproduced form for a period of at least 5 years.	**Document Review** **Patient Health Record** □ Request a sample of inpatient and outpatient health records of patients who were at the hospital in the previous 48 to 60 months. Were they promptly retrieved? Were they complete? Were they in their original or legally reproduced form? **Observation** □ Determine if health records are retained for at least 5 years, or more if required by state or local law.
IM.13.01.03, EP 1: The hospital has a system for coding and indexing medical records to make health information accessible when needed for patient care, treatment, and services. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical records system allows for timely retrieval of patient information by diagnosis and procedure.	**§482.24(b)(2) –** The hospital must have a system of coding and indexing medical records. The system must allow for timely retrieval by diagnosis and procedure, in order to support medical care evaluation studies.	**Interview** □ Verify that the hospital uses a coding and indexing system that permits timely retrieval of patient records by diagnosis and procedures.
IM.12.01.01, EP 1: The hospital develops and implements policies and procedures	**§482.24(b)(3) –**	**Document Review** **General**

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addressing the privacy and confidentiality of health information. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Policies and procedures also address the resident's personal records. **IM.12.01.01, EP 3:** The 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 hospital makes certain that unauthorized individuals cannot gain access to or alter patient records. **IM.12.01.03, EP 1:** The hospital develops and implements a written policy that addresses the security of health information, including the following: - Access and use of health information - Integrity of health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction - Intentional destruction of health information - When and by whom the removal of health information is permitted	The hospital must have a procedure for ensuring the confidentiality of patient records. Information from or copies of records may be released only to authorized individuals, and the hospital must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released by the hospital only in accordance with Federal or State laws, court orders, or subpoenas.	□ Verify that the hospital has policies that limit access to, and disclosure of, patient health records to permitted users and uses and that require written authorization for other disclosures. Are the policies consistent with regulatory requirements? □ Ensure that the hospital's policies and procedures stipulate that "original" health records are retained, unless their release is mandated under federal or state law, court order, or subpoena. **Patient Health Record** □ Verify that patient records, in all locations, are always secured from unauthorized access and released only as permitted by hospital policy and procedures. **Interview** Medical Records/Health Information Management staff □ About precautions taken to prevent physical or electronic altering of content previously entered into a patient health record or to prevent unauthorized disposal of patient records. □ Interview staff and ask them to demonstrate what safeguards are in place or precautions are taken to prevent unauthorized persons from gaining physical or electronic access to information in patient health records. [8]

[8] Access to electronic patient records is controlled through standard measures, such as business rules defining permitted access and passwords.

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Note: Removal refers to those actions that place health information outside the hospital's control.		
RC.11.01.01, 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 hospitals that elect The Joint Commission Primary Care Medical Home option: This requirement refers to care provided by both internal and external providers. **RC.12.01.01, EP 2:** The medical record contains the following clinical information: - Admitting diagnosis - Any emergency care, treatment, and services provided to the patient before their arrival - Any allergies to food and medications - Any findings of assessments and reassessments - Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient	**§482.24(c) Standard: Content of Record** The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.	**Document Review** **Patient Health Record** □ Review a sample of patient health records to ensure the documentation contained within does the following: ○ Justify admission ○ Justify continued hospitalization ○ Support the diagnosis ○ Describe the patient's progress ○ Describe the patient's response to medications ○ Describe the patient's response to services such as interventions, care, and treatments □ Verify that the health record contains complete information/documentation regarding evaluations, interventions, care provided, services, care plans, discharge plans, and the patient's response to those activities. □ Ensure that necessary information is included in patient records in a prompt manner so that health care staff involved in the care of the patient have access to the information necessary to monitor the patient's condition.

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- 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 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,		

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including any conclusions or impressions drawn from the information - Discharge plan and discharge planning evaluation - Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge - Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis.		
RC.11.01.01, EP 4: The hospital develops and implements policies and procedures for accurate, legible, complete, signed, dated, timed, medical record entries that are authenticated by the person responsible for providing or evaluating the service provided. The medical records are promptly completed, properly filed and retained, and readily accessible.	**§482.24(c)(1) -** All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.	**Document Review** **General** □ Examine the hospital's medical records system policies and procedures to determine if required documentation is being authenticated after it is created in the patient's medical record (electronic, paper, or hybrid). **Patient Health Record** □ Review a sample of open and closed patient health records to determine the following: ○ All record entries are legible and written in such a way that is not likely to be misread or misinterpreted? ○ Orders, progress notes, nursing notes, or other entries in the medical record are complete. ○ All records contain sufficient information to identify the patient; support the diagnosis/condition; justify the care, treatment, and services; document the course and results

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		of care, treatment, and services; and promote continuity of care among providers? ○ All record entries are dated, timed, and appropriately authenticated by the person who is responsible for ordering, providing, or evaluating the service provided. ○ All orders, including verbal orders, are written in the record and signed by the practitioner who is caring for the patient and who is authorized by hospital policy and in accordance with state law to write orders. **Interview** Medical Records/Health Information Management staff □ How are written and electronic signatures, written initials, codes, and stamps (when such are used for authorship identification) verified? □ For electronic medical records, ask the hospital to demonstrate the security features that maintain the integrity of entries and verification of electronic signatures and authorizations.
RC.11.02.01, EP 1: All orders, including verbal orders, are dated, timed, and authenticated by the ordering physician or other licensed practitioner who is responsible for the patient's care, and who is authorized to write orders, in accordance with hospital policy, law and regulation, and medical staff bylaws, rules, and regulations,.	**§482.24(c)(2) –** All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.	**Document Review** **General** □ Verify that the hospital has policies and procedures requiring prompt authentication by the ordering or other practitioner [9] of all orders. □ Do the hospital's policies and procedures for verbal orders include a "read back and verify" process where the receiver of the order reads back the order to the ordering practitioner to verify its accuracy?

[9] A practitioner other than the ordering practitioner, who is responsible for the care of the patient, may be permitted to authenticate an order under state law, hospital policy and medical staff bylaws, rules, and regulations.

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		Patient Health Record □ Review orders, including verbal orders, in a sample of patient health records. Have orders been dated, timed, signed and authenticated promptly by the ordering practitioner or practitioner responsible for the patient's care according to hospital policy? [3]
RC.12.01.01, EP 5: The hospital uses preprinted and electronic standing orders, order sets, and protocols for patient orders only if the the following occurs: - Orders and protocols are reviewed and approved by the medical staff and the hospital's nursing and pharmacy leadership. - Orders and protocols are consistent with nationally recognized and evidence-based guidelines. - Orders and protocols are periodically and regularly reviewed by the medical staff and the hospital's nursing and pharmacy leadership to determine the continuing usefulness and safety of the orders and protocols.- Orders and protocols are dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner or by another practitioner responsible for the care of the patient only if such a practitioner is acting in accordance with state law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.	**§482.24(c) (3)** Hospitals may use pre-printed and electronic standing orders, order sets, and protocols for patient orders only if the hospital: **(i)** Establishes that such orders and protocols have been reviewed and approved by the medical staff and the hospital's nursing and pharmacy leadership; **(ii)** Demonstrates that such orders and protocols are consistent with nationally recognized and evidence-based guidelines; **(iii)** Ensures that the periodic and regular review of such orders and protocols is conducted by the medical staff and the hospital's nursing and pharmacy leadership to determine the continuing usefulness and safety of the orders and protocols; and **(iv)** Ensures that such orders and protocols are dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner or another practitioner responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.	**Document Review** **General** □ Verify that hospital policies and procedures for standing orders do the following: ○ Address the process by which a standing order is developed, approved, monitored, initiated by authorized staff, and subsequently authenticated by physicians or other practitioners responsible for the care of the patient. ○ Specify the process whereby the physician or other practitioner responsible for the care of the patient acknowledges and authenticates the initiation of all standing orders after the fact, with the exception of influenza and pneumococcal vaccines. □ Verify that hospital standing order policies and procedures address a process for the identification and timely completion of any requisite updates, corrections, modifications, or revisions based on changes in nationally recognized, evidence-based guidelines. **Patient Health Record** □ Review a sample of patient health records for evidence of periodic evaluation and, if needed, modification of the standing order, including whether the order remains consistent with current evidence-based national guidelines, staff adheres to the protocol for initiation and execution, and there have been any preventable adverse events associated with the order.

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		□ Review a sample of health records of patients for whom a nurse-initiated standing order was used. Verify that the order was documented and authenticated by a practitioner responsible for the care of the patient. **Personnel/Credential File** □ Review a sample of personnel files or other training documents for evidence of staff training on standing order's protocol. **Interview** □ Ask the hospital's medical staff and nursing and pharmacy leaders if standing orders are used. If yes, ask them to describe how a standing order is developed and monitored and their role in the process. □ Ask to see an example of one or more standing orders, including documentation on the development of the order, to look for the following: ○ Reference to the evidence-based national guidelines that support the standing order ○ Participation of medical staff and nursing and pharmacy leaders in the review and approval of the standing order ○ Description of the protocol to be followed when initiating the execution of the order, including description of the roles and responsibilities of various types of staff ○ Description of the process for authenticating the order's initiation by the practitioner responsible for the care of the patient or another authorized practitioner

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		□ Interview staff providing clinical services in areas of the hospital where standing orders might be typically used and ask them if standing orders are used. [10]. ○ If they say yes, ask them to describe a typical scenario for which a standing order would be used and what they would do in that case. Does their description align with hospital protocol?
RC.12.01.01, EP 6: The medical history and physical examination or updates to the medical history and physical examination are placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. **RC.12.01.01, EP 7:** An assessment of the patient (in lieu of a medical history and physical examination as described in 42 CFR 482.24(c)(4)(i)(A) and (B)) is completed and documented after registration, but prior to surgery or a procedure requiring anesthesia services, when the following conditions are met: - The patient is receiving specific outpatient surgical or procedural services. - The medical staff has chosen to develop and maintain a policy that identifies, in accordance with the requirements at § 482.22(c)(5)(v), specific patients as not requiring a	**§482.24(c)(4)(i) (A) (B) (C)-** All records must document the following, as appropriate: **(i)** Evidence of— **(A)** A medical history and physical examination completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, and except as provided under paragraph (c)(4)(i)(C) of this section. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. **(B)** An updated examination of the patient, including any changes in the patient's condition, when the medical history and physical examination are completed within 30 days before admission or registration, and except as provided under paragraph (c)(4)(i)(C) of this section. Documentation of the updated examination must be placed in	**Document Review** **General** □ Verify that the hospital has policies and procedures for when specific patients are excluded from the required comprehensive medical history and physical examination, or any update to it, prior to specific outpatient surgical or procedural services. **Patient Health Record** □ Review a sample of patient health records to verify that a medical history and physical examination was completed and documented no more than 30 days before or 24 hours after a patient's admission or registration but prior to surgery or a procedure requiring anesthesia services. □ Ensure that the medical history and physical examination be placed in the patient's health record within 24 hours after admission or registration but prior to surgery or a procedure requiring anesthesia services. □ Verify that an updated examination of the patient includes the following: ○ Any changes in the patient's condition

[10] Service areas may include, but not limited, to the emergency department, labor and delivery units, and inpatient units.

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comprehensive medical history and physical examination, or any update to it, prior to specific outpatient surgical or procedural services. **PC.11.02.01, EP 2:** A medical history and physical examination is completed and documented no more than 30 days prior to, or within 24 hours after, registration or inpatient admission but prior to surgery or a procedure requiring anesthesia services. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: Medical histories and physical examinations are performed as required in this element of performance, except prior to any specific outpatient surgical or procedural services for which an assessment is performed instead as provided under 42 CFR 82.24(c)(4)(i)(C). Note 2: For law and regulation guidance pertaining to the medical history and physical examination at 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii), refer to https://www.ecfr.gov/. **PC.11.02.01, EP 3:** For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia	the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. **(C)** An assessment of the patient (in lieu of the requirements of paragraphs (c)(4)(i)(A) and (B) of this section) completed and documented after registration, but prior to surgery or a procedure requiring anesthesia services, when the patient is receiving specific outpatient surgical or procedural services and when the medical staff has chosen to develop and maintain a policy that identifies, in accordance with the requirements at § 482.22(c)(5)(v), specific patients as not requiring a comprehensive medical history and physical examination, or any update to it, prior to specific outpatient surgical or procedural services.	○ That the medical history and physical examination was completed within 30 days before admission or registration □ Ensure that documentation of the updated examination was placed in the patient's health record within 24 hours after admission or registration but prior to surgery or a procedure requiring anesthesia services.

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services. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: Medical histories and physical examinations are performed as required in this element of performance, except prior to any specific outpatient surgical or procedural services for which an assessment is performed instead as provided under 42 CFR 482.24(c)(4)(i)(C). Note 2: For law and regulation guidance pertaining to the medical history and physical examination at 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii), refer to https://www.ecfr.gov/.		
RC.12.01.01, EP 2: The medical record contains the following clinical information: - Admitting diagnosis - Any emergency care, treatment, and services provided to the patient before their arrival - Any allergies to food and medications - Any findings of assessments and reassessments - 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	**§482.24(c)(4)(ii) -** Admitting diagnosis. **§482.24(c)(4)(iii) -** Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient. **§482.24(c)(4)(iv) -** Documentation of complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia.	**Interview** □ Ask patients and staff, as appropriate, to determine if patients have experienced any complications or unfavorable reactions to drugs/anesthesia. **Document Review** **Patient Health Record** □ Review a sample of patient health records to verify that the patient's admitting diagnosis is documented in each record. □ Review a sample of health records for patient complications, hospital-acquired infections, and unfavorable reactions to drugs/anesthesia. **Personnel/Credential File** □ Review a sample of health records of patients who have orders for consultative evaluations. Are the results/reports and other clinical findings of those consultative evaluations included in the record?

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- 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 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		**Observation** □ Observe any indications of patient complications, hospital-acquired infections, or unfavorable reactions to drugs/anesthesia.

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provisions for follow-up care, including any medications dispensed or prescribed on discharge - Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis.		
RC.12.01.01, EP 3: The medical record contains any informed consent, when required by 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.	**§482.24(c)(4)(v)** - Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, to require written patient consent.	**Document Review** **Patient Health Record** □ Review a minimum of six random health records of patients who have, are undergoing, or are about to undergo a procedure or treatment that requires informed consent. Verify that each medical record contains informed consent forms. □ Verify that each completed informed consent form contains information for each of the elements listed below as the minimum elements of a properly executed informed consent, as well as any additional elements required by state law and/or hospital policy. ○ Name of the hospital where the procedure or other type of medical treatment is to take place ○ Name of the specific procedure or other type of medical treatment for which consent is being given ○ Name of the responsible practitioner who is performing the procedure or administering the medical treatment ○ Statement that the procedure or treatment, including the anticipated benefits, material risks, and alternative therapies, was explained to the patient or the patient's legal representative ○ Signature of the patient or the patient's legal representative

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		○ Date and time the informed consent form was signed by the patient or the patient's legal representative **General** □ Verify that the hospital's standard informed consent form contains the elements listed above and that it is consistent with hospital policies. If there is applicable state law, verify that the form is consistent with the requirements of that law. □ Verify that the hospital has assured that the medical staff has specified which procedures and treatments require written patient consent.
RC.12.01.01, EP 2: See above	**§482.24(c)(4)(vi) -** All practitioners' orders, nursing notes, reports of treatment, medication records, radiology, and laboratory reports, and vital signs and other information necessary to monitor the patient's condition.	**Document Review** **Patient Health Record** □ Review a sample of patient health records to verify that they records contain appropriate documentation of practitioners' orders, interventions, findings, assessments, records, notes, reports, and other information necessary to monitor the patient's condition, including the following: ○ All practitioner's orders (properly authenticated) ○ All nursing notes (including nursing care plans) ○ All reports of treatment (including complications and hospital-acquired infections) ○ All medication records (including unfavorable reactions to drugs) ○ All radiology reports ○ All laboratory reports ○ All vital signs ○ Any other information necessary to monitor the patient's condition

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		□ Is this information included in patient records in a prompt manner so that health care staff involved in the care of the patient have access to the information necessary to monitor the patient's condition?
RC.12.01.01, EP 2: See above	**§482.24(c)(4)(vii) -** Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care.	**Document Review** **Patient Health Record** □ Review a sample of patient health records to verify that a discharge summary is included to ensure proper continuity of care. □ Review records to verify that a final diagnosis is included in each discharge summary.
RC.12.01.01, EP 2: See above	**§482.24(c)(4)(viii) -** Final diagnosis with completion of medical records within 30 days following discharge.	**Document Review** **Patient Health Record** □ Select a sample of health records for patients who have been discharged for more than 30 days. Are the records complete? Does each record have the patient's final diagnosis?

Hospital Pharmaceutical Services Evaluation Module (482.25)

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NPG.12.01.01, EP 10: The hospital has a pharmacy that is directed by a registered pharmacist. If the hospital does not have a pharmacy, it has a drug storage area under competent supervision, as defined by the hospital. Note: The pharmacy or drug storage area is administered in accordance with accepted professional principles. **LD.13.01.09, EP 5:** The hospital develops and implements policies and procedures that minimizes drug errors. The medical staff develops these policies and procedures unless delegated to the pharmaceutical service.	**§ 482.25 Condition of participation: Pharmaceutical services.** The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service.	**Interview** ☐ The leader(s) for evidence of the scope and complexity of its pharmaceutical services. ☐ The leaders(s) about how the hospital has determined that the services meet the needs of its patients. ☐ The unit nursing staff if prescribed medications are routinely available and timely. ☐ The director of pharmaceutical services about how reports of frequent delays or other problems are addressed.
MM.14.01.01, EP 3: The hospital develops and implements a written policy that defines the following: - Specific types of medication orders that it deems acceptable for use - Minimum required elements of a complete medication order, which must include medication name, medication dose, medication route, and medication frequency - When indication for use is required on a medication order - Precautions for ordering medications with look-alike or sound-alike names - Actions to take when medication orders are incomplete, illegible, or unclear - Required elements for medication titration	**§ 482.25(a) Standard: Pharmacy management and administration.** The pharmacy or drug storage area must be administered in accordance with accepted professional principles.	**Interview** ☐ The director of pharmacy about how the hospital's organized pharmaceutical services responsible for the procurement, distribution, and control of all medication products used in the hospital (including medication-related devices) for inpatient and outpatient care ☐ The director of pharmacy if the hospital has a drug storage area instead of a pharmacy, does it use only drugs that are prepackaged and need no further preparation beyond that required at the point of care? ☐ The director of pharmacy and discuss how pharmacy services are integrated into its hospital-wide QAPI program ☐ Interview the director of pharmacy if the hospital conducts research involving uses investigational medications. If yes, **ask for the** policy and procedure

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orders, including the medication name, medication route, initial rate of infusion (dose/unit of time), incremental units to which the rate or dose can be increased or decreased, how often the rate or dose can be changed, the maximum rate or dose of infusion, and the objective clinical measure to be used to guide changes Note 1: Examples of objective clinical measures to be used to guide titration changes include blood pressure, Richmond Agitation–Sedation Scale (RASS), and the Confusion Assessment Method (CAM). Note 2: Drugs and biologicals not specifically prescribed as to time or number of doses are automatically stopped after a reasonable time that is predetermined by the medical staff. **MM.11.01.01, EP 1:** Drugs and biologicals are procured, stored, controlled, and distributed in accordance with federal and state laws and accepted standards of practice. Note: The hospital stores medications, including sample medications, according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions.		to ensure that investigational medications are safely controlled and administered **Document Review** **General** ☐ Verify that the hospital's medical staff either has adopted pharmaceutical services policies and procedures or has delegated this task to pharmaceutical services. ☐ Ask the pharmacy director to provide evidence that the hospital's policies and procedures are consistent with accepted professional principles. ☐ Ask the pharmacy director to provide evidence that the hospital's policies and procedures address key areas to prevent medication errors. ☐ Verify procedures for the use of investigational medications include, but are not limited to, the following: A written process for reviewing, approving, supervising and monitoring investigational medications specifying that when pharmacy services are provided, the pharmacy controls the storage, dispensing, labeling, and distribution of the investigational medication. **Personnel/Credential File (in the pharmacy)** ☐ Verify that staff was trained on applicable pharmaceutical policies and procedures. **Observation** ☐ Ensure that there is a process in place to monitor adherence to policies and procedures.
NPG.12.01.01, EP 11: The hospital has a full-time, part-time, or consulting pharmacist who is responsible for developing, supervising, and coordinating all pharmacy services activities.	**§ 482.25(a) (1)** A full-time, part-time, or consulting pharmacist must be responsible for developing, supervising, and coordinating all the activities of the pharmacy services.	**Interview** ☐ Does the hospital have a pharmacist who has been appointed to direct pharmaceutical services?

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		☐ Ask the pharmacy director to describe how policies and procedures related to pharmaceutical services are developed, approved, and implemented. What is their role in this process? ☐ Is there any evidence of problems within pharmaceutical services that suggest lack of supervision? ☐ If the director is a part-time employee or consultant, ask them how much time per week is spent on developing, supervising, and coordinating pharmaceutical services. **Document Review** **General** ☐ Verify that the hospital has written criteria for the qualifications of the pharmacy director. o Is there evidence in the pharmacy director's file that they satisfy the criteria? o Is there evidence in the director's file that they meet the qualifications established by the medical staff and have been granted privileges as a pharmacist? ☐ If the hospital has a drug storage area in lieu of a pharmacy, ensure that the storage area is under competent supervision. ☐ Review the implementation of the pharmacy director's responsibilities by doing the following: o Reviewing minutes of meetings (if any) with facility staff regarding pharmaceutical services o Reviewing the job description or the written agreement to see that the responsibilities of the pharmacist are clearly defined and include development supervision and coordination of all the activities of pharmacy services

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		○ Determining whether the pharmacy director routinely evaluates the performance and competency of pharmacy personnel
NPG.12.01.01, EP 1: Leaders provide for an adequate number and mix of qualified individuals to support safe, quality care, treatment, and services. Note 1: The number and mix of individuals is appropriate to the scope and complexity of the services offered. Services may include but are not limited to the following: - Rehabilitation services - Emergency services - Outpatient services - Respiratory services - Pharmaceutical services, including emergency pharmaceutical services - Diagnostic and therapeutic radiology services Note 2: Emergency services staff are qualified in emergency care.	**§ 482.25(a) (2)** The pharmaceutical service must have an adequate number of personnel to ensure quality pharmaceutical services, including emergency services.	**Observation** □ Determine if the pharmaceutical services staff is sufficient in number and training to provide quality services, including 24-hour, 7-day emergency coverage, or if there is an arrangement for emergency services, as determined by the needs of the patients and as specified by the medical staff. □ Determine if there are sufficient personnel to provide accurate and timely medication delivery, ensure accurate and safe medication administration, and provide appropriate clinical services, as well as the participation in continuous quality improvement programs that meet the needs of the patient population being served.
MM.13.01.01, EP 1: The hospital maintains current and accurate records of the receipt and disposition of all scheduled drugs.	**§ 482.25(a) (3)** Current and accurate records must be kept of the receipt and disposition of all scheduled drugs.	**Document Review** **General** □ Determine if the hospital's policies and procedures minimize scheduled drug diversion. □ Review records to determine if the hospital traces the movement of scheduled drugs throughout the service. □ Determine if the pharmacist is responsible for determining that all drug records are in order and that an account of all scheduled drugs is maintained and periodically reconciled. **Observation**

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		▯ Determine if there is a record system in place that provides information on controlled substances in a readily retrievable manner. ▯ Determine if there is a system, delineated in policies and procedures, that tracks movement of all scheduled drugs from the point of entry into the hospital to the point of departure either through administration to the patient, destruction, or return to the manufacture. Determine if this system provides documentation on scheduled drugs in a readily retrievable manner to facilitate reconciliation of the receipt and disposition of all scheduled drugs. ▯ Verify that the system can readily identify loss or diversion of all controlled substances in such a manner as to minimize the time frame between the actual losses or diversion to the time of detection and determination of the extent of loss or diversion.
MM.11.01.01, EP 1: Drugs and biologicals are procured, stored, controlled, and distributed in accordance with federal and state laws and accepted standards of practice. Note: The hospital stores medications, including sample medications, according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions.	**§ 482.25(b) Standard: Delivery of services.** In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law.	**Interview** ▯ The director of pharmacy or pharmacy staff how medication orders are routinely reviewed by the pharmacy before the first dose. What evidence can the hospital present that such reviews take place? ▯ The director of pharmacy or pharmacy staff about the hospital's system for monitoring the effects of medication therapies for cases specified per hospital policy. ▯ The director of pharmacy or pharmacy staff how the hospital retrieves and removes medications available for patient use when it has been informed of a drug recall. ▯ Ask pharmacy staff how they address concerns, issues, or questions about any medication order and clarify with the prescribing practitioner or another practitioner responsible for the care of the patient before dispensing. **Document Review**

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		General ☐ Are questions regarding medication orders resolved with the prescriber? Is there a written notation of these discussions documented in the patient's medical record or pharmacy copy of the prescriber's order?
MM.15.01.01, EP 1: A pharmacist supervises all compounding, packaging, and dispensing of drugs and biologicals except in urgent situations in which a delay could harm the patient or when the product's stability is short. All compounding, packaging, and dispensing of drugs and biologicals are performed in accordance with state and federal law and regulation. **MM.15.01.01, EP 2:** The hospital develops and implements policies and procedures for sterile medication compounding of nonhazardous and hazardous medications in accordance with state and federal law and regulation. Note: All compounded medications are prepared in accordance with the orders of a physician or other licensed practitioner. **MM.15.01.01, EP 3:** The hospital assesses competency of staff who conduct sterile medication compounding of nonhazardous and hazardous medications in accordance with state and federal law and regulation and hospital policies. **MM.15.01.01, EP 4:** The hospital conducts sterile medication compounding of	**§ 482.25(b) (1)** All compounding, packaging, and dispensing of drugs and biologicals must be under the supervision of a pharmacist and performed consistent with State and Federal laws.	**Interview** ☐ Determine that only pharmacists or pharmacist-supervised personnel compound, package, and dispense drugs or biologicals in accordance with state and federal law and regulation and accepted standards of practice by doing the following: o Interviewing pharmacy and hospital staff to determine who prepares and dispenses drugs and biologicals o Observing on-site preparation and dispensing operations o Inspecting drug storage areas ☐ Ask the pharmacy director to explain the risk level(s) of the compounded sterile products (CSPs) being produced in house and/or obtained from external sources. ☐ If any CSPs are produced in the hospital: o Ask pharmacy staff for one or more examples of situations in which a beyond use date (BUD) had to be determined for a CSP based on the policy. o Ask if this function was carried out within the hospital or if it was handled by external source(s) of CSPs. o Is there evidence that the BUDs are determined consistent with the hospital's policies and procedures? o Ask staff who engage in sterile and nonsterile compounding if they

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nonhazardous and hazardous medications within a proper environment in accordance with federal law and regulation and hospital policies. Note: Aspects of a proper environment include but are not limited to air exchanges and pressures, ISO designations, viable testing, and cleaning/disinfecting. **MM.15.01.01, EP 5:** The hospital properly stores compounded sterile preparations of nonhazardous and hazardous medications and labels them with beyond-use dates in accordance with state and federal law and regulation and hospital policies. **MM.15.01.01, EP 6:** The hospital conducts quality assurance of compounded sterile preparations of nonhazardous and hazardous medications in accordance with state and federal law and regulation and organization policy. **MM.15.01.01, EP 7:** For hospitals that use Joint Commission accreditation for deemed status purposes: An appropriately trained registered pharmacist or doctor of medicine or osteopathy performs or supervises in-house preparation of radiopharmaceuticals.		knowledgeable about applicable levels of aseptic practices. ☐ Ask the pharmacy director to demonstrate how the following are accomplished to ensure that sterile compounding practices are consistent with standards for the risk level(s) of CSPs being produced for/dispensed to hospital patients: o Verification of compounding accuracy and sterility o Environmental quality and controls, including environmental sampling, testing and monitoring, and cleaning and disinfection o Staff training and competency assessment, including but not limited to accuracy/precision in identifying and measuring ingredients, cleansing and garbing, aseptic manipulation skills, environmental quality and disinfection, appropriate work practices within and adjacent to the direct compounding area, verification/calibration of equipment, sterilization, and postproduction quality checks **Document Review** **General** ☐ Ask the pharmacy director to provide evidence that compounded medications used and/or dispensed by the hospital are being compounded consistent with standard operating procedures and quality assurance practices, ☐ If the hospital obtains compounded products from external compounding sources, verify that the external source(s) are registered with the Food and Drug Administration as outsourcing facilities. If not, ask the hospital to demonstrate that it systematically

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		evaluates and monitors whether the outside compounding pharmacy adheres to accepted standards for safe compounding.
		• Review the hospital's procedures for maintaining the quality of CSPs during storage, transport and dispensing.
		  ○ Are CSPs packaged in a manner to protect package integrity and sterility?
		  ○ How are CSP-specific requirements with respect to motion, light exposure, temperature, and potentially hazardous contents addressed?
		  ○ How does the hospital ensure that such information is effectively conveyed to nonpharmacy health care personnel and/or to patients/caregivers, if applicable?
		• Ensure that the hospital is systematically monitoring and tracking adherence to all of the quality assurance and staff training and competency standards described above.
		  ○ Have any problems or risks been identified?
		  ○ If so, did the hospital take effective action to protect patients, if relevant, and to effectively remedy the problem/risk?
		Observation
		• Can the hospital demonstrate that compounded medications used and/or dispensed by the hospital are being compounded consistent with standard operating procedures and quality assurance practices?

MM.13.01.01, EP 2: The hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area and locked when necessary to	**§ 482.25(b) (2)(i)** All drugs and biologicals must be kept in a secure area, and locked when appropriate.	**Interview** • Interview staff to determine whether policies and procedures to restrict access to authorized personnel are implemented and effective.

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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.	**§ 482.25(b) (2) (ii)** Drugs listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1970 must be kept locked within a secure area. **§ 482.25(b) (2) (iii)** Only authorized personnel may have access to locked areas.	☐ If patient self-administration of drugs and biologicals is permitted, interview patients and staff to determine whether policies and procedures are implemented and effective. **Document Review** **General** ☐ Review hospital policies and procedures governing the security of drugs and biologicals to determine if they provide for securing and locking as appropriate. ☐ Verify that the hospital has policies and procedures governing patient self-administration of drugs and biologicals. ☐ Verify that the hospital has a policy or procedure that requires Schedule II, III, IV, and V drugs to be kept in a locked storage area ☐ Verify that the hospital has a policy or procedure defining authorized personnel who are permitted access to locked areas where drugs and biologicals are stored. ☐ Verify that the hospital has a policy or procedure for limiting access to locked storage areas to authorized personnel only. **Observation** ☐ Verify that medications in various areas of the hospital are stored in a secure area and locked when appropriate. o Are medication storage areas periodically inspected by pharmacy staff to make sure medications are properly stored? ☐ Determine that security features in automatic dispensing cabinets are implemented and actively maintained (for example, access authorizations are regularly updated to reflect changes in personnel, assignments).

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		☐ Observe in various parts of the hospital whether Schedule II, III, IV, and V drugs are locked and stored in a secure area. ☐ Observe whether access to locked storage areas is limited to personnel authorized by the hospital's policy.
MM.13.01.01, EP 4: The 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.	**§ 482.25(b) (3)** Outdated, mislabeled, or otherwise unusable drugs and biologicals must not be available for patient use.	**Observation** ☐ Spot-check the labels of individual drug containers to verify that they conform to federal and state law and/or contain the following minimal information: o Patient's full name o Strength and quantity of the drug dispensed o Appropriate accessory and cautionary statements o Expiration date and/or, if applicable, a beyond use date (BUD) ☐ Spot-check each floor stock container to ensure labels bear the name and strength of the drug, lot and control number of equivalent, and expiration date. ☐ If the unit dose system is used, verify that each single unit dose package bears name and strength of the drug, lot and control number equivalent, expiration date, and/or, if applicable, a BUD. ☐ Inspect patient-specific and floor stock medications to identify expired, mislabeled, or unusable medications.
MM.13.01.01, EP 5: When a pharmacist is not available, only designated staff obtain drugs and biologicals from the pharmacy or storage area in accordance with policies and procedures of medical staff and pharmaceutical service, and applicable federal and state law and regulation.	**§ 482.25(b) (4)** When a pharmacist is not available, drugs and biologicals must be removed from the pharmacy or storage area only by personnel designated in the policies of the medical staff and pharmaceutical service, in accordance with Federal and State law.	**Document Review** **General** ☐ Determine through pharmacy records that, when the pharmacist is not available, drugs are removed from the pharmacy (drug storage area) only by a designated individual (in accordance with state law, if applicable) and only in amounts sufficient for immediate therapeutic needs.

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		☐ Review policies and procedures to determine who is designated to remove drugs and biologicals from the pharmacy or storage area and the amount a non-pharmacist may remove in the absence of a pharmacist. The individual(s) designated should be identified by name and qualifications. ☐ Verify that the pharmacist reviews all medication removal activity and correlates the removal with current medication orders in the patient medication profile. ☐ Determine if the pharmacist routinely reviews the contents of the after-hours supply to determine if it is adequate to meet the after-hours needs of the hospital. **Observation** ☐ Verify that a system is in place that accurately documents the removal of medications (type and quantity) from either the pharmacy or the after-hours supply.
MM.14.01.01, EP 3: The hospital develops and implements a written policy that defines the following: - Specific types of medication orders that it deems acceptable for use - Minimum required elements of a complete medication order, which must include medication name, medication dose, medication route, and medication frequency - When indication for use is required on a medication order - Precautions for ordering medications with look-alike or sound-alike names - Actions to take when medication orders are	**§ 482.25(b) (5)** Drugs and biologicals not specifically prescribed as to time or number of doses must automatically be stopped after a reasonable time that is predetermined by the medical staff.	**Interview** ☐ Ask unit staff what happens in the case of drugs with no stop date or prescribed number of doses. o Are they aware of the automatic stop policy? o Can they describe how it is enforced? **Document Review** **General** ☐ Review policies and procedures to determine that there is a protocol established by the medical staff to discontinue and review patients' medical records to determine compliance with the stop-order policy.

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incomplete, illegible, or unclear - Required elements for medication titration orders, including the medication name, medication route, initial rate of infusion (dose/unit of time), incremental units to which the rate or dose can be increased or decreased, how often the rate or dose can be changed, the maximum rate or dose of infusion, and the objective clinical measure to be used to guide changes Note 1: Examples of objective clinical measures to be used to guide titration changes include blood pressure, Richmond Agitation–Sedation Scale (RASS), and the Confusion Assessment Method (CAM). Note 2: Drugs and biologicals not specifically prescribed as to time or number of doses are automatically stopped after a reasonable time that is predetermined by the medical staff.		

MM.17.01.01, EP 2: Medication administration errors, adverse drug reactions, and medication incompatibilities as defined by the hospital are immediately reported to the attending physician or other licensed practitioner and, as appropriate, to the hospitalwide quality assessment and performance improvement program.
 	
MM.17.01.01, EP 3: The hospital has a method (such as using established benchmarks for the size and scope of services provided by the hospital or studies on reporting rates published in peer-reviewed
	§ 482.25(b) (6) Drug administration errors, adverse drug reactions, and incompatibilities must be immediately reported to the attending physician and, if appropriate, to the hospital's quality assessment and performance improvement program.	**Interview**
		- Ask hospital staff what they do when they become aware of a medication error, adverse drug reaction (ADR), or drug incompatibility.
		- Are staff aware of and do they follow the hospital's policy and procedures?
		- Ask hospital staff how they manage drug incompatibilities.
		  - What tools do they use in the clinical setting to minimize the risk of incompatibilities?
		  - How is the information related to drug incompatibilities made available to the clinical staff administering IV medications (for example, posters, online tools)?

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journals) by which to measure the effectiveness of its process for identifying and reporting medication errors and adverse drug reactions to the quality assessment and performance improvement program.		○ How often is the information updated to ensure accuracy? □ Ask hospital staff if they are aware of the hospital's policy on reporting and documentation of medication errors and adverse drug reactions. □ How does information regarding medication errors, adverse drug reactions, and incompatibilities get reported to the hospital quality assurance/performance improvement (QAPI) program? Ask staff to speak to the process. □ For QAPI reporting purposes, is the hospital's definition of an ADR and medication error based on national standards? **Document Review** **General** □ Does the hospital have policies and procedures that define medications errors, ADRs, and drug incompatibilities? ○ Do the policies and procedures address the circumstances under which they must be reported immediately to the attending physician, as well as to the hospital's QAPI program? ○ Do they address how reporting is to occur? **Observation** □ Are all medication errors and suspected ADRs promptly recorded in the patient's medical record, including those not subject to immediate reporting? ○ If upon review of a sample of records, a suspected ADR or medication error is identified, determine if it was reported immediately to the attending or covering physician, in accordance with the hospital's written policies and procedures. ○ If it is reported to a covering physician, determine if it was also reported to the

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		attending physician when they became available.
MM.13.01.01, EP 3: The hospital reports abuses and losses of controlled substances, in accordance with federal and state law and regulation, to the individual responsible for the pharmacy department or service and, as appropriate, to the chief executive officer. Note: This element of performance is also applicable to sample medications.	**§ 482.25(b) (7)** Abuses and losses of controlled substances must be reported, in accordance with applicable Federal and State laws, to the individual responsible for the pharmaceutical service, and to the chief executive officer, as appropriate.	**Interview** ☐ Interview pharmacy director, pharmacists, or pharmacy staff to determine their understanding of the hospital's controlled drug policies. o Is there a policy and procedure for handling controlled drug discrepancies? **Document Review** **General** ☐ Conduct a spot check of drug use and other inventory records to **ensure** that drugs are properly accounted for. ☐ Review reports of pharmaceutical services to determine if there are reported problems with controlled drugs and what actions have been taken to correct the situation. o Determine if controlled drug losses were reported to appropriate authorities, in accordance with state and federal law.
MM.11.01.03, EP 1: Information relating to drug interactions, drug therapy, side effects, toxicology, dosage, indications for use, and routes of administration is available to the professional staff.	**§ 482.25(b) (8)** Information relating to drug interactions and information of drug therapy, side effects, toxicology, dosage, indications for use, and routes of administration must be available to the professional staff.	**Interview** ☐ If drug information is built into the hospital's electronic health records system, ask the pharmacy director how the hospital ensures that the information is accurate and up-to-date. ☐ Ask practitioners whether needed reference information is available to them when prescribing drugs.

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		☐ Ask nursing staff whether needed reference information is available to them when administering drugs or biologicals and when monitoring patients for effects of medication therapies. **Observation** ☐ Is drug information readily available to nurses and practitioners, whether in a hard-copy or electronic format?
MM.12.01.01, EP 2: The hospital maintains a formulary, including medication strength and dosage. The formulary is readily available to those involved in medication management. Note 1: Sample medications are not required to be on the formulary. Note 2: In some settings, the term "list of medications available for use" is used instead of "formulary." The terms are synonymous.	**§ 482.25(b) (9)** A formulary system must be established by the medical staff to assure quality pharmaceuticals at reasonable costs.	**Interview** ☐ Interview the pharmacist to determine that the medical staff has established a formulary that lists drugs that actually are available in the hospital. ☐ Interview the pharmacy director to determine that there is a process for creation and periodic review of a formulary system. **Observation** ☐ Verify that the formulary lists drugs that are available.

Hospital Radiologic Services Evaluation Module (482.26)

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LD.13.03.01, EP 1: The 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 **NPG.12.01.01, EP 1:** Leaders provide for an adequate number and mix of qualified individuals to support safe, quality care, treatment, and services. Note 1: The number and mix of individuals is appropriate to the scope and complexity of the services offered. Services may include but are not limited to the following: - Rehabilitation services - Emergency services - Outpatient services - Respiratory services - Pharmaceutical services, including emergency pharmaceutical services - Diagnostic and therapeutic radiology	**§482.26 Condition of participation: Radiologic services.** The hospital must maintain, or have available, diagnostic radiologic services. If therapeutic services are also provided, they, as well as the diagnostic services, must meet professionally approved standards for safety and personnel qualifications. **a) Standard: Radiologic services.** The hospital must maintain, or have available, radiologic services according to needs of the patients.	**Interview** Ask radiology staff and leaders how the hospital: □ Determines diagnostic radiologic services meet the needs of its patients. □ Maintains or makes available diagnostic radiologic services that can be provided promptly. □ Maintains or makes available diagnostic radiologic services at all times to support the emergency department. *If the diagnostic radiologic services are **not on the same campus** as the hospital's emergency department, same-day surgery, inpatient locations, or other areas where services dependent on radiologic services are provided ask staff and leaders how the hospital:* □ Furnishes services within clinically required time frames. o Does the hospital have an arrangement with an off-site facility to furnish diagnostic services when needed? □ Ensures that staff **authorized to interpret diagnostic studies are ready to furnish** (either on site or through telecommunications media that permit remote review and interpretation of studies) **services within clinically required time frames.** □ If it is a multi-campus hospital, is able to furnish diagnostic radiologic services when needed in a clinically appropriate timeframe for each location providing inpatient, same-day surgery, and emergency services. **Document Review** **General**

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services. Note 2: Emergency services staff are qualified in emergency care.		□ Written scope and complexity of the diagnostic radiological services it provides.
PE.02.01.01, EP 4: The hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials. The policies and procedures address the following: - Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors - Disposal of hazardous medications - Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding - Periodic inspection of radiology equipment and prompt correction of hazards found during inspection - Precautions to follow and personally protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers, and MRIs). Note 2: Hazardous gases and vapors include, but are not limited to, ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste	**§482.26(b) Standard: Safety for Patients and Personnel** The radiologic services, particularly ionizing radiology procedures, must be free from hazards for patients and personnel.	**Interview** □ Radiologic services staff to determine: ○ Familiarity with policies and procedures related to safety in general and to specific clinical protocols. ○ Training at appropriate intervals to on operating equipment according to manufacturer's instructions and hospital policy. ○ They know **how to respond to adverse events**. □ Personnel permitted to enter areas where radiologic services are provided receive required training. □ Radiologist who supervises ionizing radiologic services to determine -- ○ How the hospital **monitors quality and safety of radiologic services**. ○ How protocols for various types of ionizing radiation diagnostic or therapeutic imaging modalities are designed to minimize the amount of radiation while maximizing the yield and producing diagnostically acceptable image quality. ○ How adverse events are analyzed for causes and that preventive actions are taken (Cite deficiencies both here and under the applicable quality assurance/performance improvement CoP).

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anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9)		**Document Review** **General** □ Policies, procedures, and protocols for specific radiologic services modalities that include, but are not limited to, provisions addressing the following: o For ionizing radiation services, application of the fundamental principle of As Low as Reasonably Achievable or ALARA is considered an accepted standard of practice for ionizing radiation services to which hospitals must adhere. [11] o Written protocols designed to ensure that diagnostic studies and therapeutic procedures are routinely performed in a safe manner, utilizing parameters and specifications that are appropriate to the ordered study/procedure. [12] o Identification of patients at high risk for adverse events for whom the radiologic study or procedure might be contraindicated ▪ Steps to be taken, and by which personnel, if an order is written for a radiologic study or procedure for an individual identified in policies as potentially at high risk (e.g., notify the ordering physician, cancel the procedure personally, etc.). □ Safety protocols are reviewed periodically and, if applicable, updated with documented rationale and details for changes to technical parameters

[11] ALARA is defined by the U.S. Environmental Protection Agency (EPA) as "A principle of radiation protection philosophy that requires that exposures to ionizing radiation be kept as low as reasonably achievable, economic and social factors being taken into account. The protection from radiation exposure is ALARA when the expenditure of further resources would be unwarranted by the reduction in exposure that would be achieved." (Federal Guidance Report No. 14, Radiation Protection Guidance for Diagnostic and Interventional X-ray Procedures, p. 100, November, 2014)
[12] Developed or approved by the radiologist responsible for the radiologic services, in conjunction with other qualified radiologic services personnel (e.g., a medical physicist, radiologic technologists, patient safety officers, etc.)

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		Personnel/Credential File • Staff who perform diagnostic imaging studies or therapeutic procedures using radiologic services equipment are qualified, as applicable, and receive training that includes proper operation of equipment per manufacturer's instructions and hospital policy. **Observation** • Observe one or more radiologic studies/procedures being prepped for and/or performed. Ask for the **protocol(s) for one or more studies/procedure(s)** you are going to/or did **observe** and check that they were followed. • Confirm radiologic services areas are equipped with **equipment or materials to immediately respond to an adverse event**.
PE.02.01.01, EP 4: The hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials. The policies and procedures address the following: - Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors - Disposal of hazardous medications - Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding - Periodic inspection of radiology equipment and prompt correction of	**§482.26(b)(1)** - Proper safety precautions must be maintained against radiation hazards. This includes adequate shielding for patients, personnel, and facilities, as well as appropriate storage, use and disposal of radioactive materials.	**Document Review** **General** • Verify that the hospital has written policies and procedures to ensure safety from radiation hazards. The policies and procedures must address but are not limited to the following: o Clear and easily recognizable signage identifying hazardous radiation areas o Limitations on access to areas containing radiologic services equipment o Appropriate use of shielding, including the following: • Types of personal protective shielding to be used (for example, lead aprons, lead gloves, protective eyewear, thyroid shields, portable individualized lead panels, stationary barriers); under what circumstances; and for

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hazards found during inspection - Precautions to follow and personally protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers, and MRIs). Note 2: Hazardous gases and vapors include, but are not limited to, ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9)		patients, including high-risk patients as identified in radiologic services policies and procedures, patient family members or support persons who may be needed to be with the patient during a study or procedure, and hospital personnel • Lead and concrete barriers built into the walls and other structures of the imaging areas • Identification and use of appropriate containers to be used for various radioactive materials, if applicable, when stored, in transport between locations within the hospital, in use, and during/after disposal **Observation** □ Clear and easily recognizable signage identifies hazardous radiation areas. □ Lead and concrete barriers have been built into the walls and other structures of the imaging areas. □ Limited access to areas containing radiologic services equipment. □ Personal shielding, supplies, and equipment maintained and routinely inspected by the hospital. □ Proper shielding is applied to a patient who is undergoing a procedure using ionizing radiation. □ Staff members appropriately extricate themselves from the immediate exposure field while performing a study or procedure using ionizing radiation. □ Staff wear shielding as appropriate, per hospital policy. □ Hazardous radiation materials are clearly labeled, properly transported and stored in a safe manner in the requisite containers, and disposed of in the appropriate manner.

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PE.02.01.01, EP 4: The hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials. The policies and procedures address the following: - Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors - Disposal of hazardous medications - Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding - Periodic inspection of radiology equipment and prompt correction of hazards found during inspection - Precautions to follow and personally protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers, and MRIs). Note 2: Hazardous gases and vapors include, but are not limited to, ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9)	**482.26(b)(2) -** Periodic inspection of equipment must be made and hazards identified must be properly corrected.	**Interview** □ Ask the supervising radiologist about the following: ○ Staff education (for example, frequency, topics) ○ Processes for monitoring and trending of staff radiation exposure □ Ask staff about radiation exposure education they have received **Document Review** **General** □ Policies and procedures for conducting periodic inspections of radiology equipment □ **Inspection records (logs)** to verify periodic inspections are conducted in accordance with federal and state law and regulations and manufacturer's instructions □ **Inspection and maintenance** activities performed by **qualified individuals** □ Maintenance logs document the **calibration upon installation and after major upgrades or servicing.** □ Inspection schedule and mechanism for identifying hazards, including **accurate dosimetry** determinations with phantom patients, as applicable. □ Problems identified through testing and maintenance program are properly corrected in a timely manner and that the correction is maintained over time.
PE.02.01.01, EP 5: Radiation workers are checked periodically, using exposure	**482.26(b)(3) -** Radiation workers must be checked periodically, by the use of exposure	**Document Review** **General**

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meters or badge tests, for the amount of radiation exposure.	meters or badge tests, for amount of radiation exposure.	□ Policies and procedures for radiologic services □ Review data on staff radiation exposure, including who documented the exposure.
PC.12.01.01, EP 1: Prior to providing care, treatment, and services, the 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; hospital policies; and medical staff bylaws, rules, and regulations. Note 1: This includes but is not limited to respiratory services, radiology services, rehabilitation services, nuclear medicine services, and dietary services, if provided. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: 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.	**482.26(b)(4)** - Radiologic services must be provided only on the order of practitioners with clinical privileges or, consistent with State law, of other practitioners authorized by the medical staff and the governing body to order the services.	**Interview** Radiologic services staff □ How they know which members of the medical staff have privileges to order radiologic services. □ What they expect to see in the order and what they do if more information is needed. **Document Review** **Patient Health Record** □ Radiologic services order
MS.17.01.03, EP 5: For hospitals that use Joint Commission accreditation for deemed status purposes: A full-time, part-time, or consulting radiologist who is a doctor of medicine or osteopathy, qualified by education and experience in radiology, supervises ionizing radiology services and interprets radiologic tests that the medical staff determine to	**482.26(c) – Standard: Personnel** **(1)** A qualified full-time, part-time or consulting radiologist must supervise the ionizing radiology services and must interpret only those radiologic tests that are determined by the medical staff to require a radiologist's specialized knowledge. For purposes of this section, a radiologist is a doctor of medicine or	**Document Review** **Personnel/Credential File** □ Medical staff education and experience criteria for radiologist privileges are documented □ Supervising radiologist for ionizing radiology services.

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require a radiologist's specialized knowledge.	osteopathy who is qualified by education and experience in radiology.	**General** □ Policies and procedures for diagnostic radiology services using ionizing radiation ○ Identify which types of radiologic tests require interpretation by a radiologist ○ Identify which types of radiologic tests can be interpreted by another type of privileged practitioner ○ Radiologic test interpretation policies approved by the medical staff
MS.16.01.01, EP 11: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff determines the qualifications of the radiology staff who use equipment and administer procedures. Note: Technologists who perform diagnostic computed tomography exams will, at a minimum, meet the requirements specified at NPG.13.01.01, EP 1.	**482.26(c)(2)** - Only personnel designated as qualified by the medical staff may use the radiologic equipment and administer procedures.	**Interview** □ Ask radiology services leader(s) the following: ○ How do you limit the use of equipment and performance of studies or procedures to only designated individuals? ○ How often do you assess staff competency and provide the training needed to keep skills current? **Document Review** **General** □ Policy for radiologic services: ○ Identifies personnel who the medical staff designate as qualified to use radiologic equipment and perform diagnostic or therapeutic studies or procedures. ○ Requires personnel to have appropriate training and to demonstrate competence in use of equipment and administration of procedures prior to being designated as qualified. **Personnel/Credential File** □ Radiology personnel records include training completion dates and evidence of satisfactory competence.

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		Observation Radiologic technologists using radiologic equipment or performing studies/procedures are designated to do so
RC.12.01.01, EP 2: The medical record contains the following clinical information: - Admitting diagnosis - Any emergency care, treatment, and services provided to the patient before their arrival - Any allergies to food and medications - Any findings of assessments and reassessments - 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 hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. For the definition	**482.26(d) Standard: Records** Records of radiologic services must be maintained. **(1)** - The radiologist or other practitioner who performs radiology services must sign reports of his or her interpretations.	**Patient Health Record** Radiology reports signed by the individual who interpreted the test

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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.		
RC.11.03.01, EP 1: The retention time of the original or legally reproduced medical record is determined by its use and hospital policy, in accordance with law and regulation. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Medical records are	**482.26(d)(2)(i)-(ii)** **(2)** - The hospital must maintain the following for at least 5 years: **(i)** Copies of reports and printouts. **(ii)** Films, scans, and other image records, as appropriate.	**Interview** Radiology services leader or staff □ how many years of past radiology reports, printouts, films, scans, and other image records can be accessed. **Document Review**

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retained in their original or legally reproduced form for at least five years. This includes nuclear medicine reports; radiological reports, printouts, films, and scans; and other applicable image records.		□ Records retention policy for radiology reports, printouts, films, scans, and other image records

Hospital Laboratory Services Evaluation Module (482.27)

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LD.13.03.01, EP 1: The 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 **LD.13.03.01, EP 12:** The 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.	**§482.27 Condition of Participation: Laboratory Services** The hospital must maintain, or have available, adequate laboratory services to meet the needs of its patients. The hospital must ensure that all laboratory services provided to its patients are performed in a facility certified in accordance with Part 493 of this chapter.	**Document Review** ☐ Determine the total number of laboratories, the location of each laboratory, and every location where laboratory procedures are performed. ☐ Verify that the laboratory service and all laboratory locations are integrated into the hospital-wide QAPI program. ☐ If laboratory services are contracted, verify that the review of the quality of those services is integrated into the hospital-wide QAPI program.
LD.13.03.01, EP 1: The 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.	**§482.27(a) Standard: Adequacy of Laboratory Services** The hospital must have laboratory services available, either directly or through a contractual agreement with a certified laboratory that meets requirements of Part 493 of this chapter.	**Interview** ☐ Leaders and determine which services are provided directly by the facility and which are provided through contractual agreements ☐ Interview lab director to view the referral laboratory's CLIA number and which specialty it is in.

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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 **LD.13.03.01, EP 12:** The 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.		☐ Interview the lab director to determine if the hospital provides laboratory services in multiple locations, verify that all laboratory services are operating under a current CLIA certificate. **Document Review** Review laboratory scope of services to confirm the services that are provided directly by the facility and which are provided through contractual agreements. The lab must be certified laboratory that meets requirements of Part 493. *Note: The CLIA certification may be accomplished by having one certificate for the entire hospital's laboratory services, by having one certificate for each laboratory, or by the hospital having a mixture. Whatever the arrangement, all laboratory services must be provided in accordance with CLIA requirements and under a current CLIA certificate, even when those laboratory services take place outside of a lab.* **Observation** ☐ Examine records in the lab and determine if the services, including emergency services, are provided in accordance with the hospital's policies.
LD.13.03.01, EP 13: Emergency laboratory services are available 24 hours a day, 7 days a week.	§482.27(a)(1) (1)Emergency laboratory services must be available 24 hours a day.	**Interview the lab director** ☐ Confirm emergency laboratory services are available 24 hours a day, 7 days a week (provided directly by the hospital or through on-site contracted laboratory services)

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		☐ Emergency lab services include collection, processing, and provision of results to meet a patient's emergency laboratory needs. ☐ In a hospital with multiple hospital campuses, these emergency laboratory services are available on-site 24/7 at each campus. ☐ How does the medical staff determine which laboratory services are to be immediately available to meet the patient's needs. *Note 1: The emergency laboratory services (procedures, tests, personnel) available should reflect the scope and complexity of the hospital's operation and be provided in accordance with Federal and State law, regulations and guidelines and acceptable standards of practice.* *Note 2: At a hospital with off-campus locations, the medical staff determines which laboratory services must be immediately available to meet the patient's needs. The services must be available during the hours of operation of that location.* **Interview (Individual Tracer)** ☐ Interview the emergency department staff to see if laboratory services are available to verify the 24- hour availability of emergency services and whether those services are provided when required. **Document Review** ☐ Review the written description of the emergency laboratory services.

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		Review accession records, worksheets, and test reports to verify the 24-hour availability of services. **Observation (Individual T racer)** ☐ Observe how laboratory specimens are obtained and transported to the laboratory.
LD.13.03.01, EP 14: The hospital maintains a written description of the scope of laboratory services provided that is available to the medical staff.	**§482.27(a)(2)** **(2)** A written description of services provided must be available to the medical staff.	**Document Review** ☐ Verify the existence of a written description of the laboratory services provided, including those furnished on a routine or STAT basis (either directly or under an arrangement with an outside facility). ☐ Verify that the description of services is accurate and current.
PC.13.01.05, EP 1: The laboratory develops and implements written policies and procedures for collecting, preserving, transporting, receiving, and reporting examination results for tissue specimens.	**§482.27(a)(3)** (3) The laboratory must make provision for proper receipt and reporting of tissue specimens.	**Document Review** ☐ Verify that the laboratory has written instructions for the collection, preservation, transportation, receipt, and reporting of tissue specimen results. **Observation** ☐ Review tissue records (accession records, worksheets, and test reports) to determine if the laboratory follows the written protocol.
PC.13.01.05, EP 2: The laboratory develops and implements a written policy, approved by the medical staff and a pathologist, that establishes which tissue specimens require only a macroscopic examination, and which require both a macroscopic and microscopic examination.	**§482.27(a)(4)** **(4)** The medical staff and a pathologist must determine which tissue specimens require a macroscopic (gross) examination and which require both macroscopic and microscopic examinations.	**Document Review** ☐ Verify that the laboratory has written policies, approved by the medical staff and a pathologist, that state which tissue specimens require a macroscopic (gross) examination and which tissue specimens require both macroscopic and microscopic examination.

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		Observation Verify tissue specimens are examined in accordance with the written policies. Confirm the policies are also in accordance other Federal and State laws, regulations, and guidelines.
PC.15.01.01, EP 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital develops and implements written policies and procedures, including documentation and notification procedures, addressing potentially infectious blood and blood components, consistent with Centers for Medicare & Medicaid Services requirements at 42 CFR 482.27. Note 1: The procedures for notification and documentation conform to federal, state, and local laws, including requirements for the confidentiality of medical records and other patient information. Note 2: See Glossary for the definition of potentially infectious blood and blood components.	**§482.27(b) Standard: Potentially Infectious Blood and Blood Components** **§482.27(b)(1)** Potentially human immunodeficiency virus (HIV) infectious blood and blood components. Potentially HIV infectious blood and blood components are prior collections from a donor **§482.27(b)(1)(i)** Who tested negative at the time of donation but tests reactive for evidence of HIV infection on a later donation; **§482.27(b)(1)(ii)** Who tests positive on the supplemental (additional, more specific) test or other follow-up testing required by FDA (Food and Drug Administration); and **§482.27(b)(1)(iii)** For whom the timing of seroconversion cannot be precisely estimated **§482.27(b)(2)** Potentially hepatitis C virus (HCV) infectious blood and blood components. Potentially HCV infectious blood and blood components are the blood and blood components identified in 21 CFR 610.47.	**Interview** Interview lab staff about what they would do upon being notified of potentially infectious blood and blood components. **Document Review** ☐ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV

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LD.13.03.03, EP 5: If the hospital routinely uses the services of an outside blood collecting establishment, it must have an agreement with the blood collecting establishment that governs the procurement, transfer, and availability of blood and blood components. The agreement includes that the blood collecting establishment notify the hospital within the specified timeframes under the following circumstances: - Within 3 calendar days if the blood collecting establishment supplied blood and blood components collected from a donor who tested negative at the time of donation but tests reactive for evidence of human immunodeficiency virus (HIV) or hepatitis C virus (HCV) infection on a later donation or who is determined to be at increased risk for transmitting HIV or HCV infection - Within 45 days of the test for the results of the supplemental (additional, more specific) test for HIV or HCV or other follow-up testing required by the US Food and Drug Administration -Within 3 calendar days after the blood collecting establishment supplied blood and blood components collected from an infectious donor, whenever records are available	**§482.27(b)(3)** **(3)** Services furnished by an outside blood collecting establishment. If a hospital regularly uses the services of an outside blood collecting establishment, it must have an agreement with the blood collecting establishment that governs the procurement, transfer, and availability of blood and blood components. The agreement must require that the blood collecting establishment notify the hospital -- **§482.27(b)(3)(i)** Within 3 calendar days if the blood collecting establishment supplied blood and blood components collected from a donor who tested negative at the time of donation but tests reactive for evidence of HIV or HCV infection on a later donation or who is determined to be at increased risk for transmitting HIV or HCV infection; **§482.27(b)(3)(ii)** Within 45 days of the test, of the results of the supplemental (additional, more specific) test for HIV or HCV, as relevant, or other follow-up testing required by FDA; **§482.27(b)(3)(iii)** Within 3 calendar days after the blood collecting establishment supplied blood and blood components collected from an infectious donor, whenever records are available.	**Document Review** ☐ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV ☐ Review the written agreement with the blood collecting establishment that governs the procurement, transfer, and availability of blood and blood components.

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PC.15.01.01, EP 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital receives notification of blood that is reactive to the human immunodeficiency virus (HIV) or hepatitis C virus (HCV) screening test, the hospital determines the disposition of the blood or blood components and quarantines all previously donated blood and blood components in inventory.	**§482.27(b)(4)** **(4)** Quarantine of blood and blood components pending completion of testing. If the blood collecting establishment (either internal or under an agreement) notifies the hospital of the reactive HIV or HCV screening test results, the hospital must determine the disposition of the blood or blood component and quarantine all blood and blood components from previous donations in inventory.	**Document Review** ☐ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV. This would include determining the disposition of the blood or blood components and quarantining all blood and blood components from previous donations in inventory.
PC.15.01.01, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital receives notification that the result of the supplemental (additional, more specific) test for potentially infectious blood or blood components or other follow-up testing required by the US Food and Drug Administration is negative and there are no other informative test results, the hospital may release the blood and blood components from quarantine.	**§482.27(b)(4)(i)** **(i)** If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is negative, absent other informative test results, the hospital may release the blood and blood components from quarantine.	**Document Review** ☐ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV. *Note: If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is negative, absent other informative test results, the hospital may release the blood and blood components from quarantine.*
PC.15.01.01, EP 4: For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital receives notification that the result of the supplemental (additional, more specific) test for potentially infectious blood or blood components or other follow-up testing required by the US Food and Drug Administration is positive, the hospital does the following:	**§482.27(b)(4)(ii)** **(ii)** If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is positive, the hospital must – **§482.27(b)(4)(ii)(A)** **(A)** Dispose of the blood and blood components;	**Document Review** ☐ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV. *Note: If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is*

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- Disposes of the blood and blood components - Notifies the transfusion recipients as set forth in 42 CFR 482.27(b)(6)	and **§482.27(b)(4)(ii)(B)** **(B)** Notify the transfusion recipients as set forth in paragraph (b)(6) of this section.	*positive, the hospital must dispose of the blood and blood components.*
PC.15.01.01, EP 5: For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital receives notification that the result of the supplemental (additional, more specific) test for potentially infectious blood or blood components or other follow-up testing required by the US Food and Drug Administration (FDA) is indeterminate, the hospital destroys or labels prior collections of blood or blood components held in quarantine, consistent with FDA requirements 21 CFR 610.46(b)(2) and 610.47(b)(2).	**§482.27(b)(4)(iii)** **(iii)** If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is indeterminate, the hospital must destroy or label prior collections of blood or blood components held in quarantine as set forth at 21 CFR 610.46(b)(2) and 610.47(b)(2).	**Document Review** ☐ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV. *Note: If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is indeterminate, the hospital destroys, or labels prior collections of blood or blood components held in quarantine as set forth at 21 CFR 610.46(b)(2) and 610.47(b)(2).*
LD.13.01.01, EP 7: The hospital maintains the following: - Records of the source and disposition of all units of blood and blood components for at least 10 years from the date of disposition in a manner that permits prompt retrieval - A fully funded plan to transfer these records to another hospital or other entity if the hospital ceases operation for any reason	**§482.27(b)(5)** **(5)** Recordkeeping by the hospital. The hospital must maintain -- **§482.27(b)(5)(i)** **(i)** Records of the source and disposition of all units of blood and blood components for at least 10 years from the date of disposition in a manner that permits prompt retrieval; and **§482.27(b)(5)(ii)** **(ii)** A fully funded plan to transfer these records to another hospital or other entity if such hospital ceases operation for any reason.	**Interview** ☐ Interview the lab director if there is a fully funded plan to transfer these records to another hospital or other entity if the hospital ceases operation for any reason. **Document Review** ☐ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV. ☐ Verify that the hospital maintains records of the source and disposition of all units of blood and blood components for at least 10 years from

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		the date of disposition in a manner that permits prompt retrieval. **Observation** ☐ Ask to review records of the source and disposition of all units of blood and blood components for at least 10 years from the date of disposition in a manner that permits prompt retrieval. Verify that the hospital maintains the records.
PC.15.01.01, EP 6: For hospitals that use Joint Commission accreditation for deemed status purposes: When potentially human immunodeficiency virus (HIV) or hepatitis C virus (HCV) infectious blood or blood components are administered (either directly through the hospital's own blood collecting establishment or under an agreement) or released to another entity or individual, the hospital takes the following actions: - Makes reasonable attempts to notify the patient, the attending physician or other licensed practitioner, or the physician or other licensed practitioner who ordered the blood or blood component and ask the practitioner to notify the patient, or other individuals as permitted under 42 CFR 482.27, that potentially HIV or HCV infectious blood or blood components were transfused to the patient and that there may be a need for HIV or HCV testing and counseling - Attempts to notify to the patient, legal guardian, or relative if the practitioner is unavailable or declines to make the notification	**§482.27(b)(6)** **(6)** Patient notification. If the hospital has administered potentially HIV or HCV infectious blood or blood components (either directly through its own blood collecting establishment or under an agreement) or released such blood or blood components to another entity or individual, the hospital must take the following actions: **§482.27(b)(6)(i)** **(i)** Make reasonable attempts to notify the patient, or to notify the attending physician or the physician who ordered the blood or blood component and Interview the physician to notify the patient, or other individual as permitted under paragraph (b)(10) of this section, that potentially HIV or HCV infectious blood or blood components were transfused to the patient and that there may be a need for HIV or HCV testing and counseling. **§482.27(b)(6)(ii)** **(ii)** If the physician is unavailable or declines to make the notification, make reasonable attempts to give this notification to the patient,	**Interview** ☐ If the hospital made reasonable attempts to notify the patient, or to notify the attending physician or the physician who ordered the blood or blood component and interview the physician to notify the patient, or other individual as permitted under paragraph (b)(10) of this section, that potentially HIV or HCV infectious blood or blood components were transfused to the patient and that there may be a need for HIV or HCV testing and counseling. ☐ If the physician is unavailable or declines to make the notification, does the hospital make reasonable attempts to give this notification to the patient, legal guardian or relative? ☐ How does the hospital document the notification or attempts to give the required notification in the patient's medical record. **Document Review** ☐ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at incLDreased risk of transmitting HIV or HCV.

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- Documents in the patient's medical record the notification or attempts to give the required notification	legal guardian or relative. **§482.27(b)(6)(iii)** **(iii)** Document in the patient's medical record the notification or attempts to give the required notification.	
PC.15.01.01, EP 7: If the hospital receives notification that it received potentially human immunodeficiency virus (HIV) or hepatitis C virus (HCV) infectious blood and blood components, the hospital makes reasonable attempts to give notification over a period of 12 weeks unless one of the following occurs: - The patient is located and notified. - The hospital is unable to locate the patient and documents in the patient's medical record the extenuating circumstances beyond the hospital's control that caused the notification timeframe to exceed 12 weeks. Note: For notifications resulting from donors tested on or after February 20, 2008 as set forth at 21 CFR 610.46 and 610.47, the notification effort begins when the blood collecting establishment notifies the hospital that it received potentially HIV or HCV infectious blood and blood components.	**§482.27(b)(7)** **(7)** Timeframe for notification— For donors tested on or after February 20, 2008. For notifications resulting from donors tested on or after February 20, 2008, as set forth at 21 CFR 610.46 and 21 CFR 610.47 the notification effort begins when the blood collecting establishment notifies the hospital that it received potentially HIV or HCV infectious blood and blood components. The hospital must make reasonable attempts to give notification over a period of 12 weeks unless— **§482.27(b)(7)(i)** **(i)** The patient is located and notified; or **§482.27(b)(7)(ii)** **(ii)** The hospital is unable to locate the patient and documents in the patient's medical record the extenuating circumstances beyond the hospital's control that caused the notification timeframe to exceed 12 weeks.	**Document Review** ☐ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV. **Note:** *For notifications resulting from donors tested on or after February 20, 2008, as set forth at 21 CFR 610.46 and 21 CFR 610.47 the notification effort begins when the blood collecting establishment notifies the hospital that it received potentially HIV or HCV infectious blood and blood components. The hospital must make reasonable attempts to give* notification over a period of 12 weeks unless (see below) **Note:** The patient is located and notified; or **Note:** *If the hospital is unable to locate the patient and documents in the patient's medical record the extenuating circumstances beyond the hospital's control that caused the notification timeframe to exceed 12 weeks.*
PC.15.01.01, EP 8: When notifying patients who have received potentially human immune deficiency virus (HIV) or hepatitis C virus (HCV) infectious blood or blood components, the notification includes the following: - Oral or written information explaining the need for HIV or HCV testing and	**§482.27(b)(8)** **(8) Content of notification.** The notification must include the following information: **§482.27(b)(8)(i)** **(i)** A basic explanation of the need for HIV or HCV testing and counseling.	**Interview** ☐ Lab staff to hear and see evidence of a basic explanation of the need for HIV or HCV testing and counseling. ☐ Lab staff to determine that there is enough oral or written information so that an informed decision can be made about whether to obtain HIV or HCV testing and counseling.

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counseling, so that the patient can make an informed decision about whether to obtain HIV or HCV testing and counseling - A list of programs or places where the person can obtain HIV or HCV testing and counseling, including any requirements or restrictions the program may impose	§482.27(b)(8)(ii) (ii) Enough oral or written information so that an informed decision can be made about whether to obtain HIV or HCV testing and counseling. §482.27(b)(8)(iii) (iii) A list of programs or places where the person can obtain HIV or HCV testing and counseling, including any requirements or restrictions the program may impose.	□ Lab staff and ask to see a list of programs or places where the person can obtain HIV or HCV testing and counseling, including any requirements or restrictions the program may impose. **Document Review** □ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV. □ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV. The notification must include the following information: (see below 482.27(b)(8)(i)) □
PC.15.01.01, EP 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital develops and implements written policies and procedures, including documentation and notification procedures, addressing potentially infectious blood and blood components, consistent with Centers for Medicare & Medicaid Services requirements at 42 CFR 482.27. Note 1: The procedures for notification and documentation conform to federal, state, and local laws, including requirements for the confidentiality of medical records and other patient information. Note 2: See Glossary for the definition of potentially infectious blood and blood components.	§482.27(b)(9) (9) Policies and procedures. The hospital must establish policies and procedures for notification and documentation that conform to Federal, State, and local laws, including requirements for the confidentiality of medical records and other patient information.	**Document Review** □ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV. □ Verify that the hospital establishes policies and procedures for notification and documentation that conform to Federal, State, and local laws, including requirements for the confidentiality of medical records and other patient information.

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PC.15.01.01, EP 9: If a patient has received an infectious blood or blood component, the hospital notifies the specified individual(s) under the following circumstances: - A legal representative designated in accordance with state law if the patient has been adjudged incompetent by a state court - The patient or his or her legal representative or relative if the patient is competent but state law permits a legal representative or relative to receive the information on the patient's behalf - The patient's legal representative or relative if the beneficiary of the potentially human immunodeficiency virus infectious transfusion is deceased - The parents or legal guardian if the patient is a minor	**§482.27(b)(10)** **(10)** Notification to legal representative or relative. If the patient has been adjudged incompetent by a State court, the physician or hospital must notify a legal representative designated in accordance with State law. If the patient is competent, but State law permits a legal representative or relative to receive the information on the patient's behalf, the physician or hospital must notify the patient or his or her legal representative or relative. For possible HIV infectious transfusion recipients that are deceased, the physician or hospital must inform the deceased patient's legal representative or relative. If the patient is a minor, the parents or legal guardian must be notified.	**Interview** ☐ Interview lab staff regarding notification to legal representative or relative regarding: If the patient has been adjudged incompetent by a state court, the physician or hospital must notify a legal representative designated in accordance with State law. If the patient is competent, but State law permits a legal representative or relative to receive the information on the patient's behalf, the physician or hospital must notify the patient or his or her legal representative or relative. For possible HIV infectious transfusion recipients that are deceased, the physician or hospital must inform the deceased patient's legal representative or relative. If the patient is a minor, the parents or legal guardian must be notified **Document Review** ☐ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV.
PC.15.01.01, EP 10: The hospital complies with US Food and Drug Administration regulations pertaining to blood safety issues in the following areas: - Appropriate testing and quarantining of infectious blood and blood components - Notification and counseling of potential recipients of infectious blood and blood components Note: This applies to lookback activities	**§482.27(c) Standard: General blood safety issues.** For lookback activities only related to new blood safety issues that are identified after August 24, 2007, hospitals must comply with FDA regulations as they pertain to blood safety issues in the following areas: **§482.27(c)(1)** **(1)** Appropriate testing and quarantining of infectious blood and blood components.	**Document Review** ☐ Verify that the hospital has a system in place to take appropriate action when notified that blood or blood components it received are at increased risk of transmitting HIV or HCV For lookback activities only related to new blood safety issues that are identified after August 24, 2007: Hospitals must comply with FDA regulations as they pertain to blood safety issues in the following areas:

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only related to new blood safety issues that are identified after August 24, 2007.	§482.27(c)(2) (2) Notification and counseling of recipients that may have received infectious blood and blood components.	(1) Appropriate testing and quarantining of infectious blood and blood components. (2) Notification and counseling of recipients that may have received infectious blood and blood components.

Food and Dietetic Services Evaluation Module (482.28)

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
LD.13.03.01, EP 1: The 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 **NPG.12.01.01, EP 7:** The hospital has dietetic services that are directed and adequately staffed by qualified personnel. Note: For hospitals that provide dietetic services through contracted services, the contracted service has a dietician who serves the hospital full-time, part-time, or on a consultant basis and acts as a liaison to hospital medical staff for recommendations on dietetic policies that affect patient care, treatment, and services.	**482.28 Condition of Participation: Food and Dietetic Services** The hospital must have organized dietary services that are directed and staffed by adequate qualified personnel. However, a hospital that has a contract with an outside food management company may be found to meet this Condition of Participation if the company has a dietician who serves the hospital on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this section and provides for constant liaison with the hospital medical staff for recommendations on dietetic policies affecting patient treatment.	**Document Review** ☐ Review food and dietetic scope of services to confirm the services are in compliance with Federal and State licensure requirements for food and dietary personnel as well as food service standards, laws and regulations.

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NPG.12.01.01, EP 8: The hospital has a full-time employee, qualified through education, training, or experience, who serves as director to oversee the daily management of food and dietetic services.	**482.28(a) Standard: Organization** **482.28(a)(1) -** The hospital must have a full-time employee who– **(i)** Serves as director of the food and dietetic services; **(ii)** Is responsible for daily management of the dietary services; and **(iii)**Is qualified by experience or training.	**Interview** ☐ Verify that the director of the food and dietetic services is a full-time employee. **Document Review** **Personnel/Credential File** ☐ Review the service director's job description to verify that it is position-specific and that responsibility and authority for the direction of the food and dietary service has been clearly delineated. ☐ Review the service director's personnel file to verify that he/she has the necessary education, experience, and training to manage the service, appropriate to the scope and complexity of food service operations.
NPG.12.01.01, EP 9: The hospital has a qualified dietitian on a full-time, part-time, or consultative basis.	**482.28(a)(2) -** There must be a qualified dietitian, full-time, part-time or on a consultant basis.	**Interview** ☐ If the dietitian is not full-time, determine that the number of hours spent working is appropriate to serve the nutritional needs of the patients, and that the hospital makes adequate provisions for a qualified consultant coverage when the dietitian is not available. **Document Review** **Personnel/Credential File** ☐ Review the dietitian's personnel file to determine that he/she is qualified based on education, experience, specialized training, and, if required by State law, is licensed, certified, or registered by the State.
HR.11.01.01, EP 1: The hospital's food and dietetic administrative and technical staff are competent to perform their responsibilities.	**482.28(a)(3)** - There must be administrative and technical personnel competent in their respective duties.	**Document Review** **Personnel/Credential File** ☐ Administrative and technical staff have appropriate credentials as required and have

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		received adequate training and are competent in their respective duties.
PC.12.01.09, EP 1: The nutritional needs of the individual patient are met in accordance with clinical practice guidelines and recognized dietary practices. Note: Diet menus meet the needs of the patients.	**482.28(b) Menus must meet the needs of patients.** **(1)** - Individual patient nutritional needs must be met in accordance with recognized dietary practices.	**Interview** ☐ The dietician and confirm menus meet the nutritional needs of patients. For example, does the service rely upon Dietary Reference Intakes (DRIs), including Recommended Dietary Intakes (RDAs), in developing menus? ☐ The dietician and confirm the patient's nutritional needs are assessed by a dietician. Special needs are met. ☐ How are patients identified as having specialized needs monitored? **Document Review** **Patient Health Record Review** ☐ Diets/therapeutic diets are provided as ordered. **Note:** *Does the sample of patient records being reviewed include patients identified with special nutritional needs? If not, ask to see records for several such patients. Determine if there is evidence of monitoring the dietary intake and nutritional status of patients identified as having special nutritional needs.* **Observation** ☐ When observing care in inpatient units (or observation units where meals are provided) ask staff how patients are assessed for nutritional needs.
PC.12.01.01, EP 1: Prior to providing care, treatment, and services, the 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; hospital policies; and medical staff bylaws, rules, and	**482.28(b)(2)** - All patient diets, including therapeutic diets, must be ordered by a practitioner responsible for the care of the patient, or by a qualified dietitian or qualified nutrition professional as authorized by the medical staff and in accordance with State law governing dietitians and nutrition professionals.	**Document Review** **Patient Health Record Review** ☐ Diet orders provided as prescribed by the practitioner(s) responsible for the care of the patient, a qualified dietitian, or qualified nutrition professional. **Personnel/Credential File**

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regulations. Note 1: This includes but is not limited to respiratory services, radiology services, rehabilitation services, nuclear medicine services, and dietary services, if provided. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: 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.		☐ If diet orders prescribed by a dietitian or other nutrition professional, review records to verify the individual's appointment to the medical staff with diet-ordering privileges, or was granted diet-ordering privileges without being appointed to the medical staff. ☐ Ask the hospital how it determines whether the dietician/nutrition professional is qualified under state law. ☐ Review staff records to verify that dieticians/nutrition professionals demonstrate the required qualifications.
PC.12.01.09, EP 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The dietitian and medical staff approve a therapeutic diet manual that is current and available to all medical, nursing, and food service staff. Note: For the purposes of this element of performance, current is defined as having a publication or revision date no more than five years old.	**482.28(b)(3)** - A current therapeutic diet manual approved by the dietitian and medical staff must be readily available to all medical, nursing, and food service personnel.	**Document Review** ☐ The therapeutic diet manual is current (no more than 5 years old), and ~~Has been~~ approved by both the medical staff and a qualified dietitian; ☐ Is in accordance with the current national standards, such as RDA or DRI; ☐ Includes the different types of therapeutic diets routinely ordered at the hospital; **Observation** ☐ Is readily available to MD/DOs, nursing and food service personnel; and ☐ Is consistently used as guidance for ordering and preparing patient diets.

Hospital Utilization Review Evaluation Module (482.30)

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LD.13.01.03, EP 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan that provides for review of services provided by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note: The hospital does not need to have a utilization review plan if either a Quality Improvement Organization (QIO) has assumed binding review for the hospital or the Centers for Medicare & Medicaid Services (CMS) has determined that the utilization review procedures established by the state under title XIX of the Social Security Act are superior to the procedures required in this section, and has required hospitals in that state to meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245.	**§482.30 Condition of participation: Utilization Review.** The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. **§482.30(a) Applicability.** The provisions of this section apply except in either of the following circumstances: §482.30(a)(1) A Utilization and Quality Control Quality Improvement Organization (QIO) has assumed binding review for the hospital. §482.30(a)(2) CMS has determined that the UR procedures established by the State under title XIX of the Act are superior to the procedures required in this section, and has required hospitals in that State to meet the UR plan requirements under §§ 456.50 through 456.245 of this chapter.	*The manner and degree of noncompliance with one or more of the UR standards is considered when determining whether there is condition-level compliance or noncompliance.* **Document Review** **General** ☐ Verify that the hospital has a utilization review (UR) plan that meets regulatory requirements or has an agreement with the quality improvement organization (QIO) that provides for binding utilization review. o If there is a QIO agreement, ensure that it is signed and dated. **Note:** *It is not necessary to conduct routine surveys for compliance with the provider agreement requirement to have a QIO agreement. However, a hospital that does not satisfy the UR Conditions of Participation (CoP) through either its own program or a QIO agreement may be cited for violating the UR CoP at the condition level*
LD.13.01.03, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review committee that is either a staff committee or a group outside the hospital established by the local medical society and some or all of the hospitals in the locality or in a manner approved by the Centers for Medicare & Medicaid Services. Note: If, because of the small size of the	**§482.30(b) Standard: Composition of Utilization Review Committee.** A UR committee consisting of two or more practitioners must carry out the UR function. At least two of the members of the committee must be doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in § 482.12(c)(1).	**Interview** ☐ Ask about the criteria for small hospitals to delegate the UR function to an outside group (for example, if it is impractical to have a staff committee). ☐ Determine if UR committee members are not financially involved in the hospital (ownership of 5 percent or greater) or participants in the development or execution of the patient's treatment plan. **Document Review**

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hospital, it is impracticable to have a properly functioning staff committee, the utilization review committee is established by a group outside the hospital, as specified in 42 CFR 482.30(b)(1)(ii). **LD.13.01.03, EP 4:** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's utilization review committee consists of two or more licensed practitioners, and at least two of the members of the committee are doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in42 CFR 482.12(c)(1). Note: The committee or group's reviews are not conducted by any individual who has a direct financial interest (for example, an ownership interest) in that hospital or was professionally involved in the care of the patient whose case is being reviewed. (See also MS.16.01.03, EP 5)	**§482.30(b)(1)** Except as specified in paragraphs (b) (2) and (3) of this section, the UR committee is one of the following: **§482.30(b)(1)(i)** A staff committee of the institution; **§482.30(b)(1)(ii)** A group outside the institution— **§482.30(b)(1)(ii)(A)** Established by the local medical society and some or all of the hospitals in the locality; or **§482.30(b)(1)(ii)(B)** Established in a manner approved by CMS **§482.30(b)(2)** If, because of the small size of the institution, it is impracticable to have a properly functioning staff committee, the UR committee must be established as specified in paragraph (b)(1)(ii) of this section. **§482.30(b)(3)** The committee's or group's reviews may not be conducted by any individual who— **§482.30(b)(3)(i)** Has a direct financial interest (for example, an ownership interest) in that hospital; or **§482.30(b)(3)(ii)** Was professionally involved in the care of the patient whose case is being reviewed.	**General** ☐ Review the composition of the UR committee – does it consist of two or more practitioners who are doctors of medicine or osteopathy? ☐ Is the UR committee one of the following: o A staff committee of the institution; o A group outside of the institution; o Established by the local medical society and some or all of the hospitals in the locality; or o Established in a manner approved by CMS ☐ Verify that the hospital's governing body has delegated to the UR committee the authority and responsibility to carry out the UR function.

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LD.13.01.03, EP 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's utilization review plan provides for the review of Medicare and Medicaid patients with respect to the medical necessity of the following: - Admissions to the hospital - Duration of stays - Professional services provided, including drugs and biologicals Note 1: The hospital may perform reviews of admissions before, during, or after hospital admission. Note 2: The hospital may perform reviews on a sample basis, except for reviews of extended stay cases. **LD.13.01.03, EP 7:** For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital is paid for inpatient hospital services under the prospective payment system set forth in 42 CFR Part 412, it conducts a review of duration of stays and a review of professional services as follows: - For duration of stays, the hospital reviews only cases that it determines to be outlier cases based on extended length of stay, as described in 42 CFR 412.80(a)(1)(i). - For professional services, the hospital reviews only cases that it determines to be	**§482.30(c) Standard: Scope and frequency of review.** **§482.30(c)(1)** The UR plan must provide for review for Medicare and Medicaid patients with respect to the medical necessity of— **§482.30(c)(1)(i)** Admissions to the institution; **§482.30(c)(1)(ii)** The duration of stays; and **§482.30(c)(1)(iii)** Professional services furnished, including drugs and biologicals. **§482.30(c)(2)** Review of admissions may be performed before, at, or after hospital admission. **§482.30(c)(3)** Except as specified in paragraph (e) of this section, reviews may be conducted on a sample basis. **§482.30(c)(4)** Hospitals that are paid for inpatient hospital services under the prospective payment system set forth in part 412 of this chapter must conduct review of duration of stays and review of professional services as follows: **§482.30(c)(4)(i)**	**Interview** ☐ Ask if the hospital is reimbursed under the Inpatient Prospective Payment System (IPPS). **Note:** *This requirement does not apply to IPPS–excluded hospitals or units.* ☐ For hospitals reimbursed under IPPS, verify that the following are reviewed: o Duration of stay in cases reasonably assumed to be outlier cases o Professional services in cases reasonably assumed to be outlier cases **Document Review** **General** ☐ Verify that the utilization review plan provides review for Medicare and Medicaid patients with respect to the medical necessity of admissions, length of stays, and professional services provided (including medications and biologicals). ☐ Verify that the utilization review plan provides for the review of admissions performed before, at, or after hospital admission.

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outlier cases based on extraordinarily high costs, as described in 42 CFR 412.80(a)(1)(ii).	For duration of stays, these hospitals need review only cases that they reasonably assume to be outlier cases based on extended length of stay, as described in § 412.80(a)(1)(i) of this chapter; and **§482.30(c)(4)(ii)** For professional services, these hospitals need review only cases that they reasonably assume to be outlier cases based on extraordinarily high costs, as described in § 412.80(a)(1)(ii) of this chapter.	
LD.13.01.03, EP 6: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital develops and implements a process to determine if an admission or continued stay is not medically necessary. This determination is made by one of the following: - One member of the utilization review committee if the licensed practitioner(s) responsible for the patient's care, as specified in 42 CFR 482.12(c), concur with the determination or fail to present their views when afforded the opportunity - At least two members of the utilization review committee in all other cases Note: Before determining that an admission or continued stay is not medically necessary, the utilization review committee consults the licensed practitioner(s) responsible for the	**§482.30(d) Standard: Determination regarding admissions or continued stays.** **§482.30(d)(1)** The determination that an admission or continued stay is not medically necessary— **§482.30(d)(1)(i)** May be made by one member of the UR committee if the practitioner or practitioners responsible for the care of the patient, as specified of § 482.12(c), concur with the determination or fail to present their views when afforded the opportunity; and **§482.30(d)(1)(ii)** Must be made by at least two members of the UR committee in all other cases. **§482.30(d)(2)** Before making a determination that an admission or continued stay is not medically	**Document Review** **General** ☐ Review the UR plan to determine the actions taken if admissions or continued stays that are not meeting criteria. Are they brought to the UR committee to determine the medical necessity of the admission or continued stay? ☐ Are decisions regarding medical necessity made by either of the following: o One member of the UR committee, if the practitioner(s) responsible for the patient's care concurs with the determination or fails to present their views. The practitioner must be one of those specified in §482.12(c) o At least two members of the UR committee in all cases not qualified under the above ☐ Review a sample of "medically unnecessary" decisions to verify that the physician or practitioners, as specified in §482.12(c), were informed of the

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patient's care and affords the practitioner(s) the opportunity to present their views. **LD.13.01.03, EP 10:** For hospitals that use Joint Commission accreditation for deemed status purposes: If the utilization review committee determines that admission to or continued stay in the hospital is not medically necessary, the committee gives written notification to the hospital, the patient, and the licensed practitioner(s) responsible for the patient's care, as specified in 42 CFR 482.12(c), no later than 2 days after the determination.	necessary, the UR committee must consult the practitioner or practitioners responsible for the care of the patient, as specified in § 482.12(c), and afford the practitioner or practitioners the opportunity to present their views. **§482.30(d)(3)** If the committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given, no later than 2 days after the determination, to the hospital, the patient, and the practitioner or practitioners responsible for the care of the patient, as specified in § 482.12(c);	committees expected decision and were given an opportunity to comment. ☐ Review a sample of "medically unnecessary" cases and verify that all involved parties were notified of the decision that care was medically not necessary no later than two days following the decision.
LD.13.01.03, EP 8: For hospitals that use Joint Commission accreditation for deemed status purposes: In hospitals that are not paid under the prospective payment system, the utilization review (UR) committee periodically reviews, as specified in the UR plan, each current inpatient during a continuous period of extended duration. The scheduling of the periodic reviews may be the same for all cases or differ for different classes of cases. Note: The UR committee conducts its review no later than 7 days after the day required in the UR plan. **LD.13.01.03, EP 9:** For hospitals that use Joint Commission accreditation for deemed status purposes: In hospitals paid under the prospective payment system, the utilization	**§482.30(e) Standard: Extended stay review.** **§482.30(e)(1)** In hospitals that are not paid under the prospective payment system, the UR committee makes a periodic review, as specified in the UR plan, of each current inpatient receiving hospital services during a continuous period of extended duration. The scheduling of the periodic reviews may— **§482.30(e)(1)(i)** Be the same for all cases; or **§482.30(e)(1)(ii)** Differ for different classes of cases. **§482.30(e)(2)**	**Interview** ☐ Ask if the UR committee uses a different number of days for different diagnosis or functional categories. If the committee uses a different number of days for different diagnosis or functional categories for the period of extended stay, verify that there is a written list with lengths of stay designated for each diagnosis or functional category. **Document Review** **General** ☐ Verify that the hospital's UR plan requires a periodic review of each current Medicare/Medicaid inpatient receiving hospital services of extended duration and that the review is carried out at the specified time stated in the facility's UR plan.

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review (UR) committee reviews all cases where the extended length of stay exceeds the threshold criteria for the diagnosis, as described in 42 CFR 412.80 (a)(1)(i). The hospital is not required to review an extended stay that does not exceed the outlier threshold for the diagnosis. Note: The UR committee conducts its review no later than 7 days after the day required in the UR plan.	In hospitals paid under the prospective payment system, the UR committee reviews all cases reasonably assumed by the hospital to be outlier cases because the extended length of stay exceeds the threshold criteria for the diagnosis, as described in § 412.80(a)(1)(i). The hospital is not required to review an extended stay that does not exceed the outlier threshold for the diagnosis. **§482.30(e)(3)** The UR committee makes the periodic review no later than 7 days after the day required in the UR plan.	☐ Review minutes of the UR committee to ensure that the periodic reviews of extended stay are carried out on or before the expiration of the stated period or no later than 7 days after the day required in the hospital's plan. **Note:** *Hospitals under IPPS only need to review cases reasonably assumed to be outlier cases and extended stay that exceeds the outlier threshold for the diagnosis.*
LD.13.01.03, EP 5: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's utilization review committee reviews professional services provided to determine medical necessity and to promote the most efficient use of available health facilities and services.	**§482.30(f) Standard: Review of professional services.** The committee reviews professional services provided, to determine medical necessity and to promote the most efficient use of available health facilities and services.	**Interview** ☐ Ask how the UR committee determines which professional services to review. **Document Review** **General** ☐ Review UR committee meeting minutes to ensure that the committee reviews professional services.

Hospital Physical Environment Evaluation Module (482.41)

Note: K-tag/CoP/EP review tool is required to evaluate compliance with the Life Safety Code.

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PE.01.01.01, EP 1: The 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 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 hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria. **PE.01.01.01, EP 2:** The hospital has adequate space and facilities for the services provided, 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.	**§482.41 Condition of Participation: Physical Environment** The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.	**Observation:** ☐ Verify that all locations of the hospital, including all campuses, satellites, provider-based activities, and inpatient and outpatient locations meet this CoP.
PE.01.01.01, EP 1: The hospital's building is constructed, arranged, and maintained to allow safe access and to protect the safety	**§482.41(a) Standard: Buildings** The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner	**Observation:** ☐ Verify that the condition of the hospital (including all buildings at all locations) is maintained in a manner to assure the safety and well-being of

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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 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 hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria. **PE.01.01.01, EP 2:** The hospital has adequate space and facilities for the services provided, 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. **PE.01.01.01, EP 3:** The 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.	that the safety and well-being of patients are assured.	patients, employees, and visitors in accordance with nationally recognized standards including the following: ○ Management of safety hazards and risks related to age-related factors ○ Implementation of security features to ensure the safety of vulnerable patients. ○ Securing of access to non-clinical rooms identified as hazardous locations to prevent patient and visitor entry ○ Mitigation of ligature risks in a psychiatric hospital or psychiatric unit of a hospital, including any location where patients at risk of suicide are identified ○ Mitigation of potential safety hazards specific to weather on both the exterior and interior locations **Document Review:** ☐ Review the hospital's routine and preventive maintenance schedules to determine that ongoing maintenance inspections are performed and that necessary repairs are completed. ☐ Review a copy of the most recent environmental risk assessment to determine if the hospital has identified any accessibility, age-related, security, suicide and/or weather-related risks or concerns. If environmental safety concerns have been identified in this assessment, what plans have been implemented by the hospital to ensure patient/staff safety? **Communication with Team** ☐ Refer any potential power strip use deficiencies to Life Safety Code surveyors.

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PE.04.01.03, EP 1: The hospital has emergency power and lighting in the following areas, at a minimum,: - Operating rooms - Recovery rooms - Intensive care - Emergency rooms - Stairwells Battery lamps and flashlights are available in all other areas not serviced by the emergency power supply source.	**§482.41(a)(1)** - There must be emergency power and lighting in at least the operating, recovery, intensive care, and emergency rooms, and stairwells. In all other areas not serviced by the emergency supply source, battery lamps and flashlights must be available.	**Observation:** ☐ Verify emergency power and lighting are provided for these areas in accordance with Life Safety Code and Health Care Facilities Code
PE.04.01.03, EP 2: The hospital has a system to provide emergency gas and water supply. Note 1: The system includes making arrangements with local utility companies and others for the provision of emergency sources of water and gas. Note 2: Emergency gas includes fuels such as propane, natural gas, fuel oil, or liquefied natural gas, as well as any gases the hospital uses in the care of patients, such as oxygen, nitrogen, or nitrous oxide.	**§482.41(a)(2)** - There must be facilities for emergency gas and water supply.	**Interview:** ☐ Discuss how hospital staff determine the hospital's needs for emergency gas and water. Verify that the hospital accounts for inpatients, staff, and other individuals who come into the hospital in need of care during emergencies. ☐ Discuss with staff what the source is for emergency gas and water (quantity of supplies, availability, and how obtained) ☐ Verify that arrangements have been made with utility companies and others for the provision of emergency sources of critical utilities.
PE.03.01.01, EP 3: The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients	**§482.41(b) Standard: Life Safety from Fire** The hospital must ensure that the life safety from fire requirements are met.	**Observe:** ☐ Use the K-tag/CoP/EP Review tool to evaluate compliance with the Life Safety Code.

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served. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: 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 hospitals. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: 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 hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.		
PE.03.01.01, EP 3: The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim	**§482.41(b)** **(1) Except as otherwise provided in this section—**	**Observation:** ☐ Use the K-tag/CoP/EP Review tool to evaluate compliance with the Life Safety Code.

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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: For hospitals that use Joint Commission accreditation for deemed status purposes: 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 hospitals. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: 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 hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: 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	(i) The hospital 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.) Outpatient surgical departments must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served.	

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standard(s) referenced for the activity; and results of the activity.		
PE.03.01.01, EP 6: For hospitals that use Joint Commission accreditation for deemed status purposes: Regardless of the provisions of the Life Safety Code, corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited on these doors.	**§482.41(b)** **(1) Except as otherwise provided in this section—** **(ii)** Notwithstanding paragraph (b)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors.	**Observation:** □ Use the K-tag/CoP/EP Review tool to evaluate compliance with the Life Safety Code.
PE.03.01.01, EP 3: The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: 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 hospitals. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: In consideration of a recommendation by the state survey agency	**§482.41(b)(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 hospital, but only if the waiver will not adversely affect the health and safety of the patients. **Note: Waivers can only be granted by CMS**	**Refer to The Joint Commission's website for additional guidance on waivers.**

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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 hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.		
PE.03.01.01, EP 3: The 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: For hospitals that use Joint Commission accreditation for deemed status purposes: 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	**§482.41(b)(3)** The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and safety code imposed by State law adequately protects patients in hospitals.	

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code imposed by state law adequately protects patients in hospitals. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: 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 hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: 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.02.01.01, EP 6: The hospital has procedures for the proper routine storage and prompt disposal of trash and regulated medical waste.	**§482.41(b)(4)** - The hospital must have procedures for the proper routine storage and prompt disposal of trash.	**Observation:** ☐ Verify that the hospital follows its process for storage and disposal of trash and medical waste.
PE.03.01.01, EP 4: The hospital has written fire control plans that include provisions for prompt reporting of fires; extinguishing fires; protection of patients, staff, and guests;	**§482.41(b)(5)** - The hospital must have written fire control plans that contain provisions for prompt reporting of fires; extinguishing fires; protection of patients, personnel and guests; evacuation; and cooperation with fire-fighting authorities.	**Interview:** ☐ Interview staff to verify their knowledge of their responsibilities during a fire **Document Review:** ☐ Review the hospital's fire control plan to verify that the plan includes the required elements

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evacuation; and cooperation with firefighting authorities.		
PE.03.01.01, EP 5: The hospital maintains written evidence of regular inspection and approval by state or local fire control agencies.	**§482.41(b)(6)** - The hospital must maintain written evidence of regular inspection and approval by State or local fire control agencies.	**Document Review:** □ Review copies of inspection and approval reports from state or local fire control agencies.
PE.03.01.01, EP 7: When the hospital installs alcohol-based hand rub dispensers, it installs the dispensers in a manner that protects against inappropriate access.	**§482.41(b)(7)** - A hospital may install alcohol-based hand rub dispensers in its facility if the dispensers are installed in a manner that adequately protects against inappropriate access.	**Observation:** □ Verify that ABHR dispensers are installed in accordance with Life Safety Code requirements (see K-tag/CoP/EP Review tool) and maintained in accordance with manufacturer recommendations or established policies and procedures.
PE.03.01.01, EP 8: When a sprinkler system is shut down for more than 10 hours, the hospital either evacuates the building or portion of the building affected by the system outage until the system is back in service or the hospital establishes a fire watch until the system is back in service.	**§482.41(b)(8)** When a sprinkler system is shut down for more than 10 hours, the hospital must: (i) Evacuate the building or portion of the building affected by the system outage until the system is back in service, or (ii) Establish a fire watch until the system is back in service.	**Interview:** □ Discuss with facilities staff how they would handle a situation where a sprinkler system is shut down for more than 10 hours.
PE.03.01.01, EP 9: Buildings have an outside window or outside door in every sleeping room, and for any building constructed after July 5, 2016, the sill height does not exceed 36 inches above the floor. Note 1: Windows in atrium walls are considered outside windows for the purposes of this requirement. Note 2: The sill height requirement does not apply to newborn nurseries and rooms	**§482.41(b)(9)** Buildings must have an outside window or outside door in every sleeping room, and for any building constructed after July 5, 2016 the sill height must not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows for the purposes of this requirement. (i) The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours. (ii) The sill height in special nursing care areas of new	**Observation:** □ Use the K-tag/CoP/EP Review tool to evaluate compliance with the outside window or door requirements.

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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.	occupancies must not exceed 60 inches.	
PE.04.01.01, EP 1: The hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5 and 12-6). 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 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.	**§482.41(c) Standard: Building Safety** Except as otherwise provided in this section, the hospital must meet the applicable provisions and must proceed in accordance with the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12–2, TIA 12–3, TIA 12–4, TIA 12–5 and TIA 12–6). (1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to a hospital. (2) If application of the Health Care Facilities Code required under paragraph (c) of this section would result in unreasonable hardship for the hospital, 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.	**Document Review:** ☐ Review plans, policies and procedures, and documentation to determine compliance with Health Care Facilities Code requirements. **Observation:** ☐ Use the K-tag/CoP/EP Review tool to evaluate compliance with the Health Care Facilities Code.
PE.01.01.01, EP 1: The hospital's building is constructed, arranged, and maintained to allow safe access and to protect the safety and well-being of patients.	**§482.41(d) Standard: Facilities** The hospital must maintain adequate facilities for its services.	**Document Review:** ☐ Review the facility's water supply and distribution system to ensure that the water quality is

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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 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 hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria. **PE.01.01.01, EP 2:** The 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.		acceptable for its intended use (drinking water, irrigation water, lab water, etc.). Review the facility water quality monitoring and, as appropriate, treatment system. **Observation:** □ Observe the facility layout and determine if the patient's needs are met. Toilets, sinks, specialized equipment, etc. should be accessible.
PE.01.01.01, EP 1: The 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 hospital uses state rules and regulations, or the current Guidelines for Design and Construction of	**§482.41(d)(1)** - Diagnostic and therapeutic facilities must be located for the safety of patients.	**Observation:** □ When conducting patient tracers or the building tour, determine that x-ray, physical therapy, and other specialized services are provided in areas appropriate for the service provided

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Hospitals published by the Facility Guidelines Institute. If the state rules and regulations or the Guidelines do not address the design needs of the hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria.		
PE.04.01.01, EP 2: The hospital maintains essential equipment in safe operating condition. **PE.04.01.01, EP 5:** The hospital maintains supplies to ensure an acceptable level of safety and quality. Note: Supplies are stored in a manner to ensure the safety of the stored supplies and to not violate fire codes or otherwise endanger patients. **PE.04.01.05, EP 1:** The water management program has an individual or a team responsible for the oversight and implementation of the program, including but not limited to development, management, and maintenance activities. **PE.04.01.05, EP 2:** The individual or team responsible for the water management program develops the following: - A basic diagram that maps all water supply sources, treatment systems, processing steps, control measures, and end-use points Note: An example would be a flow chart with symbols showing sinks, showers, water	**§482.41(d)(2)** - Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.	**Interview:** Interview personnel in charge of equipment maintenance to determine: - If the hospital has identified equipment that is essential for both regular operations and in an emergency situation. - If the hospital has made adequate provisions to ensure the availability of those and equipment when needed. Interview equipment users on units/departments to determine: - If equipment failures are occurring and causing problems for patient health or safety. **Document Review:** Review equipment inventory to verify the following: - The inventory is complete and includes equipment required to meet patient needs regardless of ownership. - Critical equipment is readily identified - If AEM program is used, equipment in the program is readily identified Review equipment maintenance documentation to verify the following: - All equipment is inspected and tested for performance and safety before initial use and after major repairs or upgrades

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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: 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		☐ All equipment is inspected, tested, and maintained to ensure its safety, availability and reliability in accordance with established maintenance activities based on manufacturer's recommendations or alternative equipment maintenance program Review documentation to verify: ☐ Individual(s) responsible for overseeing the development, implementation, and management of equipment maintenance programs and activities (including contractors) are qualified. Examples include training certificates or certifications. **If the hospital is following the manufacturer-recommended equipment maintenance activities and frequencies:** **Document Review:** In addition to reviewing maintenance records on equipment observed while inspecting various hospital locations for multiple compliance assessment purposes, select a sample of equipment from the hospital's equipment inventory to determine whether the hospital is following the manufacturer's recommendations. Critical equipment which poses a higher risk to patient safety if it were to fail, such as ventilators, defibrillators, robotic surgery devices, etc. should make up the sample majority. For the sample selected, determine if: ☐ The hospital has available manufacturer's recommendations (e.g., manufacturer's operation and maintenance manual, standards, studies, guidance, recall information, service records, etc.). ☐ Maintenance is being performed in accordance with manufacturer's recommendations

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actions taken when parameters are out of range. (See also IC.04.01.01, EP 2) **PE.04.01.05, EP 3:** The individual or team responsible for the water management program manages the following: - Documenting results of all monitoring activities - Corrective actions and procedures to follow if a test result outside of acceptable limits is obtained, including when a probable or confirmed waterborne pathogen(s) indicates action is necessary - Documenting corrective actions taken when control limits are not maintained Note: See PE.07.01.01, EP 1 for the process of monitoring, reporting, and investigating utility system issues. **PE.04.01.05, EP 4:** The individual or team responsible for the water management program reviews the program annually and when the following occurs: - Changes have been made to the water system that would add additional risk. - New equipment or an at-risk water system(s) has been added that could generate aerosols or be a potential source for Legionella. This includes the commissioning of a new wing or building. Note 1: The Joint Commission and the Centers for Medicare & Medicaid Services (CMS) do not require culturing for Legionella or other waterborne pathogens. Testing		**If a hospital is using an AEM for some equipment:** **Document Review:** ☐ Verify that the hospital's inventory does not include equipment ineligible for AEM, for example, any diagnostic imaging or therapeutic radiologic equipment? ☐ Verify for each type of equipment subject to the AEM program, that there is documentation indicating: o The pertinent types and level of risks to patient or staff health and safety o Alternate maintenance activities, and the maintenance strategy and any other rationale used to determine those activities o Alternate maintenance frequencies to be used, if any, and the maintenance strategy and any other rationale used to determine those frequencies o The date when AEM program maintenance activities were performed and, if applicable, further actions required/taken o If any equipment failures (not including failures due to operator error) occurred, including whether there was resulting harm to an individual. ☐ Verify the CAH has policies and procedures which address the effectiveness of its AEM program. ☐ Verify the hospital is evaluating the safety and effectiveness of the AEM program. ☐ If there is equipment on the inventory the hospital has identified as having such a very low level of risk that it has determined it can use a broad interval range or departmental "sweeps," ask the hospital for the evidence used to make this determination. Does it seem reasonable?

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protocols are at the discretion of the 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.”		**Interview:** Select a sample of equipment in the AEM program. The majority of the sample must include critical equipment which poses a higher risk to patient safety if it were to fail, such as ventilators, defibrillators, robotic surgery devices, etc. For the sample selected: □ Ask the responsible personnel to explain how the decision was made to place the equipment in an AEM program. Does the methodology used consider risk factors and make use of available evidence? □ Ask the responsible personnel to describe the methodology for applying maintenance strategies and determining alternative maintenance activities or frequencies for the sampled equipment. Can they readily provide an explanation and point to sources of information (accepted standards of practice for facility or medical equipment) they relied upon? □ Determine if maintenance is being performed in accordance with the maintenance activities and frequencies defined in the AEM program in accordance with established policies and procedures □ Verify the hospital is evaluating the safety and effectiveness of the AEM maintenance activities for this equipment and taking corrective actions when needed.
PE.01.01.01, EP 2: The 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.	**§482.41(d)(3)** - The extent and complexity of facilities must be determined by the services offered.	**Observation:** □ Verify through observation that the physical facilities are large enough and properly equipped for the scope of services provided and the number of patients served. Appropriate size of facility

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Note: The extent and complexity of facilities is determined by the services offered.		should be based on state rules and regulations and the current FGI guidelines.
PE.04.01.01, EP 3: The hospital has proper ventilation, lighting, and temperature control in all pharmaceutical, patient care, and food preparation areas.	**§482.41(d)(4)** - There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas.	**Observation:** □ Verify that food and medication preparation areas are well lit □ Verify the hospital is in compliance with ventilation requirements □ Verify that food products are stored under appropriate conditions based on nationally accepted sources □ Verify pharmaceuticals are stored in accordance with manufacturer's recommendations **Document Review:** □ Review monitoring records for temperature to make certain that appropriate levels are maintained
PE.04.01.01, EP 1: The hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). 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 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;	**§482.41(e) through (e)(1)(xi)** The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federalregulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.	**PE.04.01.01, EP 1 (482.41(e)(1)(vii) through (e)(1)(xi))** **PE.03.01.01, EP 3 (482.41(e)(1)(i) through (e)(1)(vi))**

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date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity. **PE.03.01.01, EP 3:** The 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: For hospitals that use Joint Commission accreditation for deemed status purposes: 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 hospitals. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: 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,	(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Standards for Health Care Facilities Code of the National Fire Protection Association 99, 2012 edition, issued August 11, 2011. (ii) TIA 12–2 to NFPA 99, issued August 11, 2011. (iii) TIA 12–3 to NFPA 99, issued August 9, 2012. (iv) TIA 12–4 to NFPA 99, issued March 7, 2013. (v) TIA 12–5 to NFPA 99, issued August 1, 2013. (vi) TIA 12–6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011; (viii) TIA 12–1 to NFPA 101, issued August 11, 2011. (ix) TIA 12–2 to NFPA 101, issued October 30, 2012. (x) TIA 12–3 to NFPA 101, issued October 22, 2013. (xi) TIA 12–4 to NFPA 101, issued October 22, 2013.	

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CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: 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.		

Hospital Infection Prevention and Control and Antibiotic Stewardship Programs Evaluation Module (482.42)

Note: The interview with the infection preventionist(s)/infection control professional(s) and document review for the infection prevention and control program occur during a 60-minute targeted session on Survey Day 1 (the timing of the session can be negotiated with the organization based on key staff availability). Observations of infection control–related systems and activities are evaluated throughout the survey of all organization settings by all surveyors.

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IC.04.01.01, EP 2: The infection preventionist(s) or infection control professional(s) is responsible for the following: - Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines - Documentation of the infection prevention and control program and its surveillance, prevention, and control activities - Competency-based training and education of hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the hospital, on infection prevention and control 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 hospital involved in infection prevention and control activities,	**§482.42 Condition of Participation: Infection Prevention and Control and Antibiotic Stewardship Programs** The hospital 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.	**Document Review** ☐ Review the infection prevention and control and antibiotic stewardship program documents for evidence of the following: o The hospital has an active, hospitalwide program for surveillance, prevention, and control of health care–associated infections and other infectious diseases based on national standards of practice and best practices. o The infection prevention and control program is working collaboratively with the hospital QAPI program to address issues identified in the infection control program. o The hospital has an active hospital-wide program for the optimization of antibiotic use through stewardship based on national standards of practice and best practices. o The hospital is working collaboratively between antibiotic stewardship and hospital QAPI when antibiotic use issues are identified.

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including but not limited to the antibiotic stewardship program, sterile processing department, and water management program - Communication and collaboration with the hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.11.04.01, EP 1). **IC.04.01.01, EP 3:** The hospital's infection prevention and control program has written policies and procedures to guide its activities and methods for preventing and controlling the transmission of infections within the hospital and between the hospital and other institutions and settings. The policies and procedures are in accordance with the following hierarchy of references: 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		

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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/infectioncontrol/guidelines/core-practices/index.html. Note 3: The hospital determines which evidence-based guidelines, expert recommendations, best practices, or a		

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combination thereof it adopts in its policies and procedures. **IC.04.01.01, EP 5:** The infection prevention and control program reflects the scope and complexity of the hospital services provided by addressing all locations, patient populations, and staff. **IC.05.01.01, EP 1:** The hospital's governing body 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 provides access to information technology; laboratory services; equipment and supplies; local, state, and federal public health authorities' advisories and alerts, such as the CDC's Health Alert Network (HAN); FDA alerts; manufacturers' instructions for use; and guidelines used to inform policies. **IC.05.01.01, EP 2:** The hospital's governing body ensures that the problems identified by the infection prevention and control program are addressed in collaboration with hospital quality assessment and performance improvement leaders and other leaders (for example, the medical		

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director, nurse executive, and administrative leaders). **IC.06.01.01, EP 3:** The 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 hospital. **MM.18.01.01, EP 1:** The antibiotic stewardship program reflects the scope and complexity of the hospital services provided. **MM.18.01.01, EP 3:** The leader(s) of the antibiotic stewardship program is responsible for the following: - Development and implementation of a 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 activities - Communication and collaboration with the medical staff, nursing, and pharmacy leadership, as well as with the hospital's infection prevention and control and QAPI programs, on antibiotic use issues - Competency-based training and education of hospital personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the		

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hospital, on the practical applications of antibiotic stewardship guidelines, policies, and procedures **PE.04.01.01, EP 1:** The hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). 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 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.		
HR.11.02.01, EP 2: The 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: Qualifications for laboratory	**§482.42(a) Standard:** **Infection prevention and control program organization and policies. The hospital must demonstrate that:** **(1)** An individual (or individuals), who is qualified through education, training, experience, or certification in infection prevention and control, is appointed by the governing body as the infection	**Interview** ☐ Interview the infection preventionist(s)/infection professional(s) to determine whether resources are adequate to accomplish the tasks required for the infection prevention and control program. ☐ Interview the hospital leaders about the criteria the hospital uses to determine whether the resource allocation to the IPC program matches the determined needs.

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personnel are described in the Clinical Laboratory Improvement Amendments (CLIA), under Subpart M: "Personnel for Nonwaived Testing" §493.1351-§493.1495. A complete description of the requirement is located at https://www.ecfr.gov/cgi-bin/text-idx?SID=0854acca5427c69e771e5beb52b0b986&mc=true&node=sp42.5.493.m&rgn=div6. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: 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 hospital. See Glossary for definitions of physical therapist, physical therapist assistant, occupational therapist, occupational therapy assistant, speech-language pathologist, and audiologist. Note 4: Qualifications for language interpreters and translators may be met through language proficiency assessment, education, training, and experience. The use of qualified interpreters and translators is supported by the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and Title VI of the Civil Rights Act of 1964.	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;	**Document Review** **Personnel/Credential File** ☐ Review the personnel file of the infection preventionist(s)/infection control professional(s) to determine whether they are qualified through professional education, training, experience, or certification to oversee IPC program. ☐ Verify that the individual(s) was appointed by the hospital's governing body based on recommendations by medical and nursing staff leaders.

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Note 5: 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, EP 12:** The hospital's governing body, based on the recommendation of the medical staff and nursing leaders, appoints an infection preventionist(s) or infection control professional(s) qualified through education, training, experience, or certification in infection prevention to be responsible for the infection prevention and control program.		
IC.04.01.01, EP 3: The hospital's infection prevention and control program has written policies and procedures to guide its activities and methods for preventing and controlling the transmission of infections within the hospital and between the hospital and other institutions and settings. The policies and procedures are in accordance with the following hierarchy of references: 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	**§482.42(a)(2)** The hospital infection prevention and control program, as documented in its policies and procedures, employs methods for preventing and controlling the transmission of infections within the hospital and between the hospital and other institutions and settings;	**Document Review** **General** ☐ Review policies and procedures for infection prevention and control to ensure that the hospital is employing methods for preventing and controlling the transmission of infections within the hospital and between the hospital and other health care settings. **Observation** ☐ Determine if the IPC program is being applied throughout the hospital to both inpatient and outpatient settings.

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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/infectioncontrol/guidelines/core-practices/index.html. Note 3: The hospital determines which evidence-based guidelines, expert recommendations, best practices, or a combination thereof it adopts in its policies and procedures. **IC.04.01.01, EP 4:** The hospital's policies and procedures for cleaning, disinfection, and sterilization of reusable medical and		

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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		

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reprocessing error or failure identified either prior to the release of the reprocessed item(s) or after the reprocessed item(s) was used or stored for later use Note 1: The Spaulding classification system classifies medical and surgical devices as critical, semicritical, or noncritical based on risk to the patient from contamination on a device and establishes the levels of germicidal activity (sterilization, high-level disinfection, intermediate-level disinfection, and low-level disinfection) to be used for the three classes of devices. Note 2: Depending on the nature of the incident, examples of actions may include quarantine of the sterilizer, recall of item(s), stakeholder notification, patient notification, surveillance, and follow-up.		
IC.06.01.01, EP 3: The 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 hospital. **IC.06.01.01, EP 4:** The hospital implements its policies and procedures for infectious disease outbreaks, including the following: - Implementing infection prevention and control activities when an outbreak is first	**§482.42(a)(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	**Document Review** ☐ Review documentation of surveillance activities, including the measures selected for monitoring, collection, and analysis. Based on the review, determine whether the surveillance program employes methods to permit identifying and monitoring infections and communicable diseases throughout various locations or departments. ☐ Review the water management program documentation related to the hospital risk assessment and water quality monitoring. ☐ Verify that the hospital has policies and procedures for the detection, investigation, and control of outbreaks that are consistent with state and local public health authority requirements for identification, reporting, and containing communicable diseases and outbreaks.

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recognized by internal surveillance or public health authorities - Reporting an outbreak in accordance with state and local public health authorities' requirements - Investigating an outbreak - Communicating information necessary to prevent further transmission of the infection among patients, visitors, and staff, as appropriate **IC.06.01.01, EP 5:** The 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 **PE.01.01.01, EP 1:** The 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 hospital uses state rules and regulations or the current		**Observation** ☐ Observe the hospital for the sanitary condition of its environments of care, noting the cleanliness of patient rooms, floors, horizontal surfaces, patient equipment, air inlets, mechanical rooms, food service activities, treatment and procedure areas, surgical areas, central supply, storage areas, and medication preparation areas.

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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 hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria. **PE.04.01.05, EP 1:** The water management program has an individual or a team responsible for the oversight and implementation of the program, including but not limited to development, management, and maintenance activities. **PE.04.01.05, EP 2:** The individual or team responsible for the water management program develops the following: - A basic diagram that maps all water supply sources, treatment systems, processing steps, control measures, and end-use points Note: An example would be a flow chart with symbols showing sinks, showers, water fountains, ice machines, and so forth. - A water risk management plan based on the diagram that includes an evaluation of the physical and chemical conditions of each step of the water flow diagram to identify any areas where potentially hazardous conditions may occur (these conditions are most likely to occur in areas with slow or stagnant water) Note: Refer to the Centers for Disease		

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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: Hospitals should consider incorporating basic practices for water monitoring within their water management programs that include monitoring of water temperature, residual disinfectant, and pH. In addition, protocols should include specificity around the parameters measured, locations where measurements are made, and appropriate corrective actions taken when parameters are out of range.		
IC.04.01.01, EP 5: The infection prevention and control program reflects the scope and complexity of the hospital services provided by addressing all locations, patient populations, and staff.	§482.42(a)(4) The infection prevention and control program reflects the scope and complexity of the hospital services provided.	Interview ☐ Interview hospital staff in various locations or areas on collection of infection and communicable disease data and actions to reduce the risks of infections. Document review ☐ Determine whether the infection control and prevention program is hospital-wide and program-specific in gathering and assessing infection and

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		communicable disease data and in taking steps to reduce the risks of infections. ☐ Review documentation of surveillance activities to determine whether active surveillance is suitable to the scope and complexity of the hospital's services and the population served.
MM.18.01.01, EP 2: The hospital demonstrates that an individual (or individuals), who is qualified through education, training, or experience in infectious diseases and/or antibiotic stewardship, is appointed by the governing body as the leader(s) of the antibiotic stewardship program and that the appointment is based on the recommendations of medical staff leadership and pharmacy leadership.	**§482.42(b)(1) Standard:** Antibiotic stewardship program organization and policies. The hospital must demonstrate that: **(1)** An individual (or individuals), who is qualified through education, training, or experience in infectious diseases and/or antibiotic stewardship, is appointed by the governing body as the leader(s) of the antibiotic stewardship program and that the appointment is based on the recommendations of medical staff leadership and pharmacy leadership;	**Interview** ☐ Determine whether the antibiotic stewardship leader(s): o Was appointed by the governing body based on recommendations from medical staff and pharmacy leaders and has the responsibility for the antibiotic stewardship program. o Is a physician and/or pharmacist. ☐ Ask the leader(s) about their qualifications to oversee the antibiotic stewardship program. **Note:** *Training and/or certification may be obtained through organizations such as the specialty boards in adult or pediatric infectious diseases offered for physicians by the American Board of Internal Medicine (for internists), the American Board of Pediatrics (for pediatricians), and the Society for Infectious Disease Pharmacists (for pharmacists).* o If board members are present, ask how they are involved in decisions about antibiotic stewardship leader(s). **Document Review** **General** ☐ Determine whether the leader(s) of antibiotic stewardship: o Was appointed by the governing body based on recommendations by medical staff and pharmacy leaders and has the responsibility for the antibiotic stewardship program. o Has developed and implemented the hospital's antibiotic stewardship policies.

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		Note: *Antibiotic stewardship policies should address the roles and responsibilities for antibiotic stewardship and use within the hospital, how the various hospital committees and departments interface with the antibiotic stewardship program, and how to optimize antibiotic use.* ☐ Review the criteria the hospital used to determine the resources necessary to operate effectively and ensure the resource allocation matches the determined needs. **Personnel/Credential File** ☐ Review the personnel file of the antibiotic stewardship leader(s) to determine whether they are qualified through ongoing education, training, experience, or certification to oversee the antibiotic stewardship program. **Note:** *Training and/or certification may be obtained through organizations such as the specialty boards in adult or pediatric infectious diseases offered for physicians by the American Board of Internal Medicine (for internists), the American Board of Pediatrics (for pediatricians), and the Society for Infectious Disease Pharmacists (for pharmacists).*
MM.18.01.01, EP 5: The hospitalwide antibiotic stewardship program: - Demonstrates coordination among all components of the 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	**§482.42(b)(2)** The hospital-wide antibiotic stewardship program: **(i)** Demonstrates coordination among all components of the 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; **(ii)** Documents the evidence-based use of antibiotics in all departments and services of the hospital; and **(iii)** Documents improvements, including sustained improvements, in proper antibiotic use, such as through reductions in CDI and antibiotic	**Interview** ☐ Verify with staff who prescribe antibiotics that the hospital implements and maintains an active and hospitalwide antibiotic stewardship program as an effective means to improve the hospital's antibiotic-prescribing practices. ☐ Ask staff who prescribe antibiotics how the hospital promotes the evidence-based use of antibiotics to reduce the incidence of adverse consequences of inappropriate antibiotic use, including but not limited to adverse drug events, CDIs, and the growth of antibiotic resistance in the hospital overall. **Document Review** **General**

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of the hospital. - Documents any improvements, including sustained improvements, in proper antibiotic use.	resistance in all departments and services of the hospital;	☐ Review antibiotic stewardship policies and procedures for evidence of a process for the coordination of all components of the hospital related to antibiotic use and resistance, including but not limited to the antibiotic stewardship program, the infection prevention and control program, the quality assurance/performance improvement program, the medical staff, nursing services, and pharmacy services. ☐ Confirm that the hospital develops and implements antibiotic stewardship interventions to address issues identified through its assessment activities and then monitors the effectiveness of interventions through further data collection and analysis. ☐ Verify that the hospital promotes evidence-based use of antibiotics to reduce the incidence of adverse consequences of inappropriate antibiotic use, including but not limited to treatment failures, *C. difficile* infections (CDIs), and growth of antibiotic resistance in the hospital overall. ☐ Verify that the hospital's antibiotic use is consistent with their documented evidence-based, hospitalwide antibiotic stewardship program recommendations. ☐ Review documentation of improvements and/or sustainment of improvements through the use of the evidence-based, hospitalwide antibiotic stewardship program recommendations. ☐ Confirm that the antibiotic stewardship program is updated with any advancing evidence-based improvements in antibiotic-prescribing practices.
MM.18.01.01, EP 6: The antibiotic stewardship program adheres to nationally recognized guidelines, as well as best practices, for improving antibiotic use.	**§482.42(b)(3)** The antibiotic stewardship program adheres to nationally recognized guidelines, as well as best practices, for improving antibiotic use; and	**Interview** ☐ Ask staff who prescribe antibiotics about the nationally recognized guidelines that have been implemented as part of the hospitalwide antibiotic stewardship program. **Document Review** **General**

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		☐ Verify that nationally recognized guidelines have been implemented for the evidence-based, hospitalwide antibiotic stewardship program. ☐ Verify that core elements of best practices have been included within the hospitalwide antibiotic stewardship program, including hospital leadership commitment, accountability, pharmacy expertise, tracking, reporting, education, and appropriate interventions or actions being taken to improve antibiotic use to reduce adverse events, prevent emergence of resistance, and ensure better outcomes for patients in this setting. **Note:** *See the Centers for Disease Control and Prevention's Core Elements of Antibiotic Stewardship at https://www.cdc.gov/antibiotic-use/coreelements/index.html for more information. Examples of other organizations with nationally recognized antibiotic stewardship guidelines and/or recommendations include but are not limited to the Society for Healthcare Epidemiology of America, the Infectious Diseases Society of America, the American Society for Health System Pharmacists, and the Society for Infectious Disease Pharmacists.*
MM.18.01.01, EP 1: The antibiotic stewardship program reflects the scope and complexity of the hospital services provided.	**§482.42(b)(4)** The antibiotic stewardship program reflects the scope and complexity of the hospital services provided.	**Document Review** **General** ☐ Review the parameters of the antibiotic stewardship program to determine whether it is suitable to the scope and complexity of the hospital's services.
IC.05.01.01, EP 1: The hospital's governing body 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.	**§482.42(c)(1) Standard: Leadership responsibilities** **(1)** The governing body must ensure all of the following: **(i)** Systems are in place and operational for the tracking of all infection surveillance, prevention, and control, and antibiotic use activities, in order	**Document Review** **General** ☐ Review the hospital policies and governing body meeting minutes for record of support for the infection control and antibiotic stewardship programs. ☐ Verify that the hospital policies are being followed for the tracking of all infection surveillance,

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Note: To make certain that systems are in place and operational to support the program, the governing body provides access to information technology; laboratory services; equipment and supplies; local, state, and federal public health authorities' advisories and alerts, such as the CDC's Health Alert Network (HAN); FDA alerts; manufacturers' instructions for use; and guidelines used to inform policies. **MM.18.01.01, EP 7:** The governing body 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.	to demonstrate the implementation, success, and sustainability of such activities.	prevention and control, and the monitoring of hospital antibiotic use activities.
IC.05.01.01, EP 2: The hospital's governing body ensures that the problems identified by the infection prevention and control program are addressed in collaboration with hospital quality assessment and performance improvement leaders and other leaders (for example, the medical director, nurse executive, and administrative leaders). **MM.18.01.01, EP 4:** The governing body, or responsible individual, ensures all antibiotic use issues identified by the antibiotic stewardship program are addressed in collaboration with the hospital's QAPI leadership.	**[§482.42(c)(1)** *The governing body must ensure all of the following:]* **(ii)** All HAIs and other infectious diseases identified by the infection prevention and control program as well as antibiotic use issues identified by the antibiotic stewardship program are addressed in collaboration with hospital QAPI leadership.	**Interview** ☐ Interview program leaders to confirm that the hospital's infection control program and antibiotic stewardship program are being coordinated with their QAPI leadership, medical staff, nursing services, and pharmacy services. **Document Review** ☐ Determine whether infection control and antibiotic use problems identified are reported to the hospital's leadership. ☐ Determine whether the hospital's QAPI program and staff in-service training programs address problems identified by the hospital's infection control program and antibiotic stewardship programs.

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IC.04.01.01, EP 2: The infection preventionist(s) or infection control professional(s) is responsible for the following: - Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines - Documentation of the infection prevention and control program and its surveillance, prevention, and control activities - Competency-based training and education of hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the hospital, on infection prevention and control 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 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 hospital's quality assessment and performance improvement program to	**§482.42(c)(2)(i) Standard: Leadership responsibilities** **(2)** The infection preventionist(s)/infection control professional(s) is responsible for: **(i)** The development and implementation of hospital-wide infection surveillance, prevention, and control policies and procedures that adhere to nationally recognized guidelines.	**Document Review** ☐ Verify that the hospital's infection prevention and control program, including its hospital-wide infection surveillance, prevention, and control policies and procedures, is consistent with nationally recognized standards.

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address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.11.04.01, EP 1).		
IC.04.01.01, EP 2: The infection preventionist(s) or infection control professional(s) is responsible for the following: - 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 hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the hospital, on infection prevention and control policies and procedures and their application - Prevention and control of health care–associated infections and other infectious	**[§482.42(c)(2)(ii)** *The infection preventionist(s)/infection control professional(s) is responsible for:]* **(ii)** All documentation, written or electronic, of the infection prevention and control program and its surveillance, prevention, and control activities.	**Document Review** ☐ Verify that the hospital's infection preventionist(s) and/or infection prevention and control professional(s) is documenting, in written or electronic form, the IPC program and its surveillance, prevention, and control activities.

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diseases, including auditing staff adherence to infection prevention and control policies and procedures - Communication and collaboration with all components of the hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program - Communication and collaboration with the hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.11.04.01, EP 1).		
IC.04.01.01, EP 2: The infection preventionist(s) or infection control professional(s) is responsible for the following: - Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized	**[§482.42(c)(2)(iii)** *The infection preventionist(s)/infection control professional(s) is responsible for:]* **(iii)** Communication and collaboration with the hospital's QAPI program on infection prevention and control issues.	**Document Review** ☐ Verify that the hospital's infection preventionist(s) and/or infection control professional(s) is communicating and collaborating with the hospital's QAPI program on all infection prevention and control issues.

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guidelines - Documentation of the infection prevention and control program and its surveillance, prevention, and control activities - Competency-based training and education of hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the hospital, on infection prevention and control 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 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 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		

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high-level disinfection. (For more information on competency requirements, refer to HR.11.04.01, EP 1).		
IC.04.01.01, EP 2: The infection preventionist(s) or infection control professional(s) is responsible for the following: - 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 hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the hospital, on infection prevention and control 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 hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management	**[§482.42(c)(2)(iv)** *The infection preventionist(s)/infection control professional(s) is responsible for:]* **(iv)** Competency-based training and education of hospital personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the hospital, on the practical applications of infection prevention and control guidelines, policies, and procedures.	**Document Review** ☐ Review the hospital's policies and procedures on training and educating staff to confirm that the hospital's infection preventionist(s) and/or infection control professional(s) training and education of hospital personnel and staff is competency based **Personnel/Credential File** ☐ Review a sample of personnel files to verify that training on the practical applications of infection prevention and control guidelines was completed and required competencies were met.

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program - Communication and collaboration with the hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.11.04.01, EP 1). **HR.11.03.01, EP 1:** Staff participate in ongoing education and training to maintain or increase their competency and, as needed, when staff responsibilities change. Staff participation is documented. **HR.11.04.01, EP 1:** Staff competence is initially assessed and documented as part of orientation and once every three years, or more frequently as required by hospital policy or in accordance with law and regulation.		
IC.04.01.01, EP 2: The infection preventionist(s) or infection control professional(s) is responsible for the following: - Development and implementation of hospitalwide infection surveillance,	§482.42(c)(2) *The infection preventionist(s)/infection control professional(s) is responsible for:]* §482.42(c)(2)(v)	**Document Review** ☐ Verify that the hospital's infection preventionist(s) and/or infection prevention and control professional(s) has an active role in auditing the adherence to infection prevention and control policies and procedures by hospital personnel.

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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 hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the hospital, on infection prevention and control 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 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 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	**(v)** The prevention and control of HAIs, including auditing of adherence to infection prevention and control policies and procedures by hospital personnel. **§482.42(c)(2)(vi)** **(vi)** Communication and collaboration with the antibiotic stewardship program.	☐ Verify that the hospital's infection preventionist(s) and/or infection prevention and control professional(s) is communicating and collaborating with the antibiotic stewardship program.

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ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.11.04.01, EP 1).		
MM.18.01.01, EP 3: The leader(s) of the antibiotic stewardship program is responsible for the following: - Development and implementation of a 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 activities - Communication and collaboration with the medical staff, nursing, and pharmacy leadership, as well as with the hospital's infection prevention and control and quality assessment and performance improvement programs on antibiotic use issues - Competency-based training and education for hospital personnel and staff, including medical staff and, as applicable, personnel providing contract services in the hospital, on the practical applications of antibiotic stewardship guidelines, policies, and procedures	§482.42(c)(3)(i)-(iv) **Standard: Leadership responsibilities** **(3)** The leader(s) of the antibiotic stewardship program is responsible for: **(i)** The development and implementation of a hospital-wide antibiotic stewardship program, based on nationally recognized guidelines, to monitor and improve the use of antibiotics. **(ii)** All documentation, written or electronic, of antibiotic stewardship program activities. **(iii)** Communication and collaboration with medical staff, nursing, and pharmacy leadership, as well as with the hospital's infection prevention and control and QAPI programs, on antibiotic use issues. **(iv)** Competency-based training and education of hospital personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the hospital, on the practical applications of antibiotic stewardship guidelines, policies, and procedures.	**Interview** ☐ Ask the leader(s) to describe their responsibilities for the antibiotic stewardship program. ☐ Ask the leader about: o The basis for the hospital's program o Record-keeping of program activities and antibiotic-use issues o Communication and collaboration with other hospital departments and programs o Training and education of hospital personnel and staff **Document Review** Ask the program leader(s) to see: ☐ Documentation of the program's activities (meeting minutes, reports to leadership, of any other evidence) ☐ Examples of how the program communicates and collaborates with other hospital departments and programs ☐ Examples of the training and education being provided, including orientation, in-service, refresher courses and the curriculum that is covered.
LD.11.01.01, EP 10: For hospitals that use Joint Commission accreditation for deemed status purposes: If a hospital is part of a	**§482.42(d) Standard: Unified and integrated infection prevention and control and antibiotic stewardship programs for multi-hospital systems.**	**General** ☐ Assess the manner and degree of noncompliance with the standards within this condition to

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hospital system consisting of separately certified hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member hospitals after determining that such a decision is in accordance with applicable law and regulation. Each separately certified hospital subject to the system governing body demonstrates that the unified and integrated infection prevention and control program and the antibiotic stewardship program do the following: - Account for each member 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 hospital, regardless of practice or location, are given due consideration - Have mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed - Designate a qualified individual(s) at the 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	If a hospital is part of a hospital system consisting of multiple separately certified hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member hospitals after determining that such a decision is in accordance with all applicable State and local laws. The system governing body is responsible and accountable for ensuring that each of its separately certified hospitals meets all of the requirements of this section. Each separately certified hospital subject to the system governing body must demonstrate that: **§482.42(d)(1)** The unified and integrated infection prevention and control and antibiotic stewardship programs are established in a manner that takes into account each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital; **§482.42(d)(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 hospitals, regardless of practice or location, are given due consideration; **§482.42(d)(3)** The unified and integrated infection prevention and control and antibiotic stewardship programs have mechanisms in place	determine whether there is condition-level noncompliance. ***If the hospital is part of a hospital system that has a unified and integrated infection prevention and control and antibiotic stewardship programs:*** **Document Review** ☐ Review the infection prevention and control antibiotic stewardship program and identify unified infection prevention and control and antibiotic stewardship policies and activities and how these take into account the hospitals' population and services offered. ☐ Review the infection prevention and control and antibiotic stewardship programs and identify unified infection prevention and control and antibiotic stewardship policies and procedures and identify how each separately certified hospital's unique needs and areas of concern have been considered in the development of those policies and procedures. ☐ Review the QAPI program and identify unified QAPI elements that are unique to a particular hospital. ☐ Identify the process for which these unique elements are integrated into the QAPI program. ☐ Review governing body policies for evidence that a qualified individual(s) has/have been designated as responsible for communicating with the unified infection prevention program and antibiotic stewardship program, for implementing and maintaining policies and procedures governing the infection prevention and control and antibiotic stewardship programs, and training of hospital staff.

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stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to hospital staff Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The system governing body is responsible and accountable for making certain that each of its separately certified hospitals meet all of the requirements at 42 CFR 482.42(d).	to ensure that issues localized to particular hospitals are duly considered and addressed; and **§482.42(d)(4)** A qualified individual (or individuals) with expertise in infection prevention and control and in antibiotic stewardship has been designated at the hospital as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, 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 hospital staff.	□ Review documentation that the designated individual(s) communicate(s) with the unified program leadership related to issues with infection prevention and antibiotic stewardship. □ Review hospital training documents related to education in infection prevention and antibiotic stewardship as evidence of training of hospital staff.

Hospital Discharge Planning Evaluation Module (482.43)

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PC.14.01.01, EP 1: The 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 hospital to post-discharge care; and reduces the factors leading to preventable critical access hospital and hospital readmissions. Note: The 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. **PC.14.01.01, EP 4:** The patient, the patient's caregiver(s) or support person(s), physicians, other licensed practitioners, clinical psychologists, and staff who are involved in the patient's care, treatment, and services participate in planning the patient's discharge or transfer. The patient and their caregiver(s) or support person(s) are included as active partners when planning for post-discharge care. Note 1: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). Note 2: For hospitals that use Joint Commission accreditation for deemed	**482.43 Condition of Participation: Discharge Planning** The hospital 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 hospital to post-discharge care, and reduce the factors leading to preventable hospital readmissions.	**Document Review** **General** ☐ Review the hospital's discharge planning process to determine if it focuses on the patient's goals and treatment preferences and includes the patient and their caregivers/support person. **Patient Health Record** ☐ Is the patient's discharge plan consistent with their goals? ☐ Is it evident in the plan that the patient and their caregiver/support person was included? **Interview** ☐ Ask the patient/family/caregiver how they were involved in the discharge planning process

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status purposes and have swing beds: The 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 hospital also provides sufficient preparation and orientation to residents to make sure that transfer or discharge from the hospital is safe and orderly. The hospital sends a copy of the notice to a representative of the office of the state's long-term care ombudsman.		
PC.14.01.01, EP 2: The hospital begins the discharge planning process early in the patient's episode of care, treatment, and services. **PC.14.01.01, EP 5:** The 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	**§482.43(a) Standard: Discharge planning process.** The hospital'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.	**Document Review** **General** ☐ Review the discharge planning process – which patients receive a discharge planning evaluation? ☐ Does the discharge planning process indicate how the hospital identifies patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning? (Some hospitals complete a discharge planning evaluation on all patients, which meets the intent) ☐ When is the discharge planning evaluation done? **Patient Health Record** ☐ Review a sample of medical records for those identified as likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning – was there an evaluation done?

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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.		
PC.14.01.01, EP 5: The 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.	**§482.43(a)(1)** Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge.	**Document Review** **General** ☐ Review discharge planning process – when is discharge planning evaluation completed? Does it provide adequate time to ensure that post-hospital arrangements are made? **Patient Health Record** ☐ Review closed medical record of patient who required arrangements for post-hospital care – is there evidence that discharge was delayed due to lack of a timely discharge planning evaluation?
PC.14.01.01, EP 3: As part of the discharge planning evaluation, the hospital evaluates the patient's need for appropriate posthospital services, including but not limited to hospice care services, extended	**§482.43(a)(2)** A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services, including, but not limited to,	**Document Review** **Patient Health Record** ☐ Review sample of medical records of patients who have received a discharge planning evaluation. Does it include:

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care services, home health services, and non–health care services and community-based care providers. The hospital also evaluates the availability of the appropriate services and the patient's access to those services as part of the discharge planning evaluation.	hospice care services, post-hospital 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.	○ An evaluation of a patient's likely need for post-hospital services including but not limited to hospice care, post-hospital extended care, home health, and non-health care services and community-based care providers ○ A determination of the availability of the appropriate services ○ A determination of the patient's access to those services (the hospital may make referrals on behalf of the patient).
PC.14.01.01, EP 6: The 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, 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	**§482.43(a)(3)** The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative).	**Interview** ☐ Ask the patient if the results of the discharge planning evaluation were discussed with them and if they understand their discharge plan. **Document Review** **Patient Health Record** ☐ Review a sample of medical records of patients who have received a discharge planning evaluation to determine if there is documentation that the evaluation was completed and the evaluation was discussed with the patient or caregiver/support person.

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- 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 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		

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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.		
PC.14.01.01, EP 5: The 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.	**§482.43(a)(4)** Upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient.	**Documentation Review** **General** ☐ Review discharge planning process to determine if it states a discharge plan is arranged at the request of the patient's physician.
PC.14.01.01, EP 5: See above	**§482.43(a)(5)**	**Documentation Review**

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	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.	**General** ☐ Review discharge planning process to determine if it specifies that discharge planning evaluations and discharge plans must be developed by or under supervision of a registered nurse, social worker, or other appropriately qualified personnel. **Patient Health Record** ☐ Review a sample of medical records for patients who have had a discharge planning evaluation or discharge plan created – was it completed by (or under the supervision of) a registered nurse, social worker, or other qualified personnel?
PC.14.01.01, EP 1: The 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 hospital to post-discharge care; and reduces the factors leading to preventable critical access hospital and hospital readmissions. Note: The 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.	**§482.43(a)(6)** The hospital'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.	**Documentation Review** **General** ☐ Review the discharge planning process – does it require a regular re-evaluation of the patient's condition to identify if modifications are needed to the discharge plan? **Patient Health Record** ☐ Review a sample of medical records that have a discharge plan – are the patients re-evaluated at the frequency the discharge planning process indicated?
PC.14.01.01, EP 14: The hospital assesses its discharge planning process on a regular basis, as defined by the hospital. The assessment includes an ongoing, periodic review of a representative sample of discharge plans, including those patients who were readmitted within 30 days of a	**§482.43(a)(7)** The hospital 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	**Documentation Review** **General** ☐ Review the discharge planning process – does it indicate that there is a periodic review of a representative sample of discharge plans, including those patients who were readmitted within 30 days of a previous admission?

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previous admission, to make certain that the plans are responsive to patient post-discharge needs.	within 30 days of a previous admission, to ensure that the plans are responsive to patient post-discharge needs.	☐ Ask to see the log of cases that were reviewed to verify a representative sample of discharge plans are being reviewed. Does the sample include cases of patients who were readmitted within 30 days of a previous admission? ☐ For those cases of patients who were readmitted within 30 days, are the discharge plans being reviewed for appropriateness to determine if the plan met the patient's post-discharge needs?
PC.14.01.01, EP 7: The 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 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.	**§482.43(a)(8)** The hospital 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 hospital 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.	**Documentation Review** **General** ☐ Review the discharge planning process – how are patients/families/representatives made aware of post-acute providers? **Patient Health Record** ☐ Review a sample of medical records of patients who required post-acute care providers – was data on quality measures shared with the patient/family/caregiver? Was the data shared relevant to the patient's goals? **Interview** ☐ Ask staff what data is shared with patients when they are choosing a post-acute care provider? How is the data shared? ☐ Ask patients who are selecting a post-acute care provider what data was shared with them? How was it shared?
PC.14.02.03, EP 1: The 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	**§482.43(b)** Standard: Discharge of the patient and provision and transmission of the patient's necessary medical information. The hospital 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	**Interview** ☐ Are staff who are responsible for discharge planning evaluation correctly following the hospital's policies and procedures? ☐ Ask staff if there is a process to ensure that, once the necessary postdischarge services for a patient have been determined, those services or comparable solutions are available. ☐ Verify that hospital staff has knowledge of community resources to assist in arranging services.

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a minimum, the following: - The patient's current course of illness and treatment - Postdischarge goals of care - Treatment preferences at the time of discharge	course of illness and treatment, post-discharge goals of care, and treatment preferences, at the time of discharge, to the appropriate post-acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners responsible for the patient's follow-up or ancillary care.	☐ How do staff determine if a patient requires community-based services or transfer to another facility? How do they determine that the post-acute provider can meet the patient's needs? ☐ Interview patients and their representatives about their discharge planning evaluation. If they were not aware they could request an evaluation, can the hospital provide evidence that they received notice of their right for one? ☐ Ask the patient or patient's representative if the results of the discharge planning evaluation were discussed with them. If the hospital does not require a discharge planning evaluation for all inpatients: o Does the hospital have a standard process for notifying the patient, their representative, and their physician that they may request a discharge planning evaluation and that the hospital will conduct an evaluation upon request? o Can discharge planning and unit nursing staff describe the process for a patient or their representative to request a discharge planning evaluation? o Interview attending physicians to see if they are aware that they can request a discharge planning evaluation. If they are not aware, can the hospital provide evidence of how they inform the medical staff about this? **Document Review** **General** ☐ Review the discharge planning process – what information is shared with post-acute care providers? Does it include all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care and treatment preferences at the time of discharge? ☐ Review the discharge planning process to determine when discharge planning evaluations are completed so they do not contribute to delays in discharge.

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		Patient Health Record ☐ Review a sample of medical records of patients who required post-acute care services – **was all of the information** shared with the provider/practitioner responsible for the patient's follow-up or ancillary care? ☐ Discharge planning evaluation activities are evident for patients identified as requiring a discharge planning evaluation. ☐ Review a sample of medical records to determine if the discharge planning evaluation documents the goals and preferences of the patient (or the patient's representatives) for postdischarge placement and care. ☐ Review the discharge planning evaluation for the following: ○ Does the evaluation include assessment of the patient's capacity for self-care or ability to be cared for by others in the environment? ○ Does the evaluation consider what the patient's care needs will be immediately upon discharge and whether those needs are expected to remain constant or lessen over time? ○ If the patient was admitted from their private residence, does the assessment include whether the patient is capable of addressing their care needs through self-care? ○ Does the evaluation include assessment of whether the patient will require specialized medical equipment or permanent physical modification to the home and the feasibility of acquiring equipment or the required modifications? ○ If the patient is unable to provide some or all of their self-care, does the evaluation address whether family or friends are available and willing to provide (or be trained to provide) the required care?

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		☐ Review a sample of medical records to determine if the discharge planning evaluation was completed on a timely basis to allow for appropriate arrangements to be made for posthospital care and to avoid delays in discharge. ☐ Determine when the discharge planning evaluation was initiated. If the evaluation was not begun within 24 hours of the request or identification of the need for an evaluation, ask why. ☐ Is there a pattern of delayed start or completion of the evaluation? If so, is the delay due to circumstances beyond the hospital's control (for example, inability to reach the beneficiary's support person(s), continuing changes in the patient's condition) and/or is the delay due to the hospital's failure to develop timely discharge planning evaluations? ☐ Review a sample of medical records to determine if the discharge planning evaluation results were discussed with the patient or the patient's representative. If the patient rejects the results of the evaluation, is this documented in the record? ☐ Review a sample of medical records to determine if the discharge planning evaluation results are included in the health record.
	§482.43(c) Standard: Requirements related to post-acute care services. For those patients discharged home and referred for HHA services, or for those patients transferred to a SNF for post-hospital extended care services, or transferred to an IRF or LTCH for specialized hospital services, the following requirements apply, in addition to those set out at paragraphs (a) and (b) of this section:	

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PC.14.01.01, EP 8: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient's discharge plan includes a list of home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, or long-term care hospitals that are available to the patient, participating in the Medicare program, and serving the geographic area in which the patient resides (as defined by the home health agency or in the case of a skilled nursing facility, inpatient rehabilitation facility, or long-term care hospital, in the geographic area requested by the patient). The hospital documents in the medical record that this list was presented to the patient or the patient's representative. Note 1: Home health agencies must request to be listed by the hospital. Note 2: This list is only presented to patients for whom home health care, posthospital extended care services, skilled nursing, inpatient rehabilitation, or long-term care hospital services are identified as needed.	**§482.43(c)(1)** The hospital must include in the discharge plan a list of HHAs, SNFs, IRFs, or LTCHs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, IRF, or LTCH, in the geographic area requested by the patient. HHAs must request to be listed by the hospital as available.	**Interview** ☐ Ask patients who require one of these organizations or facilities if they were given a list of these organizations/facilities in their area from which to choose. **Document Review** **Patient Health Record** ☐ Review a sample of medical records of patients who required home care, skilled nursing facility, inpatient rehabilitation, or long-term care hospital services to determine if they were provided a list of these organizations/facilities in the geographic area which they reside.
PC.14.01.01, EP 8: See above	**§482.43(c)(1)(i)** This list must only be presented to patients for whom home health care post-hospital extended care services, SNF, IRF, or LTCH services are indicated and appropriate as determined by the discharge planning evaluation.	**Document Review** **Patient Health Record** ☐ Review a sample of medical records – are lists of home health care and post-hospital extended care services provided only to those patients as indicated?

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PC.14.01.01, EP 9: For hospitals that use Joint Commission accreditation for deemed status purposes: For patients enrolled in managed care organizations, the hospital makes patients aware of the need to verify with their managed care organization which practitioners, providers, or certified suppliers are in the managed care organization's network. If the hospital has information on which practitioners, providers, or certified suppliers are in the network of the patient's managed care organization, it shares this information with the patient or the patient's representative.	**§482.43(c)(1)(ii)** For patients enrolled in managed care organizations, the hospital must make the patient aware of the need to verify with their managed care organization which practitioners, providers or certified suppliers are in the managed care organization's network. If the hospital has information on which practitioners, providers or certified supplies are in the network of the patient's managed care organization, it must share this with the patient or the patient's representative.	**Document Review** **Patient Health Record** ☐ Review a sample of medical records for those patients enrolled in managed care organizations – has the patient been made aware of the need to verify with their managed care organizations which providers or suppliers are in network? **Interview** ☐ Ask the discharge planners or staff who register patients if the hospital has information regarding which providers or suppliers are in network, is that information provided to patients?
PC.14.01.01, EP 8: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient's discharge plan includes a list of home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, or long-term care hospitals that are available to the patient, participating in the Medicare program, and serving the geographic area in which the patient resides (as defined by the home health agency or in the case of a skilled nursing facility, inpatient rehabilitation facility, or long-term care hospital, in the geographic area requested by the patient). The hospital documents in the medical record that this list was presented to the patient or the patient's representative.	**§482.43(c)(1)(iii)** The hospital must document in the patient's medical record that the list was presented to the patient or to the patient's representative.	**Document Review** **Patient Record** ☐ Is there documentation in the patient's record that the list was given to the patient or their representative?

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Note 1: Home health agencies must request to be listed by the hospital. Note 2: This list is only presented to patients for whom home health care, posthospital extended care services, skilled nursing, inpatient rehabilitation, or long-term care hospital services are identified as needed.		
PC.14.01.01, EP 10: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital informs the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of postdischarge services and, when possible, respects the patient's or their representative's goals of care and treatment preferences, as well as other preferences when they are expressed. The hospital does not limit the qualified providers or suppliers that are available to the patient.	**§482.43(c)(2)** The hospital, as part of the discharge planning process, must inform the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of post-discharge services and must, when possible, respect the patient's or the patient's representative's goals of care and treatment preferences, as well as other preferences they express. The hospital must not specify or otherwise limit the qualified providers or suppliers that are available to the patient.	**Document Review** **General** ☐ Review the discharge planning policy – does it say that the patient/patient's representative is informed of their freedom to choose among Medicare participating providers? **Interview** ☐ Ask staff how they inform patients/representatives of their freedom to choose providers? ☐ Ask patients – were they informed of their freedom to choose among Medicare participating providers?
PC.14.01.01, EP 11: For hospitals that use Joint Commission accreditation for deemed status purposes: The discharge plan identifies any home health agency or skilled nursing facility in which the hospital has a disclosable financial interest, and any home health agency or skilled nursing facility that has a disclosable financial interest in a hospital. Note: Disclosure of financial interest is	**§482.43(c)(3)** The discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare. Financial interests that are disclosable under Medicare are determined in	**Interview** ☐ Ask discharge planning staff – how patients are informed about disclosable financial interests and any home care or skilled nursing facility disclosable interests (are home care or skilled nursing facility owned by same entity as the hospital?).

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determined in accordance with the provisions in 42 CFR 420, subpart C and section 1861 of the Social Security Act (42 U.S.C. 1395x).	accordance with the provisions of part 420, subpart C, of this chapter.	

Hospital Organ, Tissue, and Eye Procurement Evaluation Module (482.45)

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	§482.45 Condition of Participation: Organ, Tissue, and Eye Procurement	
	§482.45(a) Standard: Organ Procurement Responsibilities The hospital must have and implement written protocols that:	**Document Review** □ Organ procurement policies and procedures that address the hospital responsibilities, including: ○ Timely notification of OPO or third party designated by the OPO of individuals whose death is imminent or who have died in the hospital.
TS.11.01.01, EP 1: The hospital develops and implements written policies and procedures that include the following: - A written agreement with an organ procurement organization (OPO) that includes that hospital notifying, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the 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.	**§482.45(a)(1)** Incorporate an agreement with an OPO (organ procurement organizations) 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 hospital. The OPO determines medical suitability for organ donation and, in the absence of alternative arrangements by the hospital, 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 hospital for this purpose;	**Interview** □ Interview the staff to verify that they are aware of the policies and procedures for organ, tissue, and eye procurement. **Document Review** □ Review the written agreement with the OPO to verify that it addresses all required information. See below. • Written agreement with an Organ Procurement Organization (OPO), designated under 42 CFR Part 486 that at a minimum addresses the following: ○ The criteria for referral, including the referral of all individuals whose death is imminent or who have died in the hospital. ○ Includes a definition of "imminent death;" ○ Includes a definition of "timely notification;" ○ Addresses the OPO's responsibility to determine medical suitability for organ donation. ○ Specifies how the tissue and/or eye bank will be notified about potential donors using notification protocols developed by the OPO in consultation with the hospital-designated tissue and eye bank(s); ○ Provides for notification of each individual death in a timely manner to the OPO (or designated third party) in accordance with the terms of the agreement.

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- Procedures for informing the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes, in collaboration with the designated OPO - Education and training of staff in the use of discretion and sensitivity to the circumstances, views, and beliefs of the family to discuss potential organ, tissue, or eye donations Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes; The 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 hospital. Note 3: A designated requestor is an individual who has completed a course offered or approved by the organ procurement organization. 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:		○ Ensures that the designated requestor training program offered by the OPO has been developed in cooperation with the tissue bank and eye bank designated by the hospital. ○ Permits the OPO, tissue bank, and eye bank access to the hospital's death record information according to a designated schedule, e.g., monthly, or quarterly. ○ Includes that the hospital is not required to perform credentialing reviews for, or grant privileges to, members of organ recovery teams as long as the OPO sends only "qualified, trained individuals" to perform organ recovery; and ○ The interventions the hospital will utilize to maintain potential organ donor patients so that the patient organs remain viable. ☐ Verify that the governing body has approved the organ procurement policies. **Patient Record** ☐ Review a sample of death records to verify that the hospital has implemented its organ procurement policies. **QAPI** ☐ Verify that the organ, tissue, and eye donation program is integrated into the QA program.

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//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.		
TS.11.01.01, EP 1: See above	**§482.45(a)(2)** 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;	**Document Review** □ Verify that the hospital has an agreement with at least one tissue bank and one eye bank that specifies criteria for referral of all potential tissue and eye donors, or an agreement with an OPO that specifies the tissue bank and eye bank to which referrals will be made. The agreement should also acknowledge that it is the OPO's responsibility to determine medical suitability for tissue and eye donation unless the hospital has an alternative agreement with a different tissue and/or eye bank.
TS.11.01.01, EP 1: See above	**§482.45(a)(3)** Ensure, in collaboration with the designated OPO, that the family of each potential donor is informed of its options to donate organs, tissues, or eyes, or to decline to donate. The individual designated by the hospital to initiate the request to the family must be an organ procurement representative or a designated requestor. A designated requestor is an individual who has completed a course offered or approved by the OPO and designed	**Interview** □ Does the hospital have QAPI mechanisms in place to ensure that the families of all potential donors are informed of their options to donate organs, tissues, or eyes, or to decline to donate? **Document Review** □ Verify that the hospital ensures that the family of each potential donor is informed of its options to donate organs, tissues, or eyes, including the option to decline to donate. **Interview** □ How does the hospital ensure that only OPO, tissue bank, or eye bank staff or designated requestors are approaching families to ask them to donate? **Document Review**

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	in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ or tissue donation;	☐ Review training schedules and personnel files to verify that all designated requestors have completed the required training.
TS.11.01.01, EP 1: See above	**§482.45(a)(4)** Encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of the families of potential donors;	**Interview** ☐ Interview a hospital-designated requestor regarding approaches to donation requests. **Document Review** ☐ Review the designated requestor training program to verify that it addresses the use of discretion. ☐ Review the hospital's complaint file for any relevant complaints.
TS.11.01.01, EP 2: The 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	**§482.45(a)(5)** Ensure that the hospital works cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues; maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes take place.	**Interview** ☐ How does the hospital ensure that all appropriate staff has attended an educational program regarding donation issues and how to work with the OPO, tissue bank, and eye bank? **Document Review** ☐ Review in-service training schedules and attendance sheets **Credential/Personnel File** ☐ Appropriate hospital staff, including all patient care staff, must be trained on donation issues. The training program must be developed in cooperation with the OPO, tissue bank and eye bank, and should include, at a minimum: o Consent process; o Importance of using discretion and sensitivity when approaching families; o Role of the designated requestor; o Transplantation and donation, including pediatrics, if appropriate; o Quality improvement activities; and o Role of the organ procurement organization. ☐ Training should be conducted with new employees annually, whenever there are policy/procedure changes, or when

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		problems are determined through the hospital's QAPI program. - Those hospital staff who may have to contact or work with the OPO, tissue bank and eye bank staff must have appropriate training on donation issues including their duties and roles. - Determine by review, what policies and procedures are in place to ensure that potential donors are identified and declared dead by an appropriate practitioner within an acceptable timeframe. - Verify that there are policies and procedures in place to ensure the coordination between facility staff and OPO staff in maintaining the potential donor.
TS.11.01.01, EP 1: The hospital develops and implements written policies and procedures that include the following: - A written agreement with an organ procurement organization (OPO) that includes that hospital notifying, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the 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	**§482.45(b) Standard: Organ Transplantation Responsibilities** **(1)** A hospital in which organ transplants are performed must be a member of the Organ Procurement and Transplantation Network (OPTN) established and operated in accordance with section 372 of the Public Health Service (PHS) Act (42 U.S.C. 274) and abide by its rules. The term "rules of the OPTN" means those rules provided for in regulations issued by the Secretary in accordance with section 372 of the PHS Act which are enforceable under 42 CFR 121.10. No hospital is considered to be out of compliance with section 1138(a)(1)(B) of the Act, or with the requirements of this paragraph, unless the Secretary has given the	**Document Review** - Verify by review, one year of reports submitted by the facility to the OPTN, the Scientific Registry, the OPOs, and any data submitted to the Department per request of the Secretary.

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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 to discuss potential organ, tissue, or eye donations Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes; The 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 hospital. Note 3: A designated requestor is an individual who has completed a course offered or approved by the organ procurement organization. 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).	OPTN formal notice that he or she approves the decision to exclude the hospital from the OPTN and has notified the hospital in writing. (2) For purposes of these standards, the term “organ” means a human kidney, liver, heart, lung, or pancreas. (3) If a hospital performs any type of transplants, it must provide organ transplant related data, as requested by the OPTN, the Scientific Registry, and the OPOs. The hospital must also provide such data directly to the Department when requested by the Secretary.	

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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. **TS.12.01.01, EP 1:** The hospital performing organ transplants belongs to and abides by the rules of the Organ Procurement and Transplantation Network (OPTN) established under section 372 of the Public Health Service (PHS) Act. Note: The term "rules of the OPTN" means those rules provided for in regulations issued by the Secretary of the US Department of Health & Human Services in accordance with section 372 of the PHS Act which are enforceable under 42 CFR 121.10. No hospital is considered to be out of compliance with section 1138(a)(1)(B) of the Act, or with the requirements of this paragraph, unless the Secretary has given the OPTN formal notice that the Secretary approves the decision to exclude the hospital from the OPTN and has notified the hospital in writing.		

Hospital Surgical Services Evaluation Module (482.51)

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LD.13.03.01, EP 1: The 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 **LD.13.03.01, EP 10:** If the hospital provides outpatient surgical services, the services are consistent with the quality of inpatient surgical care	**§482.51 Condition of Participation: Surgical Services** If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.	**Observation** ☐ Inspect all inpatient and outpatient operating rooms/suites. Request the use of proper PPE for the inspection. ☐ Determine if surgical services are provided in accordance with acceptable standards of practice, including but not limited to: ○ Access to surgical and recovery area, including traffic flow pattern(s) ○ Adherence to aseptic and sterile techniques, including cleaning between cases and appropriate terminal cleaning ○ Appropriate utilization of PPE for type of surgical case(s) performed ○ Equipment maintenance by the hospital's biomedical equipment program and in accordance with federal and state law, regulations, guidelines, and manufacturer's recommendations ○ Equipment availability for rapid and routine sterilization of OR equipment and materials ○ Packaging, handling, labeling, and storage of sterilized materials ○ Monitoring of temperature and humidity ○ Integration of surgical services into the hospitalwide quality assurance/performance improvement program
LD.13.03.01, EP 1: See above **LD.13.03.01, EP 11:** The surgical services are consistent with the resources available.	**§482.51(a) Standard: Organization and Staffing** The organization of the surgical services must be appropriate to the scope of the services offered.	**Document Review** **General** ☐ Review the hospital's organizational chart displaying the relationship of operating room services to other services and confirm that the chart indicates lines of authority and delegation of responsibility within the department or service.

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		☐ Review the staffing plan to ensure leadership has provided the appropriate types and number of staff to provide surgical services
NPG.12.01.01, EP 13: The surgical services include but are not limited to the following staff: - An experienced registered nurse or doctor of medicine or osteopathy who supervises the operating rooms - Licensed practical nurses (LPNs) and surgical technologists (operating room technicians) who serve as scrub nurses, if under the supervision of a registered nurse - Qualified registered nurses who perform circulating duties in the operating room Note: In accordance with applicable state laws and approved medical staff policies and procedures, LPNs and surgical technologists may assist in circulatory duties under the supervision of a qualified registered nurse who is immediately available to respond to emergencies.	**§482.51(a)(1)** - The operating rooms must be supervised by an experienced registered nurse or a doctor of medicine or osteopathy.	**Interview** ☐ Verify that a registered nurse or physician is responsible for supervising the operating rooms. **Document Review** **Personnel/Credential File** ☐ Request a copy of the supervisor's position description to verify that it specifies qualifications, duties, and responsibilities of the position. ☐ Verify that the supervisor is experienced and competent in the management of surgical services.
NPG.12.01.01, EP 13: See above	**§482.51(a)(2) -** Licensed practical nurses (LPNs) and surgical technologists (operating room technicians) may serve as "scrub nurses" under the supervision of a registered nurse	**Document Review** **General** ☐ Validate the availability of a registered nurse by requesting and reviewing a staffing schedule for the operating room. ☐ Review staffing schedules to determine adequacy of coverage by staff and RN supervisor
NPG.12.01.01, EP 13: See above	**§482.51(a)(3)** - Qualified registered nurses may perform circulating duties in the operating room. In accordance with applicable State laws and approved medical staff policies and	**Document Review** **General** o Review the staffing schedule to make certain that the circulating nurse is an RN.

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	procedures, LPNs and surgical technologists may assist in circulatory duties under the supervision of a qualified registered nurse who is immediately available to respond to emergencies.	○ Verify that RNs, LPNs, and surgical technologists are working in accordance with applicable state law and medical-staff approved policies and procedures. **Interview** □ For hospitals that utilize LPNs and STs to assist with circulating duties, inquire as to the process for RN supervisor response in emergency situations
MS.17.02.01, EP 6: The 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 **MS.17.02.01, EP 7:** The surgical service maintains a current roster listing each practitioner's surgical privileges. Note: The roster may be in paper or electronic format. **MS.17.02.03, EP 1:** Decisions on membership and granting of privileges include criteria that are directly related to the quality of health care, treatment, and services.	**§482.51(a)(4)** - Surgical privileges must be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner. The surgical service must maintain a roster of practitioners specifying the surgical privileges of each practitioner.	**Document Review** **General** □ Review the roster of practitioners to ensure it specifies the surgical privileges of each practitioner □ Review the medical staff bylaws for criteria that determine the privileges to be granted to an individual practitioner □ If the hospital utilizes RN First Assistants, surgical PA, or other non-MD/DO surgical assistants, review the criteria, qualifications and a credentialing process to grant specific privileges to individual practitioners **Personnel/Credential File (Medical Staff Credential File Review Activity)** □ Verify surgical privileges in accordance with the competencies of each practitioner. □ Verify practitioner competency appraisal as established by the hospital's QAPI program and credentialing process in accordance with scope of practice and other State laws and regulations. **Interview** □ Ask to see where the surgical roster(s) are kept including: □ A current roster with each practitioner's specific privileges ○ A current list of surgeons with suspended or restricted surgical privileges

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		○ Discuss the process for individuals requesting surgical privileges **Observation** □ Ask to see where the surgical roster(s) are kept including: ○ A current roster with each practitioner's specific privileges ○ A current list of surgeons with suspended or restricted surgical privileges
LD.13.01.09, EP 6: The hospital develops and implements surgical care policies and procedures that maintain high standards for medical practice and patient care. **LD.13.03.01, EP 1:** The 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	**§482.51(b) Standard: Delivery of Service Surgical** services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care. .	**Document Review** **General** □ Review policies and procedures that pertain to surgical services to determine whether they address the elements specified in §482.51(b) □ If the hospital uses alcohol-based skin preparations in anesthetizing locations, review the policies and procedures in place to minimize the risk of surgical fires. **Interview** □ Ask surgical services staff how their work adheres to applicable policies and procedures

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LD.13.03.01, EP 11: The surgical services are consistent with the resources available.		
	§482.51(b)(1) - Prior to surgery or a procedure requiring anesthesia services and except in the case of emergencies:	**Lead-in CoP statement**
PC.11.02.01, EP 2: A medical history and physical examination is completed and documented no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: Medical histories and physical examinations are performed as required in this element of performance, except prior to any specific outpatient surgical or procedural services for which an assessment is performed instead as provided under 42 CFR 482.24(c)(4)(i)(C). Note 2: For law and regulation guidance pertaining to the medical history and physical examination at 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii), refer to https://www.ecfr.gov/.	(i) A medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration, and except as provided under paragraph (b)(1)(iii) of this section.	**Document Review** **Patient Health Record** ☐ During record review, verify a complete history and physical (H&P) and an update if applicable, is present in the medical record prior to a surgical procedure requiring anesthesia services, even if that surgery or procedure occurs less than 24 hours after admission or registration. Note: A complete H&P is required in the medical record of all patients except in emergences and under §482.51(b)(1)(iii) and as determined by medical staff policy. ☐ Verify that the history and physical meets the following requirements in accordance the requirements of 42 CFR 482.2 (c)(5)
PC.11.02.01, EP 3: For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient	(ii) An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration when the medical history and physical examination are completed within 30	**Document Review** **Patient Health Record** ☐ During record review, verify that an updated physical exam is completed and documented within 24 hours after admission or registration when the medical history and physical exam are completed within 30

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admission, but prior to surgery or a procedure requiring anesthesia services. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: Medical histories and physical examinations are performed as required in this element of performance, except prior to any specific outpatient surgical or procedural services for which an assessment is performed instead as provided under 42 CFR 482.24(c)(4)(i)(C). Note 2: For law and regulation guidance pertaining to the medical history and physical examination at 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii), refer to https://www.ecfr.gov/.	days before admission or registration, and except as provided under paragraph (b)(1)(iii) of this section.	days before admission or registration except in circumstances provided in §482.43(b)(1)(iii).
PC.11.02.01, EP 4: When the medical staff allows an assessment (in lieu of a comprehensive medical history and physical examination) for patients receiving specific outpatient surgical or procedural services, the patient assessment is completed and documented after registration but prior to the surgery or procedure requiring anesthesia services. Note: For further regulatory guidance at 42 CFR 482.24(c)(4)(i)(A) and (B), 482.51(b)(1)(i) and (ii), and 482.22(c)(5)(v), refer to https://www.ecfr.gov/.	(iii) An assessment of the patient must be completed and documented after registration (in lieu of the requirements of paragraphs (b)(1)(i) and (ii) of this section) when the patient is receiving specific outpatient surgical or procedural services and when the medical staff has chosen to develop and maintain a policy that identifies, in accordance with the requirements at § 482.22(c)(5)(v), specific patients as not requiring a comprehensive medical history and physical examination, or any update to it, prior to specific outpatient surgical or procedural services.	**Document Review** **General** □ Review policies developed by the medical state that identify, in accordance with 482.22(c)(5)(v), specific patients that do not require a comprehensive medical history and physical examination, or any update to it, prior to specific outpatient surgical or procedural services.
RC.12.01.01, EP 3: The medical record contains any informed consent, when required by hospital policy or federal or state law or regulation.	**§482.51(b)(2)** - A properly executed informed consent form for the operation must be in the patient's	**Interview** □ Ask medical staff if they understand which procedures are considered surgery and, thus, are

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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.	chart before surgery, except in emergencies.	those that require a properly executed informed consent form. Interview two or three postsurgical patients or their representatives, as appropriate, to assess satisfaction with the informed consent discussion prior to their surgery. **Document Review** **General** Review the hospital's policies and procedures pertaining to informed consent, including circumstances when a surgery would be considered an emergency and thus not require that an informed consent form be placed in the medical record prior to surgery. **Patient Health Record** Review a minimum of six medical records of surgical patients that did not receive emergency surgery to verify that the informed consent is present in the medical record prior to surgery, except in the case of emergency surgery. When possible, review medical records of patients who are about to undergo surgery, or who are in a surgical recovery area.
PC.12.01.05, EP 1: For hospitals that use Joint Commission accreditation for deemed status purposes: At a minimum, operating room suites have the following equipment available: - Call-in system (process to communicate with or summon staff outside of the operating room when needed) - Cardiac monitor - Resuscitator (hand-held or mechanical device that provides positive airway pressure) - Defibrillator - Aspirator (hand-held or mechanical device used to suction out fluids or	**§482.51(b)(3)** - The following equipment must be available to the operating room suites: call-in system, cardiac monitor, resuscitator, defibrillator, aspirator, and tracheotomy set.	**Observation** Determine if the operating room suite has the following items available: o On-call system o Cardiac monitor o Resuscitator o Defibrillator o Aspirator (suction equipment) o Tracheotomy set (cricothyroidotomy set is not a substitute) Verify that all equipment is working and, as applicable, in compliance with the hospital's biomedical equipment inspection, testing, and maintenance program.

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secretions) - Tracheotomy set		
PC.13.01.03, EP 5: The hospital has adequate provisions for immediate postoperative care.	**§482.51(b)(4)** - There must be adequate provisions for immediate post-operative care.	**Observation** ☐ Verify that the hospital has provisions for postoperative care. ☐ Observe care provided to patients in a postanesthesia care unit(PACU) to determine if patients are monitored and assessed appropriately prior to transfer or discharge (in the case of same-day surgery patients) from the PACU. ☐ Does the hospital have a system for identifying and addressing the monitoring needs of postoperative patients transferred from the PACU to other areas of the hospital? **Interview** ☐ Ask staff in the PACU and in units who receive patients from the PACU how the needs of postoperative patients for vigilant monitoring is addressed when the patients are transferred from the PACU to other areas of the hospital.
RC.12.01.03, EP 1: The hospital has a complete and up-to-date operating room register or equivalent record that includes the following: - Patient's name - Patient's hospital identification number - Date of operation - Inclusive or total time of operation - Name of surgeon and any assistants - Name of nursing staff - Type of anesthesia used and name of person administering it - Operation performed - Pre- and postoperative diagnosis - Age of patient	**§482.51(b)(5)** - The operating room register must be complete and up-to-date.	**Document Review** **General** ☐ Examine the operating room register or equivalent record that lists all surgery performed by surgery services to ensure that it includes items specified in §482.51(b)(5).

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RC.12.01.03, EP 2: An operative report is written or dictated immediately following surgery and signed by the surgeon. The report includes the following: - Name and hospital identification number of the patient - Date and times of the surgery - Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues) - Preoperative and postoperative diagnosis - Name of the specific surgical procedure(s) performed - Type of anesthesia administered - Complications, if any - Description of techniques, findings, and tissues removed or altered - Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any - Any estimated blood loss Note 1: The exception to this requirement occurs when an operative or other high-risk procedure progress note is written immediately after the procedure, in which case the full report can be written or dictated within a time frame defined by the hospital.	**§482.51(b)(6)** - An operative report describing techniques, findings, and tissues removed or altered must be written or dictated immediately following surgery and signed by the surgeon.	**Document Review** **General** ☐ Review a minimum sample of six medical health records of patients who had a surgical encounter to make certain ensure that they contain a surgical report that was dated and signed by the responsible surgeon and includes the information specified in §482.51(b)(6).

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Note 2: If the physician or other licensed practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be written or dictated in the new unit or area of care.		

Hospital Anesthesia Services Evaluation Module (482.52)

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LD.13.01.07, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: A qualified doctor of medicine or osteopathy directs the following services when provided: - Anesthesia - Nuclear medicine - Respiratory care Note 1: The anesthesia service is responsible for all anesthesia administered in the hospital. Note 2: For respiratory care services, the director may serve on either a full-time or part-time basis. **LD.13.03.01, EP 1** The 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	**§482.52 Condition of Participation: Anesthesia Services** If the hospital furnishes anesthesia services, they must be provided in a well-organized manner under the direction of a qualified doctor of medicine or osteopathy. The service is responsible for all anesthesia administered in the hospital.	**Document Review** **General** □ Organizational chart for anesthesia services. □ Anesthesia services policies and procedures. o Do they apply in all hospital locations where anesthesia services are provided? o Do they indicate the necessary qualifications that each clinical practitioner must possess to administer anesthesia as well as moderate sedation or other forms of analgesia? o Do they address what clinical applications are considered to involve analgesia, in particular moderate sedation, rather than anesthesia, based on identifiable national guidelines? o What are the national guidelines that they are following and how is that documented? □ Does the hospital have a system by which adverse events related to the administration of anesthesia and analgesia, including moderate sedation, are tracked and acted on? **Personnel/Credential File** □ Determine that a doctor of medicine or osteopathy has the authority and responsibility for directing all anesthesia services throughout the hospital. □ Look for evidence in the director's file of their appointment privileges and qualifications, consistent with the criteria adopted by the hospital's governing body. Review the position description. o Confirm that the director's responsibilities include at least the following: ▪ Planning, directing, and supervising all activities of the service.

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		▪ Evaluating the quality and appropriateness of the anesthesia services provided to patients as part of the hospital's quality assurance/performance improvement program.
LD.13.03.01, EP 1: The 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 **PC.13.01.01, EP 1:** For hospitals that use Joint Commission accreditation for deemed status purposes: General anesthesia, regional anesthesia and monitored anesthesia, including deep sedation/analgesia, is administered only by the following individuals: - A qualified anesthesiologist - A doctor of medicine or osteopathy other than an anesthesiologist - A doctor of dental surgery or dental	**482.52(a) Standard: Organization and Staffing** The organization of anesthesia services must be appropriate to the scope of the services offered. Anesthesia must be administered only by – (1) A qualified anesthesiologist; (2) A doctor of medicine or osteopathy (other than an anesthesiologist); (3) A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law; (4) A certified registered nurse anesthetist (CRNA), as defined in §410.69(b) of this chapter, who, unless exempted in accordance with paragraph (c) of this section, is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed; or (5) An anesthesiologist's assistant, as defined in Sec. 410.69(b) of this chapter, who is under the supervision of an anesthesiologist who is immediately available if needed.	**Document Review** **Personnel/Credential File** □ Review the qualifications of individuals authorized to administer general anesthesia, regional anesthesia, and monitored anesthesia, including deep sedation/analgesia, to determine if they satisfy the requirements at §482.52(a) and (c). This includes o Director of Anesthesia o Physician who administers anesthesia but not Anesthesiologist o Dentist, Oral Surgeon, or Podiatrist who administers anesthesia under state law o Certified Reg Nurse Anesthetist o Anesthesiologist's assistant □ Determine that there is documentation of current licensure and, as applicable, current certification for all persons administering anesthesia. □ Review the qualifications of individuals authorized to furnish other anesthesia services to determine if they are consistent with the hospital's anesthesia services policies.

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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), supervised by the operating practitioner, except as provided in 42 CFR 482.52(c) regarding the state exemption for this supervision - An anesthesiologist's assistant, as defined in 42 CFR 410.69(b), supervised by an anesthesiologist who is immediately available if needed 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 482.52(c) for state exemption states: A hospital may be exempt from the requirement for doctors of medicine or osteopathy to supervise CRNAs if the state in which the hospital is		

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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 attests 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.		
PC.13.01.01, EP 1: For hospitals that use Joint Commission accreditation for deemed status purposes: General anesthesia, regional anesthesia and monitored anesthesia, including deep sedation/analgesia, is administered only by the following individuals: - A qualified anesthesiologist - A doctor of medicine or osteopathy other than an anesthesiologist - 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	**§482.52(c) Standard: State Exemption** (1) A hospital may be exempted from the requirement for MD/DO supervision of CRNAs as described in paragraph (a)(4) of this section, if the State in which the hospital 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 of CRNAs. 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	**Document Review** **Personnel/Credential File** □ Review the qualifications of individuals authorized to administer general anesthesia, regional anesthesia, and monitored anesthesia, including deep sedation/analgesia, to determine if they satisfy the requirements at §482.52(a) and (c). □ Determine that there is documentation of current licensure and, as applicable, current certification for all persons administering anesthesia. □ Review the qualifications of individuals authorized to furnish other anesthesia services to determine if they are consistent with the hospital's anesthesia services policies. **General**

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- A certified registered nurse anesthetist (CRNA), as defined in 42 CFR 410.69(b), supervised by the operating practitioner except as provided in 42 CFR 482.52(c) regarding the state exemption for this supervision - An anesthesiologist's assistant, as defined in 42 CFR 410.69(b), supervised by an anesthesiologist who is immediately available if needed - 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) anesthesiologist assistant. Note 3: The CoP at 42 CFR 482.52(c) for state exemption states: A hospital may be exempt from the requirement for doctors of medicine or osteopathy to supervise CRNAs if the state in which the 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	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. (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.	□ Determine if the state is an "opt-out state" and therefore permits CRNAs to administer anesthesia without supervision in accordance with 482.52(c). □ Review the hospital's policies and procedures governing supervision of assistants to certified registered nurse anesthetists (CRNAs) and anesthesiologist and determine whether they comply with regulatory requirements.

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exemption from doctor of medicine or osteopathy supervision for CRNAs. 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 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.		
LD.13.03.01, EP 1: The 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	**§482.52(b) Standard: Delivery of Services** Anesthesia services must be consistent with needs and resources. Policies on anesthesia procedures must include the delineation of preanesthesia and postanesthesia responsibilities. The policies must ensure that the following are provided for each patient:	**Document Review** **General** ☐ Review the policies developed on anesthesia procedures determine they address at a minimum: ○ How the hospital's anesthesia services needs will be met; ○ Delivery of anesthesia services consistent with recognized standards for anesthesia care. A well-designed anesthesia services policy would address issues such as: ▪ Patient consent; ▪ Infection control measures; ▪ Safety practices in all anesthetizing areas; ▪ Protocol for supportive life functions, e.g., cardiac and respiratory emergencies; ▪ Reporting requirements; ▪ Documentation requirements; ▪ Equipment requirements, as well as the monitoring, inspection, testing, and maintenance of anesthesia equipment in the hospital's biomedical equipment program. ○ Delineation of pre- and post-anesthesia staff responsibilities

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PC.13.01.03, EP 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital develops and implements policies and procedures for anesthesia that include the delineation of preanesthesia and postanesthesia responsibilities. The policies require the following for each patient: - A preanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in 42 CFR 482.52(a), within 48 hours prior to surgery or a procedure requiring anesthesia services. - An intraoperative anesthesia record. - A postanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in 42 CFR 482.52(a), no later than 48 hours after surgery or a procedure requiring anesthesia services. The postanesthesia evaluation for anesthesia recovery is completed in accordance with state law and hospital policies and procedures that have been approved by the medical staff and that reflect current standards of anesthesia care.		
PC.13.01.03, EP 2: See above	**§482.52(b) (1)** - A pre-anesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, performed within 48 hours prior to surgery or a procedure requiring anesthesia services.	**Document Review** **Patient Health Record** □ Review a sample of inpatient and outpatient health records for patients who had surgery or a procedure requiring anesthesia. Determine if each patient ○ Had a preanesthesia evaluation by a practitioner qualified to administer anesthesia.

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		○ Preanesthesia evaluation included at least the elements that must be performed within the 48-hour timeframe as follows: ▪ Review of the medical history, including anesthesia, drug and allergy history; and ▪ Interview, if possible given the patient's condition, and examination of the patient. Elements that must be reviewed and updated as necessary within 48 hours, but which may also have been performed during or within 30 days prior to the 48-hour time period, in preparation for the procedure: ▪ Notation of anesthesia risk according to established standards of practice (e.g., ASA classification of risk). ▪ Identification of potential anesthesia problems, particularly those that may suggest potential complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access). ▪ Additional pre-anesthesia data or information, if applicable and as required in accordance with standard practice prior to administering anesthesia (e.g., stress tests, additional specialist consultation). ▪ Development of the plan for the patient's anesthesia care, including the type of medications for induction, maintenance and post-operative care and discussion with the patient (or patient's representative) of the risks and benefits of the delivery of anesthesia. ○ Determine that the preanesthesia evaluation was updated, completed, and documented within 48 hours prior to the delivery of the first dose of medication(s) given for the purpose of inducing anesthesia for surgery or a procedure requiring anesthesia services.

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PC.13.01.03, EP 2: See above	**§482.52(b)(2)** - An intraoperative anesthesia record.	**Document Review** **Patient Health Record** Review a sample of health records for patients who had surgery or a procedure requiring anesthesia to determine that each patient has an intraoperative anesthesia record that includes the following elements: o Name and hospital identification number of the patient; o Name(s) of practitioner(s) who administered anesthesia, and as applicable, the name and profession of the supervising anesthesiologist or operating practitioner; o Name, dosage, route and time of administration of drugs and anesthesia agents; o Techniques(s) used and patient position(s), including the insertion/use of any intravascular or airway devices; o Name and amounts of IV fluids, including blood or blood products if applicable; o Timed-based documentation of vital signs as well as oxygenation and ventilation parameters; and o Any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment.
PC.13.01.03, EP 2: See above	**482.52(b)(3)** - A postanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, no later than 48 hours after surgery or a procedure requiring anesthesia services. The postanesthesia evaluation for anesthesia recovery must be completed in accordance with State law and with hospital policies and procedures that have been approved	**Document Review** **Patient Health Record** Review a sample of medical records for patients who had surgery or a procedure requiring general, regional, or monitored anesthesia to determine if A postanesthesia evaluation was completed for each patient. o Was the evaluation conducted by a practitioner who is qualified to administer anesthesia? o Was the evaluation completed and documented within 48 hours after the surgery or procedure?

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	by the medical staff and that reflect current standards of anesthesia care.	○ Were the elements of an adequate postanesthesia evaluation documented in the medical record: ▪ Respiratory function, including respiratory rate, airway patency, and oxygen saturation; ▪ Cardiovascular function, including pulse rate and blood pressure; ▪ Mental status; ▪ Temperature; ▪ Pain; ▪ Nausea and vomiting; and ▪ Postoperative hydration.

Hospital Nuclear Medicine Services Evaluation Module (482.53)

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LD.13.03.01, EP 1: The 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	**§482.53 Condition of participation: Nuclear medicine services.** If the hospital **provide**s nuclear medicine services, those services must meet the needs of the patients in accordance with acceptable standards of practice. .	**Interview** □ If nuclear medicine services are offered, determine the type(s) of services provided and the location where each service is provided. □ Can the director of nuclear medicine services demonstrate how the hospital ensures that the services are provided in accordance with acceptable standards of practice? □ Can the director point to accepted guidelines or state or other federal law that support the hospital's nuclear medicine policies and procedures? □ Can the director explain how the hospital's policies, procedures, and protocols are consistent with **ALARA** principles? **Document Review** **Policy/Procedure Review** □ nuclear medicine policies and procedures that take into consideration classes of patients who may be at higher risk for over-exposure, as well as the radiation exposure of staff when preparing, storing, transporting, administering and disposing of radioactive materials. **QAPI Review** □ the hospital's nuclear medicine services must be integrated into its hospital- wide Quality Assessment and Performance Improvement (QAPI) program, as required by §482.21. Consistent with these requirements, the hospital must monitor the quality and safety of nuclear medicine services **Observation** □ Observe one or more nuclear medicine studies to determine whether staff follows the hospital's protocols for that study. After the observation, ask staff to show you the applicable protocol and explain how they complied with it.

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LD.13.01.07, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: A qualified doctor of medicine or osteopathy directs the following services when provided: - Anesthesia - Nuclear medicine - Respiratory care Note 1: The anesthesia service is responsible for all anesthesia administered in the hospital. Note 2: For respiratory care services, the director may serve on either a full-time or part-time basis. **LD.13.03.01, EP 1:** See above **MS.16.01.01, EP 12:** For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff approves the nuclear services director's specifications for the qualifications, training, functions, and responsibilities of the nuclear medicine staff.	**§482.53(a) Standard: Organization and Staffing** The organization of the nuclear medicine service must be appropriate to the scope and complexity of the services offered. **§482.53(a)(1)** There must be a director who is a doctor of medicine or osteopathy qualified in nuclear medicine. **§482.53(a)(2)** The qualifications, training, functions, and responsibilities of nuclear medicine personnel must be specified by the service director and approved by the medical staff.	**Document Review** **General** ☐ Determine whether the scope of the nuclear medicine services offered is specified in writing. ☐ Determine whether there are nuclear medicine policies developed by the director of nuclear medicine that govern the provision of these services in every part of the hospital offering nuclear medicine services. **Personnel/Credential File** ☐ Verify that the hospital has a written description of the qualifications of the nuclear medicine services director. ○ Review the service director's file to verify that they are an MD or a DO and have the necessary education, experience, and specialized training in nuclear medicine, per the hospital's written policies ☐ Ensure that the hospital has specified, in writing, the qualifications, training, functions, and responsibilities of each category of personnel used by the hospital, whether personnel are employees or contractors, in the delivery of nuclear medicine services. ○ The written specifications must be developed by the nuclear medicine services director and approved by the hospital's medical staff. ○ Qualifications include, at a minimum, job title, education, experience, specialized training, and licensure/certification, consistent with any applicable federal and state law. The specifications must also address ongoing training for personnel. ○ Review personnel files for a sample of nuclear medicine staff to determine if they meet the prescribed qualifications and have received

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		ongoing training as required in the hospital's policies and procedures.
LD.13.03.01, EP 9: For hospitals that use the Joint Commission for deemed status purposes: If the hospital provides nuclear medicine services, and nuclear medicine staff perform laboratory tests, the services meet the applicable requirements for laboratory services specified in 42 CFR 482.27. **MM.15.01.01, EP 7:** For hospitals that use Joint Commission accreditation for deemed status purposes: An appropriately trained registered pharmacist or doctor of medicine or osteopathy performs or supervises in-house preparation of radiopharmaceuticals. **PE.02.01.01, EP 4:** The hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials. The policies and procedures address the following: - Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors - Disposal of hazardous medications - Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding - Periodic inspection of radiology equipment	**§482.53(b) Standard: Delivery of Service** **Radioactive materials must be prepared, labeled, used, transported, stored, and disposed of in accordance with acceptable standards of practice.** **§482.53(b)(1)** In-house preparation of radiopharmaceuticals is by, or under the supervision of, an appropriately trained registered pharmacist or a doctor of medicine or osteopathy. **§482.53(b)(2)** There is proper storage and disposal of radioactive material. **§482.53(b)(3)** If laboratory tests are performed in the nuclear medicine service, the 40 42 CFR Ch. IV (10–1–23 Edition) §482.54 service must meet the applicable requirement for laboratory services specified in §482.27.	**Interview** □ Ask the hospital to demonstrate how it limits access to radioactive materials at all times. □ Determine if staff use their dosimeters according to manufacturer's instructions, particularly in the appropriate placement of the dosimeter on the body, as indicated on the dosimeter. □ Ask responsible staff to demonstrate how they ensure the safe transport of radioactive materials in the hospital. □ Ask responsible staff to determine whether the appropriate container for protection devices (for example, lead for gamma emitters) are being used for storage and administration of radioactive materials. □ Ask staff to show the policy for disposal methods for radioactive waste or unused material and to explain how they ensure that these procedures are followed. □ If radiopharmaceuticals are prepared in-house, determine that the preparation is performed by, or supervised by, a registered pharmacist or MD/DO. □ Ask the supervising pharmacist or MD/DO how technicians who prepare radiopharmaceuticals are supervised. Are supervision policies based on the recommendations of the Society of Nuclear Medicine and Molecular Imaging? If not, what is the basis for the supervision policies? □ Ask what policies and procedures the hospital uses to ensure proper preparation. □ Ask what guidelines the hospital relies on for radio pharmaceutical preparation. **Document Review** **General** □ Verify that radioactive materials are prepared, labeled, used, transported, stored, and disposed of in accordance

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and prompt correction of hazards found during inspection - Precautions to follow and personally protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers, and MRIs). Note 2: Hazardous gases and vapors include, but are not limited to, ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9)		with hospital policies that are based on acceptable standards of practice. □ Verify that the hospital maintains accurate records of the receipt, distribution, and disposal of radioactive materials, including radiopharmaceuticals. □ If radiopharmaceuticals are obtained from an outside source, verify that the receipt and storage are appropriately tracked. □ Verify that the hospital has policies regarding the supervision of nuclear medicine personnel and the in-house preparation of radio pharmaceuticals. **Personnel/Credential File** □ Review personnel records of pharmacists, MDs/DOs, and nuclear medicine personnel involved in the preparation and supervision of radiopharmaceuticals to verify that they have required qualifications per state law and hospital policy. **Observation** □ If the hospital prepares radiopharmaceuticals on-site, observe the preparation to verify that proper safety precautions are used to protect staff from excess radiation and, once prepared, are stored in appropriate containers. □ Verify that a clear, recognizable label for nuclear material is appropriately displayed in all relevant areas throughout the hospital and on all radioactive materials. □ Verify that safety precautions are followed in the operations of the nuclear medicine service and that personnel and patients maintain and wear appropriate body shielding (for example, lead aprons, lead gloves, thyroid shields), when appropriate. □ Observe a staff member deliver a nuclear medicine procedure to a patient, paying attention to adherence to hospital safety protocols during the delivery of the radiopharmaceutical.

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		☐ Verify that radioactive materials, including radioactive waste, have appropriate storage and disposal. ☐ Determine how the hospital disposes of unneeded radio nuclides and radio pharmaceuticals. o Are these methods in accordance with federal and state law, regulation, and guidelines? o Are the methods described in hospital policy? ☐ Ensure that any laboratory tests performed in connection with nuclear medicine services comply with procedures for the laboratory services Condition of Participation.
PE.04.01.01, EP 4: The hospital maintains equipment and supplies appropriate for the types of nuclear medicine services offered. The equipment is maintained for safe operation and efficient performance. **PE.05.01.01, EP 1:** At least annually, a diagnostic medical physicist or nuclear medicine physicist inspects, tests, and calibrates all nuclear medicine (NM) imaging equipment. The results, along with recommendations for correcting any problems identified, are documented. These activities are conducted for all of the image types produced clinically by each NM scanner (for example, planar and/or tomographic) and include the use of phantoms to assess the following imaging metrics: - Image uniformity/system uniformity - High-contrast resolution/system spatial resolution - Sensitivity	**§482.53(c) Standard: Facilities .** Equipment and supplies must be appropriate for the types of nuclear medicine services offered and must be maintained for safe and efficient performance. The equipment must be— **(1)** Maintained in safe operating condition; and **(2)** Inspected, tested, and calibrated at least annually by qualified personnel.	**Interview** ☐ Ask nuclear medicine services staff who operate equipment what they would do if they suspected a malfunction. Does the hospital have a policy to address this and are staff familiar with it? **Document Review** **General** ☐ Does the hospital have documentation that indicates that the equipment and supplies it uses in nuclear medicine services are appropriate for use with radioactive materials? ☐ Review equipment maintenance records. Verify that equipment is tested, calibrated, and otherwise maintained at least annually, following the manufacturer's recommended procedures. ☐ Verify that, if the manufacturer requires more frequent than annual testing and maintenance, the hospital adheres to the manufacturer's prescribed schedule. **Personnel/Credential File** ☐ Can the hospital demonstrate how personnel, whether employees or contractors, who inspect, test, calibrate, and maintain nuclear medicine services equipment are qualified to do so?

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- Energy resolution - Count-rate performance - Artifact evaluation Note 1: The following test is recommended, but not required: Low-contrast resolution or detectability for non-planar acquisitions. Note 2: The medical physicist or nuclear medicine physicist is accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the medical physicist or nuclear medicine physicist. (For more information, refer to HR.11.01.03, EPs 1 and 2; HR.11.02.01, EP 2)		**Observe** ☐ Have staff demonstrate how the equipment is maintained for quality assurance in patient care.
MM.13.01.01, EP 6: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital maintains records of the receipt and distribution of radiopharmaceuticals. **PC.12.01.01, EP 1:** Prior to providing care, treatment, and services, the 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; hospital policies; and medical staff bylaws, rules, and regulations. Note 1: This includes but is not limited to respiratory services, radiology services, rehabilitation services, nuclear medicine services, and dietary services, if provided.	**§482.53(d) Standard: Records**. The hospital must maintain signed and dated reports of nuclear medicine interpretations, consultations, and procedures. **§482.53(d)(1)** The hospital must maintain copies of nuclear medicine reports for at least 5 years. **§482.53(d)(2)** The practitioner approved by the medical staff to interpret diagnostic procedures must sign and date the interpretation of these tests. **§482.53(d)(3)** The hospital must maintain records of the receipt and disposition of radiopharmaceuticals.	**Interview** ☐ Ask the hospital to demonstrate how it maintains accurate records of the receipt and distribution of radiopharmaceuticals at all locations throughout the hospital. ☐ Ask what the hospital's policy is for frequency of review of the records. Is there evidence that the hospital complies with its policy? ☐ Ask the hospital to explain how it addresses discrepancies in the records. o What actions does it take to determine whether there are errors in the records versus unaccounted loss of materials? o If applicable, what further actions does it take to locate unaccounted radioactive materials? o If applicable, what further actions does it take to prevent future recordkeeping errors? **Document Review**

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Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: 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. **RC.11.01.01, EP 4:** The hospital develops and implements policies and procedures for accurate, legible, complete, signed, dated, timed, medical record entries that are authenticated by the person responsible for providing or evaluating the service provided. The medical records are promptly completed, properly filed and retained, and readily accessible. **RC.11.03.01, EP 1:** The retention time of the original or legally reproduced medical record is determined by its use and hospital policy, in accordance with law and regulation. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Medical records are retained in their original or legally reproduced form for at least five years. This	**§482.53(d)(4)** Nuclear medicine services must be ordered only by practitioner whose scope of Federal or State licensure and whose defined staff privileges allow such referrals	**General** ☐ Verify that copies of nuclear medicine reports are maintained for at least 5 years. ☐ Verify that reports of nuclear medicine interpretations are signed and dated only by the practitioner who interpreted the study's results, as authorized by the medical staff to perform these interpretations. ☐ Verify that nuclear medicine services are ordered only by practitioners who have privileges to do so or, for outpatient services when authorized and consistent with the provisions of §482.54, by other practitioners authorized to do so by the medical staff, consistent with federal and state law.

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includes nuclear medicine reports; radiological reports, printouts, films, and scans; and other applicable image records. **RC.12.01.01, EP 2:** The medical record contains the following clinical information: - Admitting diagnosis - Any emergency care, treatment, and services provided to the patient before their arrival - Any allergies to food and medications - Any findings of assessments and reassessments - 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		

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Note: When rapid titration of a medication is necessary, the 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		

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30 days following discharge, including final diagnosis.		

Outpatient Services Evaluation Module (482.54)

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
LD.13.03.01, EP 1: The 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	**§482.54 Condition of Participation:** Outpatient Services If the hospital provides outpatient services, the services must meet the needs of the patients in accordance with acceptable standards of practice.	**Document Review:** ☐ Review hospital's scope of services (see survey procedures for 482.54 (a) (1)
LD.13.03.01, EP 5: If the hospital provides outpatient services, the services are integrated with inpatient services.	**482.54(a) Standard:** Organization Outpatient services must be appropriately organized and integrated with inpatient services.	**Interview:** ☐ Director of outpatient services to understand scope and complexity of services provided and organization of the service(s) ☐ Director of outpatient services and staff about established procedures and communication methods to facilitate continuity of care ☐ Verify that outpatient services are integrated into hospital wide QAPI program (A-1081) **Document Review:** ☐ Review the hospital scope of services ☐ Policies to assure the integration of outpatient services, including an established method of communication

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		between outpatient service departments to corresponding inpatient services. **Patient Health Record Review:** - Review 1-2 outpatient medical records of patients who were admitted to acute care to confirm that pertinent information from the outpatient record has been included in the inpatient record. **Observation:** - For each outpatient location visited, observe for staffing, equipment, and supplies to support the scope and complexity of services provided at each location. Services provided are in accordance with acceptable standards of practice
LD.13.01.07, EP 2: The hospital assigns one or more individuals who are responsible for outpatient services. **NPG.12.01.01, EP 1:** Leaders provide for an adequate number and mix of qualified individuals to support safe, quality care, treatment, and services. Note 1: The number and mix of individuals is appropriate to the scope and complexity of the services offered. Services may include but are not limited to the following: - Rehabilitation services - Emergency services - Outpatient services - Respiratory services - Pharmaceutical services, including emergency pharmaceutical services - Diagnostic and therapeutic radiology services.	**482.54(b) Standard: Personnel** The hospital must – (1) Assign one or more individuals to be responsible for outpatient services. (2) Have appropriate professional and nonprofessional personnel available at each location where outpatient services are offered, based on the scope and complexity of outpatient services.	**Interview** - Identify the individual(s) responsible for providing direction for outpatient services. **Document review** - Policies and procedures to determine the person's responsibility. **Personnel file review** - Review the job description and personnel file of the individual(s) responsible for a selection of outpatient services to ensure qualifications are in accordance with State law, acceptable standards of practice and hospital policy to direct the service for which they are responsible. **Observation:** - Visit several on- and off-campus locations where hospital outpatient services are provided. - Based on scope and complexity of the services being offered, there is sufficient staff/personnel with the appropriate education, experience, certifications, current

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Note 2: Emergency services staff are qualified in emergency care.		licensure where appropriate, and competencies for assigned responsibilities.
PC.12.01.01, EP 2: Any physician or other licensed practitioner who orders outpatient services meets the following conditions: - Responsible for the care of the patient - Licensed in the state where they provide care to the patient - Acting within their scope of practice under state law - Authorized in accordance with state law and policies adopted by the medical staff and approved by the governing body to order the applicable outpatient services Note: This applies to physicians or other licensed practitioners who are appointed to the hospital's medical staff or have been granted privileges, as well as practitioners not appointed to the medical staff who satisfy the above criteria.	**482.54(c) Standard: Orders for Outpatient Services** Outpatient services must be ordered by a practitioner who meets the following conditions: **(1)** Is responsible for the care of the patient. **(2)** Is licensed in the State where he or she provides care to the patient. **(3)** Is acting within his or her scope of practice under State law. **(4)** Is authorized in accordance with State law and policies adopted by the medical staff, and approved by the governing body, to order the applicable outpatient services. This applies to the following: (i) All practitioners who are appointed to the hospital's medical staff and who have been granted privileges to order the applicable outpatient services. (ii) All practitioners not appointed to the medical staff, but who satisfy the above criteria for authorization by the medical staff and the hospital for ordering the applicable outpatient services for their patients.	**Interview and patient health records review** ☐ Outpatient services must be ordered by a physician or other licensed practitioner who orders outpatient services meets the following conditions: ☐ Is responsible for the care of the patient ☐ Is licensed in the state where they provide care to the patient ☐ Is acting within his or her scope of practice under state law ☐ Is authorized in accordance with state law and medical staff policies approved by the governing body to order the applicable outpatient services
LD.13.03.01, EP 1: See above	**Standard-level Tag for §482.54 Condition of Participation: Outpatient Services** If the hospital provides outpatient services, the services must meet the	**Interview** ☐ Verify that equipment, staff and facilities are adequate to provide the outpatient services offered at each location are in accordance with acceptable standards of practice. ☐ Verify that outpatient services at all locations are in compliance with the hospital CoP.

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	needs of the patients in accordance with acceptable standards of practice.	☐ Determine locations and type(s) of outpatient services provided. **Document Review** ☐ Verify that the hospital's outpatient services are integrated into its hospitalwide QAPI program.

Hospital Emergency Services Evaluation Module (482.55)

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
LD.13.03.01, EP 1: The 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 **LD.13.03.01, EP 7:** If the hospital provides emergency services, the services meet the needs of its patients in accordance with accepted standards of practice, are organized under the direction of a qualified member of the medical staff, and are integrated with other departments of the hospital.	**§482.55 Condition of Participation: Emergency Services** The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. No IGs/SP	**Interview** **General** ☐ Ask staff how the hospital meets the emergency needs of its patients in accordance with acceptable standards of practice and as per applicable law and regulation.
	§482.55(a) Standard: Organization and Direction. *If emergency services are provided at the hospital –*	

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LD.13.03.01, EP 1: See above **LD.13.03.01, EP 7:** See above	§482.55(a) - *[If emergency services are provided at the hospital --]* (1) The services must be organized under the direction of a qualified member of the medical staff;	**Interview** Leaders about emergency services, including who leads these services, and the medical staff's criteria for this position. **Document Review** **General** ☐ Verify that emergency services are organized under the direction of a qualified member of the medical staff. Note: *A single emergency services director must be identified and be responsible for the hospital's emergency services.* ☐ Has the medical staff established criteria for the qualifications of the emergency services director in accordance with state law and acceptable standards of practice?
LD.13.03.01, EP 1: See above **LD.13.03.01, EP 7:** See above	§482.55(a) - *[If emergency services are provided at the hospital --]* (2) The services must be integrated with other departments of the hospital;	**Interview** ☐ Ask emergency services staff how the hospital's other departments provide emergency patients the care and services needed within safe and appropriate times (for example, emergency surgery, on-call staff response times, lab turnaround times for critical patients) **Document Review** **General** ☐ Verify that there are established procedures for emergency services provided at the hospital and that they are integrated with other hospital services, such as laboratory, radiology, and operating services, etc. to provide continuity of care. Note: *For hospitals that offer urgent care services on the hospital campus or in provider-based clinics in the communities they serve, verify that there are established procedures and integration in those locations.*

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MS.16.01.01, EP 9: If the hospital provides emergency services, the medical staff establishes and is continually responsible for the policies and procedures governing emergency medical care.	§482.55(a) - *[If emergency services are provided at the hospital --]* (3) The policies and procedures governing medical care provided in the emergency service or department are established by and are a continuing responsibility of the medical staff.	**Document Review** **General** ☐ Verify that policies and procedures for emergency medical services (including triage of patients) are established, evaluated, and updated on an ongoing basis. Note: *The emergency service or emergency department policies must be current and revised as necessary based on the ongoing monitoring conducted by the medical staff and the emergency service or department QAPI activities.*
	§482.55(b) Standard: Personnel The hospital must ensure the emergency services personnel requirements are met.	
LD.13.01.07, EP 1: The hospital's emergency services are supervised by a qualified member of the medical staff.	§482.55(b)(1) - The emergency services must be supervised by a qualified member of the medical staff.	**Document Review** **General** ☐ Verify that the hospital's medical staff has established criteria for the qualifications a medical staff member must possess to be granted privileges for supervising the provision of emergency care services. ☐ Verify that a qualified member of the medical staff is designated to supervise emergency care services. Note: *The role of the emergency services supervisor must include expectations for the supervisor to be in the hospital and immediately available, when needed, to provide direction and/or direct care during the ED's operating hours.* Note: *Qualifications include necessary education, experience, and specialized training, consistent with state law and acceptable standards of practice.*

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NPG.12.01.01, EP 1: Leaders provide for an adequate number and mix of qualified individuals to support safe, quality care, treatment, and services. Note 1: The number and mix of individuals is appropriate to the scope and complexity of the services offered. Services may include but are not limited to the following: - Rehabilitation services - Emergency services - Outpatient services - Respiratory services - Pharmaceutical services, including emergency pharmaceutical services - Diagnostic and therapeutic radiology services. Note 2: Emergency services staff are qualified in emergency care.	**§482.55(b)(2)** - There must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility.	**Document Review** **General** ☐ Review emergency services policies and procedures for the following: o The categories and numbers of MD/DOs, specialists, RNs, EMTs, and emergency department support staff needed to meet its anticipated emergency needs. o Medical staff criteria that is in accordance with state law and regulation and acceptable standards of practice delineating the qualifications required for each category of emergency services staff (for example, emergency physicians, specialist MDs/DOs, RNs, EMTs, midlevel practitioners). o The needs anticipated by the facility are specific to the assigned duties for emergency care staff. o Clear chain of command. **Interview** ☐ Ask leaders and emergency services director how they determine the categories and numbers of MDs/DOs, specialists, RNs, EMTs, and ED support staff the hospital needs to meet its anticipated emergency care services needs. ☐ Ask staff to verify how the hospital conducts periodic assessments of its emergency needs to anticipate the policies, procedures, staffing, training, and other resources that may be required to address likely demands. ☐ Based on their level of participation in emergency care, ask staff to describe how they maintain knowledge of the following: o Parenteral administration of electrolytes, fluids, blood, and blood components

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		○ Care and management of injuries to extremities and the central nervous system ○ Prevention of contamination and cross infection

Hospital Rehabilitation Services Evaluation Module (482.56)

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
PC.12.01.01, EP 4: If the 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 hospitals that use Joint Commission accreditation for deemed status purposes: The provision of rehabilitation services is in accordance with 42 CFR 409.17.	**§482.56 Condition of Participation: Rehabilitation Services** If the hospital provides rehabilitation, physical therapy, occupational therapy, audiology, or speech pathology services, the services must be organized and staffed to ensure the health and safety of patients.	**Interview** □ What types of rehabilitation services are provided at the hospital. **Document Review** **General** □ Review the hospital's policies and procedures to verify that the scope of rehabilitation services offered is defined in writing. □ If services are provided under an arrangement, review policies and contracts. □ For each service, determine that adequate types and numbers of qualified staff are available to ensure safe and efficient provision of treatment. □ Determine if the hospital's rehabilitation services are integrated into its hospital wide quality assurance/performance improvement program.
PC.12.01.01, EP 4: See above	**§482.56(a) Standard: Organization and Staffing** The organization of the service must be appropriate to the scope of the services offered.	**Document Review** **General** □ Review the hospital's policies and procedures to verify that the scope of rehabilitation services offered is defined in writing. □ For each service, determine that adequate types and numbers of qualified staff are available to ensure safe and efficient provision of treatment in accordance with acceptable standards of practice. **Patient Health Record** □ Review a sample of medical records to verify that a qualified professional evaluates the patient and initiates each treatment episode.

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		Personnel/Credential File (HR File Review/Competency Activity) □ Review a sample of personnel files to verify current licensure, certifications, and ongoing training, consistent with applicable state law. **Interview** □ Ask leadership to describe how services are provided (single discipline department vs. multidiscipline department) and to delineate the established lines of authority and responsibility
HR.11.02.01, EP 3: The director of rehabilitation services has the knowledge, experience, and capabilities to supervise and administer the services.	§482.56(a)(1) (1) The director of the services must have the necessary knowledge, experience, and capabilities to properly supervise and administer the services.	**Document Review** **Personnel/Credential File (HR File Review/Competency Activity)** □ Verify that each service is accountable to an individual who directs the overall operation of that service. □ Review the service director's position description to verify that they have been granted the authority and responsibility for operation of the service, consistent with hospital policies, state law, and accepted standards of practice. □ If the director does not work full time, review timesheets to determine if the number of hours spent working is appropriate to the scope of services provided. □ Review the director's personnel file to determine that they have the necessary education, experience, and specialized training to properly supervise and administer the service. This includes maintaining current licensure and certifications as required by state law. **Interview** □ Ask the director if they have the necessary knowledge, experience, and capabilities to properly supervise and administer the service.

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HR.11.02.01, EP 1: The 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: Qualifications for laboratory personnel are described in the Clinical Laboratory Improvement Amendments, under Subpart M: "Personnel for Nonwaived Testing" §493.1351-§493.1495. A complete description of the requirement is located at https://www.ecfr.gov/cgi-bin/text-idx?SID=0854acca5427c69e771e5beb52b0b986&mc=true&node=sp42.5.493.m&rgn=div6. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: 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 hospital. See Glossary for definitions of physical therapist, physical therapist assistant, occupational therapist, occupational therapy assistant, speech-language pathologist, and audiologist. Note 4: Qualifications for language interpreters and translators may be met	**§482.56(a)(2)** **(2)** Physical therapy, occupational therapy, or speech-language pathology or audiology services, if provided, must be provided by qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists as defined in part 484 of this chapter	**Document Review** **Personnel/Credential File (HR File Review/Competency Activity)** □ Review the staff's personnel file to determine that they have the necessary education, experience, and specialized training to properly supervise and administer the service. This includes maintaining current licensure and certifications as required by state law.

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through language proficiency assessment, education, training, and experience. The use of qualified interpreters and translators is supported by the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and Title VI of the Civil Rights Act of 1964. Note 5: 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.		
PC.12.01.01, EP 1 Prior to providing care, treatment, and services, the 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; hospital policies; and medical staff bylaws, rules, and regulations. Note 1: This includes but is not limited to respiratory services, radiology services, rehabilitation services, nuclear medicine services, and dietary services, if provided. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: 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.	**§482.56(b) Standard: Delivery of Services** Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital's medical staff to order the services in accordance with hospital policies and procedures and State laws.	**Document Review** **Patient Health Record** □ Review a sample of medical records of patients receiving rehabilitation services. • Who wrote the orders for the rehabilitation services? • Is the practitioner responsible for the care of the patient privileged to write orders for rehabilitation services? • Does the practitioner meet hospital medical staff policy criteria to order services, as well as state law for ordering rehabilitation services? **Interview** □ Does the hospital permit acceptance of orders from outside practitioners who do not practice at the hospital? If so, evaluate for compliance with §482.54(c).

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RC.12.01.01, EP 2: The medical record contains the following clinical information: - Admitting diagnosis - Any emergency care, treatment, and services provided to the patient before their arrival - Any allergies to food and medications - Any findings of assessments and reassessments - 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 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	**§482.56(b)(1)** **(1)** All rehabilitation services orders must be documented in the patient's medical record in accordance with the requirements at §482.24.	**Document Review** **Patient Health Record** □ Review a sample of medical records of patients who received rehabilitation services. Verify that the rehabilitation service orders are legible, complete, dated, timed, and authenticated and meet all other medical record requirements specified at §482.24.

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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.		
PC.12.01.01, EP 4: If the 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 hospitals that use Joint Commission accreditation for deemed status purposes: The provision of rehabilitation services is in accordance with 42 CFR 409.17.	§482.56(b)(2) (2)The provision of care and the personnel qualifications must be in accordance with national acceptable standards of practice and must also meet the requirements of §409.17 of this chapter.	**Interview** □ What national standards of rehabilitation practice provide the basis for its rehabilitation services. Review supporting documentation **Document Review** **Patient Health Record** □ Review a sample of health records of patients who received rehabilitation services. Determine whether the required care plan was developed and implemented. **Personnel/Credential File** □ Review a sample of employee personnel files to verify that rehabilitation service providers (that is, physical therapists,

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		physical therapy assistants, occupational therapists, occupational therapy assistants, and/or speech-language pathologists) have the necessary education, experience, training, and documented competencies to provide rehabilitation services.

Hospital Respiratory Care Services Evaluation Module (482.57)

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
LD.13.03.01, EP 1: The 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	**§482.57 Condition of Participation: Respiratory Care Services** The hospital must meet the needs of the patients in accordance with acceptable standards of practice. The following requirements apply if the hospital provides respiratory care services.	**Interview** □ Ask if the hospital provides any degree of respiratory care services. **Document Review** **General** □ Determine that the type and amount of respiratory care provided meets the needs of the patients and is delivered in accordance with acceptable standards of practice. □ Determine if the hospital's respiratory services are integrated into its hospitalwide quality assurance/performance improvement program.
LD.13.03.01, EP 1: See above	**§482.57(a)** **Standard: Organization and Staffing** The organization of the respiratory care services must be appropriate to the scope and complexity of the services offered.	**Document Review** **General** □ Review the hospital's organizational chart to determine the relationship of respiratory care services to other services provided by the hospital. □ Review the hospital policies and procedures to verify that the scope of diagnostic and/or therapeutic respiratory care services provided is defined in writing.
LD.13.01.07, EP 3: For hospitals that use Joint Commission accreditation for deemed status purposes: A qualified doctor of medicine or osteopathy directs the following services when provided: - Anesthesia - Nuclear medicine - Respiratory care	**§482.57(a)(1)** There must be a director of respiratory care services who is a doctor of medicine or osteopathy with the knowledge, experience and capabilities to supervise and administer the service properly. The director may serve on either a full-time or part-time basis.	**Interview** □ Interview respiratory care staff regarding the role and oversight activities conducted by the director. **Document Review** **Personnel/Credential File** □ Verify that a respiratory care services director has been appointed and that they have fixed lines of authority and delegated responsibility for operation of the service.

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Note 1: The anesthesia service is responsible for all anesthesia administered in the hospital. Note 2: For respiratory care services, the director may serve on either a full-time or part-time basis.		□Review the service director's credentialing file to determine that they are an MD or a DO and have the necessary education, experience, and specialized training to supervise and administer the service properly.
NPG.12.01.01, EP 1: Leaders provide for an adequate number and mix of qualified individuals to support safe, quality care, treatment, and services. Note 1: The number and mix of individuals is appropriate to the scope and complexity of the services offered. Services may include but are not limited to the following: - Rehabilitation services - Emergency services - Outpatient services - Respiratory services - Pharmaceutical services, including emergency pharmaceutical services - Diagnostic and therapeutic radiology services. Note 2: Emergency services staff are qualified in emergency care.	**§482.57(a)(2)** There must be adequate numbers of respiratory therapists, respiratory therapy technicians, and other personnel who meet the qualifications specified by the medical staff, consistent with State law.	**Interview** □ Interview respiratory care staff regarding services provided, schedules, and availability of staff throughout the day and week to determine if the number and type of staff available is appropriate to the volume and types of treatments furnished. If needed, review staffing and on-call schedules. **Document Review** **Personnel/Credential File** □ Review a sample of personnel files for respiratory care staff to determine that they meet the qualifications specified by the medical staff, consistent with state law.
LD.13.01.09, EP 7: If respiratory care services are provided, services are delivered in accordance with policies and procedures approved by the medical staff.	**482.57(b)Standard: Delivery of Services** Services must be delivered in accordance with medical staff directives.	**Document Review** **General** □ Review the hospital's policies that are developed and approved by the medical staff for the provision of respiratory care services.
HR.11.02.01, EP 1: The 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	**§482.57(b)(1)** Personnel qualified to perform specific procedures and the amount of supervision required for personnel to carry out specific procedures must be designated in writing.	**Document Review** □ Review treatment logs, job descriptions of respiratory care staff, and policies and procedures to determine the following: □ Duties and responsibilities of staff □ Qualifications and education required, including licensure, consistent with state law

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(such as that offered by the Certification Board for Infection Control). Note 2: Qualifications for laboratory personnel are described in the Clinical Laboratory Improvement Amendments (CLIA), under Subpart M: "Personnel for Nonwaived Testing" §493.1351-§493.1495. A complete description of the requirement is located at https://www.ecfr.gov/cgi-bin/text-idx?SID=0854acca5427c69e771e5beb52b0b986&mc=true&node=sp42.5.493.m&rgn=div6. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: 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 hospital. See Glossary for definitions of physical therapist, physical therapist assistant, occupational therapist, occupational therapy assistant, speech-language pathologist, and audiologist. Note 4: Qualifications for language interpreters and translators may be met through language proficiency assessment, education, training, and experience. The use of qualified interpreters and translators is supported by the Americans		☐ Specialized training or experience needed to perform specific duties

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with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and Title VI of the Civil Rights Act of 1964. Note 5: 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.		
LD.13.03.01, EP 15: For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital provides respiratory care services and respiratory care staff perform blood gasses or other clinical laboratory tests, the applicable requirements for laboratory services specified in 42 CFR 482.27 are met	**§482.57(b)(2)** If blood gases or other clinical laboratory tests are performed in the respiratory care unit, the unit must meet the applicable requirements for laboratory services specified in §482.27.	**Interview** □ Ask if blood gases or other clinical laboratory tests are performed in the respiratory care unit.
PC.12.01.01, EP 1: Prior to providing care, treatment, and services, the 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; hospital policies; and medical staff bylaws, rules, and regulations. Note 1: This includes but is not limited to respiratory services, radiology services, rehabilitation services, nuclear medicine services, and dietary services, if provided. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: Patient diets, including therapeutic diets, are ordered by the physician or other licensed practitioner	**482.57(b)(3)** Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital's medical staff to order the services in accordance with hospital policies and procedures and State laws.	**Interview** □Ask the respiratory therapist(s) if the hospital permits acceptance of orders from outside practitioners who do not practice at the hospital? If so, evaluate for compliance with §482.54(c). **Document Review** **Patient Health Record** □ Review a sample of health records of patients receiving respiratory care services. □ Determine who wrote the orders for respiratory care services □ Determine if the practitioner responsible for the care of the patient privileged to write orders for respiratory care services? **Personnel/Credential File** □ Verify the practitioner meet hospital medical staff policy criteria to order services, as well as state law for ordering respiratory care services

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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.		□ Verify that the practitioner responsible for the care of the patient is privileged to write orders for respiratory care services
RC.12.01.01, EP 2: The medical record contains the following clinical information: - Admitting diagnosis - Any emergency care, treatment, and services provided to the patient before their arrival - Any allergies to food and medications - Any findings of assessments and reassessments - 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	**§482.57(b)(4)** All respiratory care services orders must be documented in the patient's medical record in accordance with the requirements at §482.24.	**Document Review** **Patient Health Record** □ Review a sample of patient medical records for patients who received respiratory care services. Determine whether the respiratory care services orders are legible, complete, dated, timed, and authenticated and meet all other medical record requirements as specified at §484.24.

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Note: When rapid titration of a medication is necessary, the 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.		

Hospital Special Provisions Applying to Psychiatric Hospitals Evaluation Module (482.60)

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	§482.60-Special Provisions Applying to Psychiatric Hospitals – Psychiatric hospitals **must**	
NPG.12.03.01, EP 1: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The psychiatric hospital does the following: - Is primarily engaged in providing, by or under the supervision of a doctor of medicine or osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons. - Meets the Medicare Conditions of Participation specified in 42 CFR 482.1 through 482.23, and 42 CFR 482.25 through 482.57. - Meets the staffing requirements specified in 42 CFR 482.62.	**§482.60(a)** Be primarily engaged in providing, by or under the supervision of a doctor of medicine or osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons.	The hospital will be deemed to meet standard (a), **If** it meets standards **(c) and (d)**. **§482.60(c) Maintain clinical records on all patients, including records sufficient to permit CMS to determine the degree and intensity of treatment furnished to Medicare beneficiaries as specified in §482.61; and** ***and*** **§482.60(d) Meet the staffing requirements specified in §482.62.** See Survey Procedure for **§482.61** and **§482.62.**
NPG.12.03.01, EP 1: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The psychiatric hospital does the following: - Is primarily engaged in providing, by or under the supervision of a doctor of medicine or osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons. - Meets the Medicare Conditions of Participation specified in 42 CFR 482.1 through 482.23, and 42 CFR 482.25 through 482.57.	**§482.60(b)** Meet the Conditions of Participation specified in §§482.1 through 482.23 and §§482.25 through 482.57;	

- Meets the staffing requirements specified in 42 CFR 482.62.		
RC.11.01.01, EP 5: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The psychiatric hospital maintains clinical records on all patients to determine the degree and intensity of treatments, as specified in 42 CFR 482.61.	**§482.60(c)** Maintain clinical records on all patients, including records sufficient to permit CMS to determine the degree and intensity of treatment furnished to Medicare beneficiaries as specified in §482.61; and	
NPG.12.03.01, EP 1: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The psychiatric hospital does the following: - Is primarily engaged in providing, by or under the supervision of a doctor of medicine or osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons. - Meets the Medicare Conditions of Participation specified in 42 CFR 482.1 through 482.23, and 42 CFR 482.25 through 482.57. - Meets the staffing requirements specified in 42 CFR 482.62.	**§482.60(d)** Meet the staffing requirements specified in §482.62.	

Psychiatric Hospitals Special Medical Record Requirements Evaluation Module (482.61)

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RC.11.01.01, EP 5: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The psychiatric hospital maintains clinical records on all patients to determine the degree and intensity of treatments, as specified in 42 CFR 482.61.	**§482.61 Condition of Participation: Special Medical Record Requirements for Psychiatric Hospitals** The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.	**Interview** ☐ Interview staff and patients to validate the care/services identified within the patient health record. **Document Review** **Patient Health Record** ☐ Verify the patient health record contains the status of the patient, plan for interventions, the patient's response to interventions, and how interventions impacted patient outcomes. **Observation** ☐ Verify the care/services being provided to patients within the active environment are consistent with the documentation in patients' health records.
RC.11.01.01, EP 6: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The medical record 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,	**§482.61(a) Standard: 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 patient is hospitalized.	**Document Review** **Patient Health Record** ☐ Review patient health records to validate care/services related to psychiatric conditions for which the patient is hospitalized.

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and others; an assessment of home plans, family attitudes, and community resource contacts; and a social history - When indicated, a 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 recommendations from appropriate services concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge		
RC.11.01.01, EP 6: See above	**§482.61(a)(1)** The identification data must include the patient's legal status.	**Interview** Interview staff to understand the terminology they use in defining "legal status." **Document Review** **Patient Health Record** ☐ Review patient health records to verify they include the patient's legal status. [13] ☐ If evaluation and recertification is required by the State, determine that legal documentation supporting this status is present in the patient health record. ☐ Verify that changes in legal status are recorded in the patient health record with the date of change.
RC.11.01.01, EP 6: See above	**§482.61(a)(2)** A provisional or admitting diagnosis must be made on every patient at the time of admission and must include the diagnosis of	**Document Review** **Patient Health Record**

[13] Legal Status is defined in the State statutes and dictates the circumstances under which the patient was admitted and/or is being treated - i.e., voluntary, involuntary, committed by court, evaluation and recertification are in accordance with state requirements.

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	intercurrent diseases as well as the psychiatric diagnosis.	☐ Verify that the patient record contains an admitting diagnosis, the diagnosis of intercurrent nonpsychiatric diseases,[14] and the psychiatric diagnosis. In the absence of a diagnosis verify there is documented justification for the omission. ☐ Review the patient health record to determine if o Abnormal physical examination findings and/or laboratory findings justified by further diagnostic testing and/or development of an intercurrent diagnosis, and, if so, was such done? o An identified physical illness requires immediate treatment, is the treatment being given? o An identified physical illness is likely to impact on the patient's eventual outcome. To what extent has this potential impact been addressed by the team?
RC.11.01.01, EP 6: See above	**§482.61(a)(3)** The reasons for admission must be clearly documented as stated by the patient and/or others significantly involved.	**Document Review** **Patient Health Record** ☐ Verify that the reason for the patient's admission is documented in the health record and includes who provided the information and any supporting factors such as: o The patient's description of problems, stresses, situations experienced prior to hospitalization and whether they still exist. o An informants direct or indirect knowledge of the patient's behavior. o Staff's knowledge of the patient's pattern of behavior. What made hospitalization necessary?

[14] Attention should be paid to physical examination notes, including known medical conditions, even allergies and recent exposure to infections, illness, or substance abuse, and to available laboratory or test reports which identify abnormal findings to see that these are reflected by appropriate diagnosis. Diagnostic categories should include physical illness when present.

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		○ Changes/events in the patient's environment (death, separations of significant others) which contributed to the need for hospitalization. If relevant, has staff explored how these changes/events will impact the patient's treatment and have they been addressed by the treatment team? ○ An interruption or change in the patient's medication.
RC.11.01.01, EP 6: See above	**§482.61(a)(4)** The social service records, including reports of interviews with patients, family members, and others, must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.	**Document Review** **Patient Health Record** ☐ Review a sample of patient health records to determine that a psychosocial history/assessment has been completed on all patients and that it includes the following components: A. ***Factual and Historical Information*** 1. Specific reasons for the patient's admission or readmission; 2. A description of the patient's past and present biopsychosocial functioning; 3. Family and marital history, dynamics, and patient's relationships with family and significant others; 4. Pertinent religious and cultural factors; 5. History of physical, sexual and emotional abuse; 6. Significant aspects of psychiatric, medical, and substance abuse history and treatment as presented by family members and significant others; 7. Educational, vocational, employment, and military service history; 8. Identification of community resources including previously used treatment sources; 9. Identification of present environmental and financial needs. B. ***Social Evaluation*** 1. Patient strength and deficits;

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		2. High risk psychosocial issues requiring early treatment planning and intervention - i.e., unattended child(ren) in home; prior noncompliance to specific treatment and/ or discharge interventions; and potential obstacles to present treatment and discharge planning. C. ***Conclusions and Recommendations*** Assessment of Sections A and B shall result in the development of (C) recommendations related to the following areas: 1. Anticipated necessary steps for discharge to occur; 2. High risk patient and/or family psychosocial issues requiring early treatment planning and immediate intervention regardless of the patient's length of stay; 3. Specific community resources/ support systems for utilization in discharge planning - i.e., housing, living arrangements, financial aid, and aftercare treatment sources; 4. Anticipated social work role(s) in treatment and discharge planning. ☐ Does the psychosocial history/assessment indicate: o Clear identification of the informants(s) and sources of information? o Whether information is considered reliable? o Patient participation to the extent possible in provision of data relative to treatment and discharge planning? o Integration of significant data including identified high risk psychosocial issues (problems) into the treatment plan? o How does the hospital ensure the information is reliable?
RC.11.01.01, EP 6: See above **PC.11.02.03, EP 1:** The assessment for patients who receive treatment for emotional and behavioral disorders includes	**§482.61(a)(5)** When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.	**Document Review** **Patient Health Record** ☐ Verify that a history and physical examination, sufficient to discover all structural, functional, systemic and metabolic disorders, was performed upon admission.

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the following, based on their age and needs: - Psychiatric evaluation - Psychological assessments, including intellectual, projective, neuropsychological, and personality testing - For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Complete neurological examination at the time of the admission physical examination, when indicated (For more information on physical examination, see PC.11.02.01, EP 2)		☐ Is there evidence that a "screening" neurological examination was done and recorded at the time of the physical examination? ☐ Was the neurological screening or history indicative of possible involvement (tremors, paralysis, motor weakness or muscle atrophy, severe headaches, seizures, head trauma? ☐ Did the presence of an abnormal physical finding or laboratory finding justify the need for further diagnostic testing, or for the development of an intercurrent diagnosis? If the finding justified further follow-up in either situation, was such follow-up done? ☐ If indicated, was a complete, comprehensive neurological exam ordered, completed and recorded in the medical record in a timely manner?
PC.11.02.03, EP 2: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: 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	**§482.61(b) Standard: Psychiatric Evaluation.** Each patient must receive a psychiatric evaluation that must— **§482.61(b)(1)** Be completed within 60 hours of admission; **§482.61(b)(2)** Include a medical history **§482.61(b)(3)** Contain a record of mental status**;** §**482.61(b)(4)** Note the onset of illness and the circumstances leading to admission; **§482.61(b)(5)** Describe attitudes and behavior;	**Document Review** **Patient Health Record** ○ Review a sample of patient health records to determine if each patient received a psychiatric evaluation that contains the necessary information to justify the diagnosis and planned treatment including: ○ The patient's chief complaints and/or reaction to hospitalization, recorded in patient's own words where possible. ○ Why is the patient in the hospital? Was it his/her idea? (Does he/she feel ill/disturbed/frightened?) ○ Is the patient in the hospital against his/her will? Who decided to hospitalize/why? ○ Past history of any psychiatric problems and treatment, including prior precipitating factors, diagnosis, course and treatment. ○ Has the patient been chronically ill?

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	§482.61(b)(6) Estimate intellectual functioning, memory functioning and orientation; and §482.61(b)(7) Include an inventory of the patient's assets in descriptive, not interpretive fashion.	○ Continuously/repeatedly? How severely has the past illness/treatment interfered with the patient's development and/or adjustment? ○ Are there persistent symptoms/signs/behaviors that must be addressed and treated in order to favorably impact on the future psychiatric course? ○ What medications or supports helped him/her improve in the past? ○ Are the same resources available to impact on the patient's treatment during this episode? ○ Past family, educational, vocational, occupational and social history. ○ To what extent, if any, is there a presence or absence of familial predisposition? ○ What is the patient's educational level? Was he/she a good student? Is he/she still interested in learning? ○ What jobs has the patient held? For how long? Is he/she now employed/unemployed? For how long? Has he/she ever worked? ○ How does the patient get along with people? As a child, did he/she have friends? Does he/she have friends now? ○ Within the psychiatric evaluation does one find the specific signs and symptoms, and other factors, that justify the diagnosis? ○ Review a sample of patient health records to determine if patients received a psychiatric evaluation within 60 hours of admission. ☐ Review a sample of patient health records to determine if patient psychiatric evaluations include a non-psychiatric medical history that includes the following: ○ Relevant past surgery

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		○ Past medical conditions and disabilities especially those of a chronic nature ○ How these have contributed to the patient's psychiatric condition ○ Are any of these conditions still present to any significant degree? Are they likely to impact on the patient's recovery/remission? Should they be addressed immediately? ○ Does the facility have the capability to intervene? If not, how is the need to be met? ☐ Review a sample of patient health records to determine that patients psychiatric evaluations include a record of mental status. ○ Does the mental status evaluation describe the appearance and behavior, emotional response, verbalization, thought content, and cognition of the patient as reported by the patient and observed by the examiner at the time of the examination. *Should include patient specific supportive information.* ☐ Review a sample of patient health records to determine that patient psychiatric evaluations include the onset of illness and the circumstances leading to admission. Does the documentation include: ○ How long has the patient been ill? Was it a gradual or sudden onset? Is this a recurrence? ○ What were the precipitating factors? What happened? ○ What symptoms, signs, behaviors made this hospitalization necessary? ○ What treatment has the patient already received before coming to the hospital? ○ Any medication the patient received?

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		○ Patient psychiatric evaluations describe attitudes and behavior. [15] ○ Patient psychiatric evaluations estimate intellectual functioning, memory functioning and orientation; and ○ Patient psychiatric evaluations include an inventory of the patient's assets [16] in descriptive, not interpretive fashion.
PC.11.03.01, EP 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: 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-range 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	**§482.61(c)(1) Standard Treatment Plan.** Each patient must have an individualized, comprehensive treatment plan based on an inventory of the patient's strengths and disabilities. **Interpretive Guidelines §482.61(c)(1)** The patient and treatment team collaboratively develop the patient's treatment plan. The treatment plan is the outline of what the hospital has committed itself to do for the patient, based on an assessment of the patient's needs. The facility selects its format for treatment plans and treatment plan updates.	**Interview:** ☐ Interviews with patients, families, treatment staff and others involved directly or indirectly with active treatment. **Document Review** **Patient Health Record** ☐ Verify that patients have an individualized, comprehensive treatment plan [17] that is developed by the patient and treatment team using: ○ Information gained from assessing/evaluating the patient ○ Information contained in the psychiatric evaluation and in the assessments/diagnostic data collected by the total treatment team. ○ Assessment summaries formulated by team members of various disciplines. The treatment

[15] The problem statement should describe behavior(s) which require change in order for the patient to function in a less restrictive setting. The identified problems may also include behavioral or relationship difficulties with significant others which require active treatment in order to facilitate a successful discharge.

[16] Assets (strengths) are personal attributes i.e., knowledge, interests, skills, aptitudes, personal experiences, education, talents and employment status, which may be useful in developing a meaningful treatment plan. For purposes of the regulation, words such as "youth," "pretty," "Social Security income," and "has a car" do not represent assets.

[17] Treatment planning depends on several variables; whether the admission is limited to crisis intervention, short-term treatment or long-term treatment. The briefer the hospital stay the fewer disciplines may be involved in the patient's treatment. There must be evidence of periodic review of the patient's response and progress toward meeting planned goals.

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		team identifies which patient disabilities will be treated during hospitalization. ○ Patient strengths (must be identified). (See also §482.61(b)(7).) ☐ Verify that there is evidence of a periodic review of the patient's response and progress towards goals. The review intervals are determined by the hospital, however, consideration must be given to the type of psychiatric program(s) under review to determine the timeframe for treatment plan review. [18] ○ If the patient has made progress toward meeting goals, or if there is a lack of progress, the review must justify: (1) continuing with the current goals and approaches; or (2) revising the treatment plan to increase the possibility of a successful treatment outcome. **Document Review:** General ☐ How is the facility ensuring the patient's treatment plans are being reviewed by the team and how does it monitor the attendance of all relevant participants at the treatment plan team meetings? ○ Review any meeting attendance logs. Who is monitoring consistent attendance? ○ Are the patient's observed behaviors consistent with the problems and strengths identified in the plan or update? ○ Have the views which the patient communicated to the surveyor regarding problems which require treatment during hospitalization and plans for discharge, been incorporated in the plan or update?

[18] The hospital's review system must be sufficiently responsive to ensure the treatment plan is reviewed: whenever a goal(s) has been accomplished; when a patient is regressing; when a patient is failing to progress; or when a patient requires a new treatment goal.

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		Observation: *Determination of compliance regarding treatment plans is accomplished by the surveyor using the following methods, and to the extent possible, the following order:* ☐ Observation of the patient and staff at planned therapies/meetings. ☐ Reviews of scheduled treatment programs (individual, group, family meetings, therapeutic activities, therapeutic procedures). ☐ Attendance at multidisciplinary treatment planning meetings.
PC.11.03.01, EP 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: 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-range 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	**§482.61(c)(1)(i)** *The written plan* must *include—* A substantiated diagnosis;	**Document Review** **Patient Health Record** ☐ Verify that the written treatment plan includes a substantiated diagnosis. [19] o What specific problems will be treated during the patient's hospitalization? o Are physical problems identified and included in the treatment plan if they require treatment, or interfere with treatment, during the patient's hospitalization?
PC.11.03.01, EP 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Each patient has an individual comprehensive treatment plan	**§482.61(c)(1)(ii)** *The written plan* must *include—* Short-term and long range goals;	**Document Review** **Patient Health Record** ☐ Verify that the written treatment plan includes short-term and long range goals.

[19] Does the treatment plan identify and precisely describe problem behaviors rather than generalized statements i.e., "paranoid," "aggressive," "depressed?" or generic terminology i.e., "alteration in thought process," "ineffective coping," "alteration in mood?"

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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-range 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		○ How do treatment plan goals relate to the problems being treated? ○ Do goals indicate the outcomes to be achieved by the patient? ○ Are the goals written in a way that allow changes in the patient's behavior to be measured? ○ If not apparent, what criteria do staff use to measure success? ○ How relevant are the treatment plan goals to the patient's condition?
PC.11.03.01, EP 3: See above	**§482.61(c)(1)(iii)** *The written plan* must *include—* The specific treatment modalities utilized;	**Document Review** **Patient Health Record** ☐ Do the pieces of the treatment plan work together to achieve the greatest possible gain for the patient? **Observation** *Observation of staff implementing treatment, both in structured and non-structured settings, is a major criterion to determine whether active treatment is being provided in accordance with planned treatment.* ☐ Verify that the written treatment plan includes the specific treatment modalities utilized. ○ Are qualified staff observed following the methods, approaches and staff intervention as stated? ○ Are observed treatment methods, approaches and interventions from all disciplines included in the plan?

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		○ Does the hospital integrate its activities, therapies, treatments, and patient routines to work for the patient's therapeutic interest first ○ Do the disciplines present at observed treatment planning meetings represent all of the patient's needs? ○ If the patient attends treatment planning, how do the staff prepare the patient to participate? If the patient does not attend do staff provide a reason. ○ Is there a process to enable staff to reach a consensus regarding how treatment will be carried out? ○ Is the patient included in the decision-making, whenever possible? ○ Are the final decisions regarding treatment approaches defined clearly by the end of the discussion? ○ How does the patient get to know his/her treatment regime? ○ How does the treatment team encourage the patient to accept responsibility for engaging in the treatment regime, rather than accepting it passively? **Interview:** □ Can staff explain the focus of the treatment modality they have provided? □ Can patients discuss their treatment regime and how it was developed?
PC.11.03.01, EP 3: See above	**§482.61(c)(1)(iv)** The responsibilities of each member of the treatment team; and	**Interview** □ Are the patients able to name the staff responsible for implementing their treatment? Is this information consistent with the treatment plan? **Observation**

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		☐ Are staff who are designated in the treatment plan observed carrying out treatment activities and therapies?
PC.11.03.01, EP 3: See above	**§482.61(c)(1)(v)** Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.	**Document Review** **Patient Health Record** ☐ Do the treatment notes relative to the treatment plan? ☐ Do the notes indicate how staff is carrying out the treatment plan? ☐ Do the notes include the patient's response to interventions?
RC.11.01.01, EP 6: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The medical record 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	**§482.61(c)(2)** The treatment received by the patient must be documented in such a way to assure that all active therapeutic efforts are included.	**Interview** **Patient Interview** ☐ Does the patient know his/her diagnosis? ☐ What did the patient contribute to the formulation of the treatment plan? Goals of treatment? ☐ If the patient receives medication, does the patient understand the reason for the medication? o The name of the medication? o The dose prescribed? o The time of administration? o The desired effects? o The potential side effects? o If medication is changed, is there a rationale for the change? **Document Review** **General** ☐ Verify that the hospital has policies and procedures that address the following areas: o Informed consent o Confidentiality, privacy, and security o Therapeutic use of restrictions, such as visitors, mail, and phone calls.

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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 recommendations from appropriate services concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge		○ Seclusion and restraint (must address patient protection and safety while in a restricted setting). **Patient Health Record** ☐ Review the patient record to verify that the patient was educated about their medications, intended effects, and potential side effects. ☐ Does the record indicate that the patient is a danger to self or others? If so, what did the staff do to care for the patient in the current environment before progressing to a more restrictive setting? ☐ Are staff members recording their observations relative to the patient's response to the treatment modalities, including medication? ☐ Is there evidence that the patient was afforded the opportunity to participate in his/her plan of care? ☐ What progress has the patient made? Has the patient achieved his/her optimal level of functioning? If not, why? Are these reasons/barriers reflected in the current treatment plan? Do treatment and progress notes support these insights? ☐ Does the observed status of the patient in the various treatment modalities correspond to the progress note reports of status? ☐ Do all treatment team members document their observations and interventions so that the information is available to the entire team? ☐ If a restrictive procedure is used (e.g., restraint and/or seclusion), is there evidence that attempts were made systematically to treat the patient in the least restrictive manner? ☐ Is there evidence that the rights of the patient were protected while in the restrictive setting in accordance with Federal and State law and accepted standards of practice? **Observation**

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		Look for evidence that each patient's rights are being addressed and protected
RC.12.01.01, EP 4: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Progress notes are documented in accordance with applicable state scope-of-practice laws and hospital policies by the following qualified practitioners: - Doctor(s) of medicine or osteopathy or other licensed practitioner(s) who is responsible for the care of the patient - Nurse(s) - Social worker(s) or social service staff involved in the care of the patient - When appropriate, others significantly involved in the patient's active treatment modalities The patient's condition determines the frequency of progress notes, but they must be recorded at least weekly for the first 2 months and at least once a month thereafter. The progress notes must contain recommendations for revisions in the treatment plan as indicated, as well as a precise assessment of the patient's progress in accordance with the original or revised treatment plan.	**§482.61(d) – Standard: Recording Progress.** Progress notes must be recorded by the physician(s), psychologists, or other licensed independent practitioner(s) responsible for the care of the patient as specified in §482.12(c); nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. **§482.61(d) . . .** The frequency of progress notes is determined by the condition of the patient but must be recorded at least weekly for the first 2 months and at least once a month thereafter **. . .** **§482.61(d)** . . .and must contain recommendations for revisions in the treatment plan as indicated . . . **§482.61(d)** . . . as well as [must contain] a precise assessment of the patient's progress in accordance with the original or revised treatment plan.	**Document Review** **Patient Health Record** ☐ Review progress notes authored by physicians, psychologists, nurses, social workers, and others significantly involved in active treatment modalities. ☐ Verify that the progress notes contain the following: ○ A precise assessment of the patient's progress in accordance with the original or revised treatment plan. ○ A chronological picture of the patient's progress or lack of progress towards attaining short and long-range goals outlined in the individual treatment plan ○ Goals of the treatment plan ○ Evaluation of aftercare/discharge plans ○ Documentation substantiating changes/revisions in the treatment plan and subsequent assessment of the patient's responses and progress ○ Recommendations for revisions in the treatment plan ☐ What is the frequency of progress notes in relation to the condition of the patient? ○ Verify that progress notes are recorded at least weekly for the first 2 months and at least once a month thereafter. **Observation** ☐ Is there a correlation between the patient care observed and what is described in the progress notes?
RC.11.01.01, EP 6: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The medical	**§482.61(e) Standard: Discharge planning and discharge summary.** The record of each patient who has been	**Document Review** **Patient Health Record**

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record 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 recommendations from appropriate services concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge	discharged must have a discharge summary that includes a recapitulation of the patient's hospitalization and... **§482.61(e)** [The record of each patient who has been discharged must have a discharge summary that includes] . . . recommendations from appropriate services concerning follow-up or aftercare as well as ... **§482.61(e)** *[The record of each patient who has been discharged must have a discharge summary that includes]* ... a brief summary of the patient's condition on discharge.	Review a sample of patient health records for patients that have been discharged ☐ To verify a discharge summary is included. Verify that the summary includes: ○ A summary of the patient's condition on discharge. ○ Description of services and supports appropriate to the patient's needs and that will be effect on the day of discharge. ○ Recommendations from appropriate services concerning follow-up or aftercare. ○ A description of arrangements with treatment and other community resources for the provision of follow-up services. ○ A plan outlining psychiatric, medical/physical treatment and the medication regimen as applicable. ○ Specific appointment date(s) and names and addresses of the service provider(s). ○ Description of community housing/living arrangement. ○ Economic/financial status or plan, i.e., supplemental security income benefits. ○ Recreational and leisure resources; and A complete description of the involvement of family and significant others with the patient after discharge. ☐ To determine if the patient health record includes: ○ Verification of appointment sources, dates and addresses. This includes a contact person name, specific appointment date and time for the initial follow-up visit ○ Documentation that the patient was involved in discharge and aftercare planning process.

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		○ Documentation indicating the participation of multidisciplinary staff in discharge planning process. ○ Evidence that contact with the post-hospital treatment entity included communication of treatment recommendations (including information regarding the patient's medications) ○ Indication that discharge related documents were made available to the patient, family, community treatment source and/or any other appropriate sources.
(1) IM.13.01.05, EP 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The 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. **(2) IM.13.01.05, EP 2:** For hospitals that use Joint Commission accreditation for deemed status purposes: The 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. **(3) IM.13.01.05, EP 3:** For hospitals that use Joint Commission accreditation for deemed status purposes: In accordance	**§482.61 (f) Standard: Electronic notifications.** If the hospital 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 hospital must demonstrate that— (1) The system's notification capacity is fully operational and the hospital uses it in accordance with all State and Federal statutes and regulations applicable to the hospital's exchange of patient health information. (2) The system sends notifications that must include at least patient name, treating practitioner name, and sending institution name. (3) To the extent permissible under applicable federal and state law and regulations, and not inconsistent with the patient's expressed privacy	**Interview** ☐ Ask health information management staff if the hospital's electronic health records system notification features are operational. ○ What type of information is being exchanged and with who? ○ Are staff able to disable the notification features to meet the patient's expressed privacy preferences?

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with the patient's expressed privacy preferences and applicable laws and regulations, the 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 **(3)(i) IM.13.01.05, EP 3:** See above **(3)(i)(ii) IM.13.01.05, EP 3:** See above **(4) IM.13.01.05, EP 4:** For hospitals that use Joint Commission accreditation for deemed status purposes: In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the 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 hospital's emergency department or inpatient services. **(4)(i) IM.13.01.05, EP 4:** See above **(4)(i)(ii) IM.13.01.05, EP 4:** See above **(5) IM.13.01.05, EP 5:** For hospitals that use Joint Commission accreditation for	preferences, the system sends notifications directly, or through an intermediary that facilitates exchange of health information, at the time of: (i) The patient's registration in the hospital's emergency department (if applicable). (ii) The patient's admission to the hospital's inpatient services (if applicable). (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: (i) The patient's discharge or transfer from the hospital's emergency department (if applicable). (ii) The patient's discharge or transfer from the hospital's inpatient services (if applicable). (5) The hospital 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	

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deemed status purposes: The 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 a hospital has a process to send patient event notifications while working within the constraints of its technology infrastructure. There may be instances in which a 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 a hospital system's capabilities. **(5)(i) IM.13.01.05, EP 5:** See above	entities, which need to receive notification of the patient's status for treatment, care coordination, or quality improvement purposes: (i) The patient's established primary care practitioner; (ii) The patient's established primary care practice group or entity; or (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.	

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(5)(ii) **IM.13.01.05, EP 5:** See above (5)(iii) **IM.13.01.05, EP 5:** See above		

Hospital Special Staff Requirements for Psychiatric Hospitals Evaluation Module (482.62)

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NPG.12.03.01, EP 4: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: 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	**§482.62 Condition of Participation: Special Staff Requirements for Psychiatric Hospitals** The hospital **must** have adequate numbers of qualified professional and supportive staff to evaluate patients, formulate written, individualized comprehensive treatment plans, provide active treatment measures and engage in discharge planning.	**Observation** ☐ Observe sampled patients and others during structured sessions and in unstructured settings to ensure behavioral evidence of a rational organization of resources. **Interview** ☐ Interview patients and staff to determine whether necessary treatment modalities and other services are being provided in a timely manner. **Document Review** **Patient Health Record** ☐ Review a sample of patient health records to determine if necessary active treatment assessments, treatments, evaluations, and activities have been conducted and documented. ☐ Review other records, such as restraint and seclusion records, incident reports, medication error reports, and reports of patient/staff injuries, to determine the extent to which staffing levels or deployment contributed to negative patient outcomes. ☐ Evaluate all outcome data in light of the success or failure observed during the survey relevant to each patient receiving active treatment and achieving desired outcomes of care. **Note:** Evaluating outcome data is the primary basis for assessing the adequacy of the hospital's staffing under this special condition.
NPG.12.03.01, EP 4: See above	**§482.62(a)(1) Standard: Personnel.** The hospital must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to: (1) Evaluate Patients.	**Observation** ☐ Verify that there is adequate staff to complete the admission workups (assessment, diagnostic data gathering) in a timely manner. **Document Review** **Patient Health Record** ☐ Review a sample of patient health records to ensure that there is continuing evaluation of the patient's progress and response to treatment. o Are evaluations delayed or missing?

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NPG.12.03.01, EP 4: See above	**§482.62(a)(2)** [The hospital must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to:] (2) Formulate written individualized, comprehensive treatment plans;	**Observation** • Observe a treatment team meeting. Is there sufficient discipline participation to ensure that the treatment plan meets the patient's individualized needs? **Interview** • What problems prevent staff members from attending treatment meetings? • Do they relate to staffing? **Document Review** **Patient Health Record** • Review a sample of patient health records to determine if the continuing evaluation of the patient's progress is missing or delayed to the extent that it is not useful to the treatment team for the purpose of planning individualized treatment.

NPG.12.03.01, EP 4: See above	**§482.62(a)(3)** [The hospital must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to:] (3) Provide active treatment measures; and	**Observation**
		• Through observation, interviews, and record reviews, determine if patients receive active treatment.
		  ○ Is the distribution of staff consistent with particular patient needs?
		  ○ Is appropriate staffing sufficient to carry out treatment plans?
		  ○ Does the patient attend therapies that are relevant to the identified problems that brought them to the hospital?
		  ○ Are staff absences and/or vacancies preventing the patient from receiving active treatment?
		  ○ Are patients not attending therapeutic activities off the unit because there is no staff to escort them?
		  ○ Are therapeutic groups not available on the unit for patients who are not able to go off the unit?
		  ○ Are patients observed not engaged in activities while staff attend to administrative tasks?
		  ○ Are active treatment sessions or activities exclusively carried out at discrete time intervals? Or is active

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		treatment implemented as the patient's needs emerge during the course of the day? **Document Review** **General** ☐ Review quality assurance data to determine if there is a pattern of serious incidents occurring on particular shifts and/or days of the week. ☐ Is there a consistent, observable pattern of evidence that hospital staff provide, reinforce, and otherwise implement measures to achieve active treatment objectives? **Interview** ☐ Ask patients to describe their treatment modalities. ☐ Ask patients if they believe the treatment being provided is helpful. ☐ Interview patients if the content and scheduling of activities are directly related to their treatment objectives or if the content and scheduling are generalized, nontherapeutic "time fillers"? ☐ Ask staff to describe how treatment interventions relate to patients' treatment objectives. ☐ At any point in time, for any of the observed patient's experiences in the hospital, is the thrust of the patient's treatment plan observable during staff and/or patient interactions?
NPG.12.03.01, EP 4: See above	**§482.62(a)(4)** [The hospital must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to:] (1) Engage in discharge planning.	**Interview** ☐ Ask patients if they participate in the discharge planning process. If not, why? ☐ Interview staff to determine if they are aware of the discharge plans for the patients they are working with? **Document Review** **Personnel/Credential File** ☐ Do record review and interviews indicate that all relevant staff have participated in discharge planning?
MS.17.01.03, EP 6: For psychiatric hospitals that use Joint Commission	**§482.62(b) Standard:** Director of inpatient psychiatric services;	**Document Review** **General**

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accreditation for deemed status purposes: 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. The number and qualifications of doctors of medicine and osteopathy are adequate to provide essential 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… §482.62(b) …The number and qualifications of doctors of medicine and osteopathy must be adequate to provide essential psychiatric services.	☐ Just prior to the end of the survey, schedule a meeting with the clinical director. By the time of this meeting, the surveyor should already have conducted required observation, interviews and record reviews for at least a majority of the patients in the sample. Collect any additional information that is necessary to consider in light of outcomes observed for patients, including the following: o Qualifications of the clinical director o Leadership exhibited for the scope of psychiatric/medical treatment programs needed by patients o Rationale for medical staffing coverage ☐ If necessary, follow up on letters of complaint, previously reported serious problems, and/or discrepancies with Data Collection Medical Staff Coverage (CMS-729). **Interview with Clinical Director** **General** ☐ How many staff are board certified? Fully trained? ☐ How many full-time/part-time specialties are represented? ☐ How are medical staff deployed? ☐ To what programs/units are they assigned? Why? ☐ How much time do physicians spend on the units? ☐ Based on observations, interviews, and medical record reviews, is coverage adequate to meet the needs of sampled patients? ☐ To meet the needs of other patients observed during the survey?
MS.17.01.03, EP 6: See above	§482.62(b)(1) 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.	**Document Review** **Personnel/Credential File (Medical Staff Credentialing Activity)** ☐ Review the clinical director's personnel folder or ask the clinical director if they have one of the following: o Certification of the American Board of Psychiatry and Neurology and/or certification of the American Osteopathic Board of Neurology and Psychiatry o If no certification, evidence that the person took the Boards would satisfy that the person had the training

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		and equivalency to be admitted to the board examination. ○ If indicated, medical school and residency training ○ Length of time they have been employed at the facility ○ Length of time they have been at their position ○ To be admitted to the American Board Examinations the following conditions must be met: ○ 1. License without restrictions ○ 2. Graduation from a medical school approved by either the Medical Osteopathic Association or the American Medical Association ○ 3. A successful completion of an approved residency-training program for at least 3 years before 1988 that the America Council on Graduate Medical Education (ACGME) approves. After 1988, it has to be a four year accredited program.
MS.16.01.01, EP 8: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: 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.	**§482.62(b)(2)** The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.	**Document Review** **General** ☐ Verify mechanisms the director uses to monitor and evaluate the work of the medical staff (for example, personal interviews, quality improvement reports, incident reports). ☐ When problems are discovered by the clinical director, determine how they corrected. ☐ Verify that services, notes, and reports are timely. ☐ Ensure that medications are used appropriately for each patient's diagnosis?
NPG.12.03.01, EP 5: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Doctors of medicine or osteopathy and other appropriate professional staff are available to	**§482.62(c) Standard: Availability of medical personnel.** Doctors of medicine or osteopathy and other appropriate professional personnel must be available to provide necessary medical and	**Document Review** ☐ How did the hospital meet the medical/surgical/diagnostic needs represented by each patient in the sample? ☐ Were these done timely? ☐ Appropriately?

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provide necessary medical and surgical diagnostic and treatment services. If medical and surgical diagnostic and treatment services are not available within the hospital, the hospital has an agreement with an outside source for these services to ensure that they are immediately available, or the hospital establishes an agreement for transferring patients to a general hospital that participates in the Medicare program.	surgical diagnostic and treatment services. If medical and surgical diagnostic services and treatment are not available within the institution, the institution must have an agreement with an outside source of these services to ensure that they are immediately available or a satisfactory agreement must be established for transferring patients to a general hospital that participates in the Medicare program.	☐ If contracts are not current or available, how are these services provided for the patient, if needed? ☐ Is there evidence of negative outcomes as a result of these arrangements? ☐ Are reports from other services such as pharmacy, radiology, and clinical laboratory timely? ☐ Appropriate?
See Nursing Services 482.23 **HR.11.02.01, EP 2:** For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a director of psychiatric nursing that 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.	**§482.62(d) Standard: Nursing services.** The hospital or 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 patient's active treatment program and to maintain progress notes on each patient. **§482.62(d)(1)** 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	**Interview** ☐ Ask staff about the orientation and continuing education they receive. Listen for responses that might indicate individualized treatment interventions are addressed. ☐ Ask staff who provides the required leadership and supervision for the psychiatric nursing department. ☐ Speak with the Director of Nursing about o Their educational background and psychiatric nursing and leadership skills. *If the DON has less than a Master's Degree in Psychiatric Nursing, expect to hear/see evidence of experience and ongoing training in psychiatric nursing.* o Implementation of continuous quality improvement programs o Provision of orientation, in-service, and continuing education programs for nursing personnel, especially in the areas of psychiatric nursing, nursing process, prevention and management of violence, CPR and Universal Precautions. **Document Review** **General**

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NPG.12.03.01, EP 4: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: 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	for Nursing or be qualified by education and experience in the care of the mentally ill. **§482.62(d)(1)** . . . 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.	☐ Check the outlines/content of orientation programs and ongoing continuing education programs for Licensed Practical Nurses and mental health workers to determine if they stress individualized treatment interventions. **Patient Health Record** Review the selected sample of patient health records to determine if: ☐ Nursing assessments are completed on all patients? ☐ Multidisciplinary treatment plans reflect nursing input which include specific nursing interventions for nursing problems (e.g. violence toward self/others, physical/medical crises)? ☐ Nursing care is evaluated by an R.N., with changes in the care based on the patient's progress or lack thereof? ☐ Nursing services are being provided in accordance with safe, acceptable standards of nursing practice. **Observation** ☐ Are intrusive techniques (e.g. seclusion, restraint, electroconvulsive therapy (ECT), and/or medical procedures) and patient incidents (e.g. medication errors, patient falls, patient-to-patient and patient-to-staff injuries) monitored in accordance with hospital policy, State statutes and safe nursing practice? ☐ Are nursing personnel observed relating to patients in a therapeutic manner? Are nursing services being provided in accordance with safe, acceptable standards of nursing practice?
NPG.12.03.01, EP 4: See above **NPG.12.03.01, EP 2**: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The hospital makes certain a registered professional nurse is available 24 hours a day.	**§482.62(d)(2)** The staffing pattern must ensure the availability of a registered nurse 24 hours each day. . . **§482.62(d)(2)** . . .There must be adequate numbers of registered nurses, licensed practical nurses,	**Observation** The nursing staffing patterns should be reviewed on a sample of approximately 25% of the certified wards. The staffing, including levels of nursing personnel, should be reviewed for the day(s) of the survey and evaluated based on the level of needs presented by the patients. Review additional staffing patterns if a problem or concern is identified. Base decisions regarding extent of additional data (number of wards and dates) to review on the degree of problem/concern. Review patient

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	and mental health workers to provide the nursing care necessary under each patient's active treatment program.	need assessment/patient acuity for any wards as deemed necessary based on problems/concerns found in the sampling review.
LD.13.03.01, EP 18: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities to meet the needs of its patients. Note: 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.	**§482.62(e) Standard: Psychological Services.** The hospital must provide or have available psychological services to meet the needs of the patients.	**Interview** Ask the service clinical leaders about ☐ The number of full-time, part-time, and consulting psychologists available. How do they determine that this number is adequate to provide necessary services to patients. ☐ The types of psychological services offered for example, assessments, therapy. ☐ How does the hospital or Psychological Service Department determine whether or not: it meets the needs of patients? Its services are underutilized or over-utilized? ☐ Why have psychological services staff been deployed in the manner that they have? **Observation** ☐ Did the patients in the sample have a need for psychological services or testing? Were they provided in a timely manner and with sufficient intensity? ☐ Did any of the patients in the sample indicate a need for psychological services, but none were requested? ☐ Do certain groups of patients receive testing routinely? Dementia? Children? Adolescents? Why? ☐ Once tests are performed, are results reported in sufficient time to be integrated in the patient's active treatment and treatment plan?
NPG.12.03.01, EP 6: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a director	**§482.62(f) Standard: Social Services.** There must be a director of social services who monitors and evaluates the quality and	**Interview** ☐ Ask the director about their qualifications, experience, and scope of duties within the position.

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of social services who monitors and evaluates the quality and appropriateness of social services. Note: Social services are provided in accordance with accepted standards of practice and established policies and procedures. **HR.11.02.01, EP 5**: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The director of social services has a master's degree from an accredited school of social work or is qualified by education and experience in the social services needs of the mentally ill. Note: If the director does not hold a master's degree in social work, at least one staff member has this qualification. **PC.14.01.01, EP 4**: The patient, the patient's caregiver(s) or support person(s), physicians, other licensed practitioners, clinical psychologists, and staff who are involved in the patient's care, treatment, and services participate in planning the patient's discharge or transfer. The patient and their caregiver(s) or support person(s) are included as active partners when planning for postdischarge care. Note 1: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (refer to the Glossary). Note 2: For hospitals that use Joint	appropriateness of social services furnished. The services must be furnished in accordance with accepted standards of practice and established policies and procedures. **§482.62(f)(1)** The director of the social work department or service must have a master's degree from an accredited school of social work or must be qualified by education and experience in the social services needs of the mentally ill. If the director does not hold a master's degree in social work, at least one staff member must have this qualification. **§482.62(f)(2)** 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.	☐ If a MSW staff member, other than the director, is performing any of these duties, what are the staff member's experience and scope of duties performed? Why were these duties delegated? ☐ To what extent is the director's knowledge of the social work needs of the various wards? Why has the social work staff and services provided throughout the hospital been deployed in the manner it has? ☐ How does the director periodically audit the quality of social work services furnished? What are the outcomes of audits conducted? What percentage of psychosocial assessments was completed and available in written form at the time of the interdisciplinary treatment plan? How does the patient's social needs as addressed by the social worker in the psychosocial assessment compare against the goals developed in the interdisciplinary treatment plan? Ask social work staff ☐ If they are routinely involved in providing services to the patient that are identified in the treatment plan. ☐ If they have provided active treatment in accordance with the patient's treatment plan. ☐ To what extent they provide discharge planning services to the patient in the way of: supportive individual, couple, family, or group therapy focused on discharge goals of the patient? Carrying out a liaison role with community resource providers? ☐ If they have assured that adequate information is provided to post-hospital patient service providers. **Document Review** **General** ☐ The duties, functions, and responsibilities of the director of social services/social work should be clearly delineated and documented in the facility's policies and procedures. If the director is not MSW qualified and at least one staff member is MSW qualified, verify the duties, functions, and responsibilities of the MSW.

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Commission accreditation for deemed status purposes and have swing beds: The 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 hospital also provides sufficient preparation and orientation to residents to make sure that transfer or discharge from the hospital is safe and orderly. The hospital sends a copy of the notice to a representative of the office of the state's long-term care ombudsman.		
(g) LD.13.03.01, EP 18: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities to meet the needs of its patients. Note: 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. **(g)(1) LD.14.03.01, EP 21:** See above	**482.62(g) Standard: Therapeutic Activities.** The hospital must provide a therapeutic activities program. **§482.62(g)(1)** The program must be appropriate to the needs and interests of patients and be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning. **§482.62(g)(2)** The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each patient's active treatment program.	**Interview** Ask the Therapeutic Activities Director about ☐ Their qualifications, experience, duties and responsibilities of the Therapeutic Activities Director and discipline supervisor(s). ☐ How the program is organized. ☐ Why therapeutic activities staff has been deployed in the manner they have. **Observation** ☐ Is there evidence that sampled patients and staff are familiar with the goals and staff interventions described in the patient's treatment plan? Are these observed interventions being carried out? What is the patient's response? Are these interventions and activities of sufficient frequency and intensity to achieve maximum therapeutic benefit?

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(g)(2) NPG.12.03.01, EP 3: The number of qualified therapists, support personnel, and consultants available is adequate to provide therapeutic activities consistent with each patient's active treatment.		☐ Did the patients in the sample have a need for any therapeutic activities? Were their needs met? ☐ Did any of the patients in the sample indicate a need for therapeutic activities, but none were considered? ☐ What kinds of services are provided to the patient population? ☐ Are activity areas/sites accessible and available to meet the patient's individual needs? Are the facilities and resources adequate to enable implementation of goals set in the patient's treatment plan? ☐ Does the program utilize available community resources to provide opportunities for socialization, leisure, and therapeutic and/or rehabilitation activities for patients who can participate outside the hospital setting? ☐ Are current activity schedules clearly posted for patient and staff reference and use? Are the scheduled activities related to the particular patient area and specific treatment needs of patients? ☐ Are patient needs met consistently at all times including evenings and weekends? ☐ If a large number of patients are assigned to the same therapeutic activity, do patients have individualized goals within their treatment plans?

Hospital Swing Beds Evaluation Module (482.58)

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	Condition of Participation: §482.58 Special requirements for hospital providers of long-term care services ("swing-beds") A hospital that has a Medicare provider agreement must meet the following requirements in order to be granted an approval from CMS to provide post-hospital extended care services, as specified in §409.30 of this chapter, and be reimbursed as a swing-bed hospital, as specified in §413.114 of this chapter:	**CMS RO makes the determination whether the hospital has satisfied the eligibility criteria and awards approval of swing-bed status.** The eligibility criteria at 42 CFR 482.58(a) requires: • The hospital has a Medicare provider agreement; • An initial applicant hospital may seek swing-bed approval. If the applicant hospital meets all Federal requirements for participation, including those for swing-bed approval, the applicant hospital's approval for swing-bed services will be effective with the effective date of the hospital's Medicare participation agreement **Survey Procedures (Use Appendix PP to survey) and score to existing TJC EPs mapped to 482.58 and the identified skilled nursing facility requirements contained in subpart B of part 483)** ☐ There must be discharge orders from acute care hospital inpatient services and subsequent admission orders for swing-bed services, the same as if the patient had been transferred to a separately certified skilled nursing facility. ☐ The same clinical record may be used for a swing-bed patient, but it must include discharge orders from acute care hospital inpatient services and admission orders to swing-bed services, and the swing-bed services (which may be SNF or NF level services) must be clearly delineated within the clinical record. ☐ An on-site survey must be conducted and the hospital must meet all the requirements of 42 CFR 482.58 before the hospital can obtain swing bed approval. ☐ Surveyors assess the manner and degree of non-compliance with the swing bed standards in determining whether there is condition-level compliance or standard-level non-compliance.
	§482.58 (a) Eligibility. A hospital must meet the following eligibility requirements:	**Observation** ☐ Verify that the hospital has fewer than 100 hospital beds, excluding beds for newborns and beds in intensive care units.

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	(1) The facility has fewer than 100 hospital beds, excluding beds for newborns and beds in intensive care type inpatient units (for eligibility of hospitals with distinct parts electing the optional reimbursement method, see §413.24(d)(5) of this chapter). (2) The hospital is located in a rural area. This includes all areas not delineated as "urbanized" areas by the Census Bureau, based on the most recent census. (3) The hospital does not have in effect a 24-hour nursing waiver granted under §488.54(c) of this chapter. (4) The hospital has not had a swing-bed approval terminated within the two years previous to application.	**Note:** *A hospital licensed for more than 100 beds may be eligible for swing-bed approval if it uses and staffs for fewer than 100 beds.* ○ Count the beds in each nursing unit. Do not count beds in recovery rooms, intensive care units, operating rooms, newborn nurseries, or stretchers in emergency departments. However, do count the beds within rehabilitation and psychiatric units that are excluded from the inpatient prospective payment system (IPPS).
IM.12.01.01, EP 1 and 2 **LD.13.02.01,EP 2 and 3** **PC.11.03.01, EP 2** **RI.11.01.01, EP 1, 5 and 8** **RI.12.01.01, EP 1,3,4 and 6** **RI.11.02.01, EP 1** **RI.13.01.03, EP 1,2 and 3**	**§482.58(b) Skilled nursing facility services.** The facility is substantially in compliance with the following skilled nursing facility requirements contained in subpart B of part 483 of this chapter. §482.58(b)(1) Resident rights (§483.10(b)(7), (c)(1), (c)(2)(iii), (c)(6), (d), (e)(2), and (4), (f)(4)(ii) and (iii), (h), (g)(8) and (17), and (g)(18) introductory text of this chapter). §483.10(b)(7): In the case of a resident adjudged incompetent under the laws of a State by a court of competent	**Interview/Patient Health Record** ☐ Surveyors must check whether there has been a delegation of resident rights or designation of a resident representative. ☐ Surveyors must also determine, through interview and record reviews, whether or not the resident's delegation of rights has been followed by facility staff. ☐ Determine through interview and record review if the resident has been found to be legally incompetent by a court in accordance with state law. **If yes:** ☐ Verify the appropriate legal documentation for a court-appointed resident representative is present in the resident's medical record.

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	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. 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. (ii)The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii)To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. §483.10(c)(1): The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(2)(iii): The right to be informed, in advance, of changes to the plan of care. §483.10(c)(6): The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	☐ Review court orders or other legal documentation to determine the extent of the court appointed resident representative's authority to make decision on behalf of the resident and any limitations on that authority that may have been ordered by the court. ☐ Determine if the court-appointed representative is making decisions for the resident beyond the scope of the resident representative's decision-making authority and the facility is relying on that authority as the basis of a practice (e.g., health care treatment, managing resident funds, discharge decision). If so, a deficiency may be cited under this regulation. ☐ Determine if the resident was involved in care planning activities and able to make choices, to the extent possible. ☐ Observe resident care and daily activities (e.g., participation in activities) for adherence to resident's or court-appointed resident representative's goals, choices, and preferences. Even when there is a court-appointed resident representative, the facility should seek to understand the resident's goals, choices, and preferences and have honored them to the extent legally possible. **If no:** ☐ Determine how decisions are being made for the resident. Does the resident maintain all of his/her rights, even if he/she has designated a representative to assist with decision-making unless a court has limited those rights under state law, and only to the extent that has been specified by a court under state law? Has the resident designated a resident representative and is facility staff respecting the authority of this designate surrogate decision-maker to act on behalf of the resident? ☐ Are all residents informed of their plan of care or treatment in the most understandable manner possible, and given an opportunity to voice their views? Autonomy is also expressed through gestures and actions and this also should be recognized. Residents even without capacity or declared incompetent may be able to express their needs and desires.

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	§483.10(d): Choice of attending physician. The resident has the right to choose his or her attending physician. The physician must be licensed to practice, and 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. 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. The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options. (5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice. §483.10(e)(2):The right to retain and use personal possessions, including furnishings, and clothing, as space	☐ Determine whether same-sex spouses are treated in the same manner as an opposite-sex spouse in all states and territories. ☐ If the resident has delegated a resident representative, verify the appropriate documentation is present in the resident's medical record. During **observations, interviews, and record reviews**, surveyors must: ☐ Interview the resident, and/or his or her representative to determine the level of participation in care planning. ☐ Identify ways staff involve residents and/or their representative(s) in care planning. ☐ Determine if care plan meetings are scheduled to accommodate residents and/or their representative. ☐ Determine how facility staff addressed questions or concerns raised by a resident or his or her representative, including if they are addressed at times when it would be beneficial to the resident, such as when they are expressing concerns or raising questions. ☐ Determine if the resident and representative were unable to participate, did facility staff consult them in advance about care and treatment changes. ☐ Interview staff to determine how they inform residents or their representative of their rights and incorporate their personal preferences, choices, and goals into their care plan. ☐ When the resident request is something that facility staff feels would place the individual at risk (i.e., the resident chooses not to use the walker, recommended by therapy), is there a process in place to examine the risk/benefit and guide decision-making? ☐ Review the resident's medical record to determine if facility staff included an assessment of the resident's strengths and needs and whether these, as well as the resident's personal and cultural preferences, were incorporated when developing his or her care plan. ☐ Determine how facility staff observes and responds to the non-verbal communication of a resident who is unable to

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	permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(e)(4): The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(f)(4)(ii): The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time. §483.10(f)(4)(iii): The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time. §483.10(g)(8): The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense.	verbalize preferences (i.e., if the resident spits out food, is this considered to be a choice and alternative meal options offered). **Interview** ☐ Through interviews with facility staff and residents and/or their representatives, determine how residents or their representative are informed of and are supported in: o His or her right to choose a physician; o How to contact their physician and other primary care professionals responsible for their care; o His or her options to choose an alternate physician or other primary care professional. ☐ If his or her physician is unable or not willing to provide necessary care and services, determine if facility staff worked with the resident to choose another physician. ☐ If facility staff refused to allow a resident to retain his or her personal possession(s), determine if such a restriction was appropriate due to insufficient space, protection of health and safety, and maintaining other resident rights, and whether the reason for the restriction was communicated to the resident. ☐ Through interviews with residents, their representative, family members, visitors and others as permitted under this requirement, determine if they know that they are able to visit 24-hours a day, subject to a resident's choice and reasonable restrictions as defined above. ☐ Review the facility's written visitation policy and procedures to determine whether they support the resident's right to visitors and whether they explain those situations where visitors may be restricted due to clinical or safety concerns. ☐ If a concern is identified, interview facility staff to determine how they ensure 24-hour or immediate access as permitted under these requirements

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	§483.10(g)(17): The facility must— 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— The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18):[introductory text]: The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per diem rate. §483.10(h): Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.	☐ Ask residents about mail service both incoming and outgoing. ☐ Interview the resident, resident's representative and facility staff to determine if: ○ Residents are informed in a manner they understand of their right to request or refuse treatment; ○ A resident has an advance directive and if staff are aware of what this directive states; ○ A resident does not have an advance directive and, if so, how the resident was informed of his or her right to develop one and was the resident provided assistance in doing so; and ○ Staff periodically assess a resident's decision-making capacity, how often and how and by whom is this done. ☐ During interviews with residents, their representatives, visitors or families determine if their privacy has been honored by facility staff. ☐ Interview the representative of the Office of the State Long-Term Care Ombudsman who serves residents of the facility, to determine if the facility allows him/her to examine the resident's records with the permission of the resident or resident representative or as otherwise authorized by State law. **Patient Health Record** ☐ Review the resident's medical record to determine if: ○ The resident has an advance directive and a copy is located in the medical record; and ○ The facility has policies and procedures to implement advance directives. **Observation**

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		☐ Observe for situations where facility staff may not be honoring the resident's privacy, including during visits, treatment, or leaving medical records out for public view. ☐ Are there signs regarding care information posted in view in residents' rooms? If these are observed, determine if such signs are there by resident or resident representative direction. If so, these signs are allowable. ☐ Is personal resident information communicated in a way that protects the confidentiality of the information and the dignity of residents? ☐ If concerns are found, interview staff regarding facility policy or procedures regarding protecting resident privacy and confidentiality.
PC.14.01.01, EP 4,12 and 13 **PC.14.01.03, EP 1** **RC.12.03.01, EP 1-4**	**§482.58(b)(2) Admission, transfer, and discharge rights (§483.5 definition of transfer and discharg**e, §483.15(c)(1), (c)(2)(i), (c)(2)(ii), (c)(3), (c)(4), (c)(5), and (c)(7)) §483.5: definition of transfer and discharge: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility. §483.15(c)(1): Facility requirements— (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless— (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge	**Interview** ☐ Determine whether a transfer or discharge is resident- or facility-initiated. The determination that a transfer or discharge is facility-initiated does not equate to noncompliance if the requirements in this regulatory section are met. ☐ Were the resident's needed/requested possessions transferred with the resident to the new location? Ask resident or his or her representative if they understand why the transfer or discharge occurred. **Document Review** **General** ☐ Review the facility's notice before transfer which must include all the following elements at the time notice is provided: ○ The specific reason for the transfer or discharge, including the basis under §§483.15(c)(1)(i)(A)-(F); ○ The effective date of the transfer or discharge; ○ The specific location (such as the name of the new provider or description and/or address if the location is a

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	is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii)The facility may not transfer or discharge the resident while the appeal is pending, pursuant to §431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to §431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.	residence) to which the resident is to be transferred or discharged; ○ An explanation of the right to appeal the transfer or discharge to the State; ○ The name, address (mail and email), and telephone number of the State entity which receives such appeal hearing requests; ○ Information on how to obtain an appeal form; ○ Information on obtaining assistance in completing and submitting the appeal hearing request; and ○ The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care ombudsman. ○ For nursing facility residents with intellectual and developmental disabilities (or related disabilities) or with mental illness (or related disabilities), the notice must include the name, mailing and e-mail addresses and phone number of the state agency responsible for the protection and advocacy for these populations. **Patient Health Record** □ For resident-initiated discharges, the medical record should contain documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, a discharge care plan, and documented discussions with the resident or, if appropriate, his/her representative, containing details of discharge planning and arrangements for post-discharge care. Additionally, the comprehensive care plan should contain the resident's goals for admission and desired outcomes, which should be in alignment with the discharge if it is resident-initiated. □ If a surveyor has concerns about whether a resident-initiated transfer or discharge was actually a facility-

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	§483.15(c)(2)(i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). §483.15(c)(2)(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by— (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(3): Notice before transfer. Before a facility transfers or discharges a resident, the facility must— (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii)	initiated transfer or discharge, the surveyor should investigate further through interviews and record review. ☐ Review nursing notes and any other relevant documentation to see if appropriate orientation and preparation of the resident prior to transfer and discharge has occurred. ☐ Through record review and interviews, determine if the resident received sufficient preparation prior to transfer or discharge, and if they understood the information provided to them. ☐ Was the facility's notice before transfer provided at least 30 days prior to the transfer or discharge of the resident.

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	Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4): Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when— (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5): Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii)The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and	

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	telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii)For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(7): Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be	

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	provided in a form and manner that the resident can understand.	
HR.11.02.01, EP 4 **PC.13.02.01, EP 1 and 2** **RI.13.01.01, EP 1-5**	**§482.58(b)(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)) §483.12(a)(1): The facility must (1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. §483.12(a)(2): Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. §483.12(a)(3)(i): Not employ or otherwise engage individuals who (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law. §483.12(a)(3)(ii): Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property.	**Interview** ☐ Ask residents about the facility and how they are treated by staff, other residents, or visitors. ☐ Ask family members or legal representatives that are present if they have any concerns about how a resident is being treated. ☐ Ask staff about the orientation and training they receive in recognizing signs that a resident may have experienced some form of abuse or neglect. ☐ Ask staff if the facility uses any form of restraints. If they are used, ask about the policy and procedure that governs use. ☐ Interview the staff member responsible for quality assurance activities to determine what type of data is collected to monitor use of restraints or seclusion. Determine who receives and evaluates this data and is responsible for taking action to reduce the use of such measures. **Document Review** **General** ☐ Review facility policies and procedures on the following; o Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. o Investigation of any such allegations. o Response to allegations of abuse, neglect, exploitation, or mistreatment. ☐ Review the facility's screening policies for new hires to determine the criteria, such as being found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law or have a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property, that would automatically exclude a candidate from employment.

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	§483.12(a)(4): Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. §483.12(b)(1): The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. §483.12(b)(2): Establish policies and procedures to investigate any such allegations. §483.12(c): In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated	**Patient Health Record** ☐ Review patient health records of a sample of residents who experience some form of restraints to determine the amount of time the restraint was used, and if and when re-evaluation of the need for restraints occurred. **Observation** ☐ Observe whether staff members make remarks and behave in a manner that may indicate concerns with staff treatment of residents.

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	(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	
PC.14.02.01, EP 2	**§482.58(b)(4) Social services** (§483.40(d) of this chapter). §483.40(d): The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.	**Interview** ☐ Ask leaders and clinical staff about the medically-related social services that are available to residents. ☐ Ask staff how they determine a resident is in need of medically-related social services. **Document Review** **Patient Health Record** ☐ Review a sample of resident records to determine if medically-related social services are provided for each resident.
PC.14.02.01, EP 2	**§482.58(b)(4) Patient activities** (§483.24(c)) §483.24(c): Activities (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and	**Interview** ☐ Ask facility staff about the activities program for residents. Determine if the program is based on resident assessments, care plans and preferences. ☐ Ask the leader activities program leader about their qualifications and experience. ☐ Ask a sample of residents about the activities and if they are meeting their interests. **Document Review** **General** ☐ Review the facility's ongoing program to support residents in their choice of group, individual, and independent activities.

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	interaction in the community. (2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who— (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State.	☐ If there is a calendar or list of activities available review this schedule and arrange to view a group activity that is taking place. ☐ Determine the basis for the activity offerings including comparing them to what residents expressed during interview and what is reflected in sampled resident health records documentation. **Personnel/Credential Files** Review the personnel file of the activities director to verify their qualifications, experience and certification or eligibility for certification. **Patient Health Record** Review a sample of resident health records to determine from the comprehensive assessments and care plans, and preferences of each resident to determine. **Observation** Observe residents engaged in activities while tracing through the facility.
RC.12.03.01, EP 5 : For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: When the 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	**§482.58(b)(5) Discharge summary** (§483.20(l)) [Note: The regulations at §483.20(l) setting forth the requirements for a nursing home resident discharge summary was revised and re-designated as §483.21(c)(2) in 2016 (81 FR 68858, Oct. 4, 2016) which provides, "When the facility anticipates discharge a resident must have a discharge summary that includes, but is not limited to: (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	**Interview** ☐ If there is a resident ready for discharge to home, ask them or their representative if they were given written discharge instructions that were conveyed in a language and manner they understood. **Document Review** **Patient Health Record** ☐ Review a sample of resident discharge summaries to determine that they include an accurate and current description of the clinical status of the resident and sufficiently detailed, individualized care instructions, to ensure that care is coordinated and the resident transitions safely from one setting to another.

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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	results. (ii) A final summary of the resident's status to include items in paragraph (b)(2) 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 legal representative. (iii) Reconciliation of all pre-discharge medications with the resident's postdischarge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services."]	☐ Items required to be in the final summary of the resident's status are: ○ • Identification and demographic information; ○ • Customary routine; ○ • Cognitive patterns; ○ • Communication; ○ • Vision; ○ • Mood and Behavior patterns; ○ • Psychosocial well-being; ○ • Physical functioning and structural problems; ○ • Continence; ○ • Disease diagnoses and health conditions; ○ • Dental and nutritional status ○ • Skin condition; ○ • Activity pursuit; ○ • Medications; ○ • Special treatments and procedures; ○ • Discharge planning (as evidenced by most recent discharge care plan); ○ • Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the MDS; and ○ • Documentation of participation in assessment. This refers to documentation of who participated in the assessment process. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care/direct access staff members on all shifts. ☐ In addition to the above, pursuant to §483.15(c)(2)(iii), the facility (transferring nursing home) must convey the following information to the receiving provider when a resident is discharged (or transferred) from that facility: ○ • Contact information of the practitioner (at the transferring nursing home) responsible for the care of the resident;

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		○ • Resident representative information, if applicable, including contact information; ○ • Advance directive information; ○ • All special instructions or precautions for ongoing care, as appropriate; ○ • Comprehensive care plan goals; and ○ • All other necessary information, including a copy of the resident's discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care. ☐ Determine the medical record identifies the receiving facilities for which or physicians/practitioners to whom the discharge summary is provided. ☐ For residents discharged to their home, the medical record should contain documentation that written discharge instructions were given to the resident and if applicable, the resident representative. ○ Discharge instructions and accompanying prescriptions provided to the resident and if applicable, the resident representative must accurately reflect the reconciled medication list in the discharge summary. ☐ Review the post-discharge plan of care to determine if it was developed with the participation of the Interdisciplinary team and the resident and, with the resident's consent, the resident's representative.
PC.14.02.01, EP 2	§**482.58(b)(5) Social services** (§483.40(d) and 483.70(p)) §483.40 (d): The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. §483.70 (p): Social worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time	See **§482.58(b)(4)**. **Document Review** **Personnel/Credentials File** Review the personnel/credentials file of the social worker to determine they meet the required qualifications/experience.

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	basis. A qualified social worker is: (1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and (2) One year of supervised social work experience in a health care setting working directly with individuals.	
HR.11.02.01, EP 1 **PC.12.01.01, EP 1** **PC.14.02.01, EP 8**	**§482.58(b)(6) Discharge planning** (§483.20(e)) §483.20(e) Coordination. A facility must coordinate assessments with the preadmission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes— (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.	During **observations, interviews, and record reviews**, surveyors will determine the following: ☐ For residents with a Level II determination and recommendations, has the facility incorporated the determination and recommendations into the resident's assessment and care plan? ☐ How does the facility identify residents with newly evident or possible serious mental disorder, ID or a related condition? ☐ If a resident was identified with newly evident or possible serious MD, ID or a related condition, did the facility refer the resident to the appropriate state-designated authority for review? ☐ Is there evidence that the facility provides the next care setting with the resident's PASARR Level II recommendations when a resident with MD or ID transitions to another care setting? ☐ Has the facility arranged for the resident to receive specialized services through off-site visits, if appropriate, to meet the resident's needs as identified in the resident's PASARR Level II recommendations?

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PC.14.02.01, EP 3-7	**§482.58(b)(7) Dental services (§483.55(a)(2), (3), (4), and (5) and (b) of this chapter).** **§483.55 Dental services.** The facility must assist residents in obtaining routine and 24-hour emergency dental care. (a) Skilled nursing facilities. A facility… (2) May charge a Medicare resident an additional amount for routine and emergency dental services; (3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; (4) Must if necessary or if requested, assist the resident— (i) (ii) In making appointments; and By arranging for transportation to and from the dental services location; and (5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. (b) Nursing facilities. The facility-	**Interview** ☐ Interview the resident and/or resident representative to determine if any concerns have been promptly addressed to the resident's or the resident representative's satisfaction. Determine if the facility provided the assistance to obtain dental services needed or requested by the resident or resident representative and whether the facility assisted the resident with arranging transportation to the dental appointment. ☐ If there is a concern related to missing or damaged dentures, determine if the facility provided the assistance to obtain dental services needed or requested by the resident or resident representative and whether the facility assisted the resident with arranging transportation to the dental appointment. **Document Review** **General** ☐ Review the facility's 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 **Patient Health Record** ☐ Review a resident's record for identification of the resident's dental needs and the resident's responsiveness to dental services. **Observation** ☐ Observe the resident to determine if his or her dental status is consistent with the comprehensive assessment or if the resident exhibited signs of dental health concerns that may not have been identified.

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	(1) Must provide or obtain from an outside resource, in accordance with §483.70(g), the following dental services to meet the needs of each resident: (i) (ii) Routine dental services (to the extent covered under the State plan); and Emergency dental services; (2) Must, if necessary or if requested, assist the resident— (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; (3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; (4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and (5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.	

Hospital Emergency Management Evaluation Module (482.15)

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EM.09.01.01, EP 1: The hospital has a written comprehensive emergency management program that utilizes an all-hazards approach. The program includes, but is not limited to, the following: - Leadership structure and program accountability - Hazard vulnerability analysis - Mitigation and preparedness activities - Emergency operations plan and policies and procedures - Education and training - Exercises and testing - Continuity of operations plan - Disaster recovery - Program evaluation **EM.09.01.01, EP 3:** The hospital complies with all applicable federal, state, and local emergency preparedness laws and regulations.	**§482.15** The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital **must develop and maintain a comprehensive emergency preparedness program** that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:	**Interview** □ Ask leaders to describe the hospital's emergency preparedness program. □ Ask leaders to describe how the hospital used an all-hazards approach when developing its program. **Document Review** **General** □ Verify that the hospital has a written policy on its emergency preparedness program. ***Note:*** *CMS does not require any particular system for meeting the requirements. It is up to each hospital to be able to demonstrate in writing its emergency preparedness program.*
EM.12.01.01, EP 1: The 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	**§482.15(a) Emergency Plan**. The [facility] **must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years**. The plan must do all of the following: The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.	**Interview** □ Ask hospital leaders to identify the hazards (for example, natural, humanmade, facility, geographic) that were identified in the hospital's risk assessment and how the risk assessment was conducted. **Document Review** **General** □ Verify that the hospital has an emergency preparedness plan that is reviewed and updated at least every 2 years and the plan contains all the required elements that includes: ▪ Hazard vulnerability analysis ▪ Emergence operation plan and policies and procedures ▪ Communications plan

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- Surge plans (such as flu or pandemic plans) - Identifying alternate treatment areas or locations - Sheltering in place - Evacuating (partial or complete) or relocating services - Safety and security - Securing information and records **EM.17.01.01, EP 3:** The 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		▪ Continuity of operations ▪ Education and training ▪ Exercises and testing ▪ Program evaluation (after-action/improvement plans) ▪ Unified and integrated EM program (if applicable) **Note:** *Ask for documentation of the date of the last review and updates that were made to the plan based on the review.*
EM.11.01.01, EP 1: The 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 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	**§482.15(a)(1)-(2)** (a) **Emergency Plan.** The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment.	**Interview** □ Ask hospital leaders which hazards (for example, natural, humanmade, facility, geographic) were included in the hospital's risk assessment, why they were included, and how the risk assessment was conducted. **Document Review** **General** □ Ask to see written documentation on the hospital's risk assessments and associated strategies. ▪ Verify that the risk assessment is based on the hospital and the community. ▪ Ensure that the risk assessment takes an all-hazards approach specific to the geographic

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accredited facilities are in different geographic locations, experience different hazards or threats, or the patient population and services offered are unique to this facility. **EM.11.01.01, EP 2:** The hospital's hazard vulnerability analysis includes the following: - Natural hazards (such as flooding, wildfires) - Human-caused hazards (such as bomb threats or cyber/information technology crimes) - Technological hazards (such as utility or information technology outages) - Hazardous materials (such as radiological, nuclear, chemical) - Emerging infectious diseases (such as the Ebola, Zika, or SARS-CoV-2 viruses) **EM.11.01.01, EP 3:** The 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 hospital and its ability to provide services. The findings are documented. **EM.11.01.01, EP 4:** The hospital uses its prioritized hazards from the hazard vulnerability analysis to identify and implement mitigation and preparedness actions to increase the resilience of the hospital and helps reduce disruption of essential services or functions.		location of the hospital and encompasses potential hazards, such as emerging infectious diseases. **Note:** *Surveyors are not expected to analyze a hospital's risk assessment to determine whether the identified risks are appropriate. Surveyors may consider the geographic location and review the remaining standards to determine that the hospital has addressed the hazards within their risk assessment through their policies and procedures.*
EM.12.01.01, EP 2: The hospital's emergency operations plan identifies the	**§482.15(a)(3) [(a) Emergency Plan.** The plan must do the following:]	**Interview** □ Ask leaders to describe the following:

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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, EP 1:** The 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 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 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.	**(3)** Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.	▪ The hospital's patient populations that would be at risk during an emergency event ▪ Services that the hospital would be able to provide during an emergency and any plans to address services needed that cannot be provided by the hospital during an emergency as part of continuity of operations and services ▪ How the hospital plans to continue operations during an emergency ▪ How the hospital delegates authority and implements succession plans □ Ask leaders if the hospital has delegations and succession plans that use roles and responsibilities instead of staff names (for example, Safety Officer = Emergency Department Charge Nurse or Pharmacy Department Lead), identify an individual who would be designated in one of the roles and ask them to describe their role based on the hospital's emergency preparedness program. **Document Review** **General** □ Verify that the written emergency plan includes the following: ▪ Addresses the patient population, including, but not limited to, persons at-risk ▪ The type of services the hospital has the ability to provide in an emergency ▪ Continuity of operations, including delegations of authority and succession plans

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EM.13.01.01, EP 2: The hospital's continuity of operations plan identifies in writing how and where it will continue to provide its essential business functions when the location of the essential or critical service has been compromised due to an emergency or disaster incident. Note: Example of options to consider for providing essential services include use of off-site locations, space maintained by another organization, existing facilities or space, telework (remote work), or telehealth. **EM.13.01.01, EP 3:** The hospital has a written order of succession plan that identifies who is authorized to assume a particular leadership or management role when that person(s) is unable to fulfill their function or perform their duties. **EM.13.01.01, EP 4:** The hospital has a written delegation of authority plan that provides the individual(s) with the legal authorization to act on behalf of the 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 hospital can perform its essential functions. Delegations of authority will specify a particular function that an individual is authorized to perform and includes restrictions and limitations associated with that authority.		
EM.12.01.01, EP 6: The hospital's emergency operations plan includes a	**§482.15(a)(4)** [(a) **Emergency Plan**. The plan must do the following:]	**Interview**

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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.	**(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.	□ Ask hospital leaders to describe their process for ensuring cooperation and collaboration with local, tribal, regional, state, and federal emergency preparedness officials during a disaster or emergency situation.
EM.12.01.01, EP 1: The 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, EP 3:** The hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every	**§482.15(b) (**b) **Policies and procedures.** [Facilities] **must develop and implement emergency preparedness policies and procedures**, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. **The policies and procedures must be reviewed and updated at least every 2 years.**	**Document Review** **General** □ Verify that the hospital has written emergency preparedness policies and procedures that are based on the emergency plan. ▪ Ensure that the policies and procedures were developed with a facility- and community-based risk assessment and communication plan, using an all-hazards approach. **Note:** *Policies and procedures must be reviewed and updated at least every 2 years*.

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two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program		
EM.12.01.01, EP 4: The emergency operations plan includes written procedures for how the 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 **EM.12.02.11, EP 4:** The 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 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	**§482.15(b)(1) [(b) Policies and procedures… The policies and procedures must be reviewed and updated at least every 2 years.** At a minimum, the policies and procedures must address the following: **(1)** The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: **(i)** Food, water, medical and pharmaceutical supplies **(ii)** Alternate sources of energy to maintain the following: **(A)** Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. **(B)** Emergency lighting. **(C)** Fire detection, extinguishing, and alarm systems. **(D)** Sewage and waste disposal.	**Document Review** **General** □ Verify that the hospital's emergency preparedness policies and procedures include: ▪ Provision of subsistence needs, including but not limited to food, water, and pharmaceutical supplies for patients and staff ▪ Alternate sources of energy, including emergency power necessary to maintain the following: • Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions • Emergency lighting • Fire detection, extinguishing, and alarm systems • Sewage and waste disposal **Note:** *Policies and procedures must be reviewed and updated at least every 2 years.*

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levels cannot be maintained, the hospital considers partial or full evacuation or closure. **PE.03.01.01, EP 4:** The hospital has written fire control plans that include provisions for prompt reporting of fires; extinguishing fires; protection of patients, staff, and guests; evacuation; and cooperation with firefighting authorities.		
EM.12.02.07, EP 2: The 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 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.	**§482.15(b)(2) [(b) Policies and procedures… The policies and procedures must be reviewed and updated at least every 2 years.** At a minimum, the policies and procedures must address the following: **(2)** A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.	**Interview** □ Ask staff to describe and/or demonstrate the tracking system used to document locations of patients and staff. **Document Review** **General** □ Verify that the hospital's emergency preparedness policies and procedures include a tracking system to be used during emergencies that includes: ▪ A system to track the location of on-duty staff and sheltered patients in the hospital's care during an emergency. ▪ If on-duty staff and sheltered patients are relocated during the emergency, the hospital must document the specific name and location of the receiving facility or other location. **Note:** *Policies and procedures must be reviewed and updated at least every 2 years.*
EM.12.01.01, EP 3: The 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.	**§482.15(b)(3) [(b) Policies and procedures… The policies and procedures must be reviewed and updated at least every 2 years.** At a minimum, the policies and procedures must address the following: **(3)** Safe evacuation from the [facility], which includes consideration of care and	**Interview** □ Ask staff to describe how they would handle a situation in which a patient refused to evacuate **Document Review** **General** □ Verify that the hospital's emergency preparedness policies and procedures include safe evacuation from the hospital, including the following:

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Note 2: Safe evacuation from the hospital includes consideration of care, treatment, and service needs of evacuees, staff responsibilities, and transportation. **EM.12.02.01, EP 5:** The 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 hospital plans to communicate with - Testing the functionality of the 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.	treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.	▪ Consideration of care and treatment needs of evacuees ▪ Staff responsibilities ▪ Transportation ▪ Identification of evacuation location(s) ▪ Primary and alternate means of communication with external sources of assistance **Note:** *Policies and procedures must be reviewed and updated at least every 2 years.*
EM.12.01.01, EP 3: The 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 hospital includes consideration of care, treatment,	**§482.15(b)(4) (b) Policies and procedures… The policies and procedures must be reviewed and updated at least every 2 years.** At a minimum, the policies and procedures must address the following: **(4)** A means to shelter in place for patients, staff, and volunteers who remain in the [facility].	**Document Review** **General** □ Verify that the hospital's emergency preparedness policies and procedures include how the hospital will provide a means to shelter in place for patients, staff, and volunteers who on remain in the hospital. □ Verify that the hospital's policies and procedures for sheltering in place align with its emergency plan and risk assessment. **Note:** *Policies and procedures must be reviewed and updated at least every 2 years.*

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and service needs of evacuees, staff responsibilities, and transportation.		
IM.11.01.01, EP 1: The 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.	**§482.15(b)(5) ([(b) Policies and Procedures.... The policies and procedures must be reviewed and updated at least every 2 years.** At a minimum, the policies and procedures must address the following: **(5)** A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.	**Document Review** **General** □ Verify that the hospital's emergency preparedness policies and procedures include a medical record documentation system that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records. **Note:** *Policies and procedures must be reviewed and updated at least every 2 years.*
EM.12.02.03, EP 1: The 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 hospital determines that it will never use volunteers during disasters, this is documented in its plan. **EM.12.02.03, EP 2:** The hospital's staffing plan addresses the management of all staff and volunteers as follows: - Reporting processes - Roles and responsibilities for essential	**§482.15(b)(6) (b) Policies and procedures... The policies and procedures must be reviewed and updated at least every 2 years.** At a minimum, the policies and procedures must address the following: **(6)** The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.	**Interview** □ Ask hospital leaders to explain their staffing strategies. ▪ Do they use volunteers? ▪ Do they have other emergency staffing strategies if no volunteers are used? **Document Review** **General** □ Verify that the hospital's emergency preparedness policies and procedures include: ▪ Use of volunteers and other emergency staffing strategies during an emergency ▪ Addressing surge needs during an emergency **Note:** *Policies and procedures must be reviewed and updated at least every 2 years.*

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functions - Integration of staffing agencies, volunteer staffing, or deployed medical assistance teams into assigned roles and responsibilities		
EM.12.02.05, EP 1: The 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.	**§482.15(b)(7) (b) Policies and procedures… The policies and procedures must be reviewed and updated at least every 2 years.** At a minimum, the policies and procedures must address the following: **(7)** The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.	**Interview** □ Ask hospital leaders to explain the arrangements in place for transportation in the event of an evacuation. **Document Review** **General** □ Verify that the hospital's emergency preparedness policies and procedures include written arrangements and/or agreements the hospital has with other facilities to receive patients in the event the hospital is not able to care for them during an emergency. **Note:** *Policies and procedures must be reviewed and updated at least every 2 years.*
EM.12.01.01, EP 7: The hospital must develop and implement emergency preparedness policies and procedures that address the role of the 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 hospitals that receive Medicare, Medicaid, or Children's Health Insurance Program reimbursement. Note 2: For more information on 1135 waivers, visit https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Resources/Waivers-and-flexibilities and https://www.cms.gov/about-cms/agency-	**§482.15(b)(8) (b) Policies and procedures… The policies and procedures must be reviewed and updated at least every 2 years.** At a minimum, the policies and procedures must address the following: **(8)** The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.	**Document Review** **General** □ Verify that the hospital's emergency preparedness policies and procedures include the hospital's role in providing care and treatment at alternate care sites under an 1135 waiver. **Note:** *This policy and procedure requirement does not require a hospital to have an 1135 waiver on hand at the time of the survey, as such waivers are established or granted by CMS only during a declared emergency period. Section 1135 waivers by nature are time limited.* **Note:** *Policies and procedures must be reviewed and updated at least every 2 years.*

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information/emergency/downloads/consolidated**medicareffsemergencyqsas.pdf.**		
EM.09.01.01, EP 3: The hospital complies with all applicable federal, state, and local emergency preparedness laws and regulations. **EM.12.01.01, EP 1:** The 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, EP 3:** The 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:	**§482.15(c) (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years.**	**Interview** □ Ask hospital leaders or the designee responsible for the emergency program to explain how they collaborate with federal, state, and local officials to ensure their communication plan complies with federal, state and local requirements. **Document Review** **General** □ Verify that the hospital has a written emergency preparedness communication plan, that complies with Federal, State and local laws. **Note:** *The communication plan must be reviewed and updated at least every 2 years.*

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- Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program		
EM.12.02.01, EP 1: The 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.	**§482.15(c)(1) [(c) The communication plan**... must be reviewed and updated at least every 2 years. The communication plan must include all of the following: **(1)** Names and contact information for the following: **(i)** Staff. **(ii)** Entities providing services under arrangement. **(iii)** Patients' physicians **(iv)** Other [hospitals and CAHs]. **(v)** Volunteers.	**Document Review** **General** □ Verify that the hospital's emergency preparedness communication plan includes names and contact information for staff, entities under arrangement, physicians, other hospitals and CAHs, and volunteers **Note:** *Hospitals that use electronic data storage should be able to provide evidence of data backup with hard copies or by demonstrating the ability to reproduce contact lists or access these data during emergencies.* **Note:** *The communication plan and contact information must be reviewed and updated at least every 2 years.*
EM.12.02.01, EP 1: The 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:	**§482.15(c)(2) [(c) The communication plan**... must be reviewed and updated at least every 2 years. The communication plan must	**Document Review** **General** □ Verify that the hospital's emergency preparedness communication plan includes contact information for federal, state, tribal, regional, and local emergency

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- 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.	include all of the following: **(2) Contact information for the following:** **(i) Federal, State, tribal, regional, and local emergency preparedness staff.** **(ii) Other sources of assistance.**	preparedness officials and other sources of assistance. □ Verify that the hospital has contact information for the State Survey Agency and/or public health departments. **Note:** *The communication plan and contact information must be reviewed and updated at least every 2 years.*
EM.12.02.01, EP 5: The 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 hospital plans to communicate with - Testing the functionality of the hospital's alternate/backup communication systems or equipment Note: Examples of alternate/backup communication systems include amateur	**§482.15(c)(3) The communication plan…** must be reviewed and updated at least every 2 years. The communication plan must include all of the following: **(3) Primary and alternate means for communicating with the following:** **(i) [Facility] staff.** **(ii) Federal, State, tribal, regional, and local emergency management agencies.**	**Document Review** **General** □ Verify that the hospital's emergency preparedness communication plan includes primary and alternate means for communicating with facility staff and federal, state, tribal, regional, and local emergency management agencies. **Note:** *Hospitals have the discretion to use alternate communication systems that best meet their needs.* **Note:** *The communication plan must be reviewed and updated at least every 2 years.* □ Verify that the hospital's communication plan includes the types of communication equipment and/or communication systems that will be used for primary and alternate means of communicating. **Note:** *Hospitals may use pagers, cell phones, radio transceivers (that is, walkie-talkies), and various*

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radios, portable radios, text-based notifications, cell and satellite phones, and reverse 911 notification systems.		*other radio devices (such as Ham Radio systems, as well as satellite telephone communications systems. However, those in rural or remote areas may have difficulty using some communications systems, which should be outlined with their risk assessment.* □ Verify that the hospital's communication plan includes procedures for when and how alternate communication methods will be used and who uses them. **Observation** □ Ask to see the communications equipment or communication systems listed in the plan
EM.12.02.05, EP 1: The 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. **EM.12.02.01, EP 4:** In the event of an emergency or evacuation, the 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	**§482.15(c)(4)-(6) The communication plan**... must be reviewed and updated at least every 2 years. The communication plan must include all of the following: **(4)** A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. **(5)** A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). **(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).	**Document Review** **General** □ Verify that the hospital's emergency preparedness communication plan includes a method for sharing information and medical documentation for patients under its care, as necessary, with other health providers to maintain the continuity of care. □ Verify that the hospital has policies and procedures addressing the means it will use to release patient information, including the general condition and location of patients. **Note:** *The communication plan must be reviewed and updated at least every 2 years.*

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information is consistent with 45 CFR 164.510(b)(1)(ii) and (b)(4).		
EM.12.02.01, EP 3: The hospital's communication plan describes how the hospital will communicate with and report information about its organizational needs, available occupancy, and ability to provide assistance to relevant authorities. Note: Examples of hospital needs include shortages in personal protective equipment, staffing shortages, evacuation or transfer of patients, and temporary loss of part or all organization function.	**§482.15(c)(7) The communication plan…** must be reviewed and updated at least every 2 years. The communication plan must include all of the following: **(7)** A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.	**Document Review** **General** □ Verify that the hospital's emergency preparedness communication plan includes a means of providing information about the hospital's needs and its ability to provide assistance to the authority having jurisdiction, the Incident Command Center, or a designee. □ Verify that the hospital's communication plan includes a means of providing information about its occupancy. **Note:** *The communication plan must be reviewed and updated at least every 2 years.*
EM.15.01.01, EP 1: The hospital has a written education and training program in emergency management that is based on the hospital's prioritized risks identified as part of its hazard vulnerability analysis, emergency operations plan, communications plan, and policies and procedures. Note: If the hospital has developed multiple hazard vulnerability analyses based on the location of other services offered, the education and training for those facilities are specific to their needs. **EM.16.01.01, EP 1:** The 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	**§482.15(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section.** **The training and testing program must be reviewed and updated at least every 2 years.**	**Document Review** **General** □ Verify that the hospital has a written training and testing program that is based on the hospital's risk assessment, has incorporated its policies and procedures, as well as its communication plan within training required for staff. **Note:** *Refer to the hospital's risk assessment when determining if the training and testing program reflects the risks and hazards identified within the hospital's program.* **Note:** *Training and testing program must be reviewed and updated at least every 2 years.*

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plans - Six critical areas (communications, staffing, patient care and clinical support, safety and security, resources and assets, utilities) Note 1: The planned exercises should attempt to stress the limits of its emergency response procedures to assess how prepared the hospital may be if a real event or disaster were to occur based on past experiences. Note 2: An AAR is a detailed critical summary or analysis of an emergency or disaster incident, including both planned and unplanned events. The report summarizes what took place during the event, analyzes the actions taken by participants, and provides areas needing improvement. **EM.17.01.01, EP 3:** The hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program		
EM.15.01.01, EP 2: The hospital provides initial education and training in emergency management to all new and existing staff, individuals providing services under arrangement, and volunteers that is consistent with their roles and	**FOR HOSPITALS §482.15(d)(1) Training program. The [facility] must do all of the following:** **(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing**	**Interview** □ Ask various staff about the hospital's initial and subsequent (at least every 2 years) training courses to verify staff knowledge of emergency procedures. **Document Review**

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responsibilities in an emergency. The initial education and training include the following: - Activation and deactivation of the emergency operations plan - Communications plan - Emergency response policies and procedures - Evacuation, shelter-in-place, lockdown, and surge procedures - Where and how to obtain resources and supplies for emergencies (such as procedure manuals or equipment) Documentation is required. **EM.15.01.01, EP 3:** The hospital provides ongoing education and training to all staff, individuals providing services under arrangement, and volunteers that is consistent with their roles and responsibilities in an emergency. The education and training occur at the following times: - At least every two years - When roles or responsibilities change - When there are significant revisions to the emergency operations plan, policies, and/or procedures - When procedural changes are made during an emergency or disaster incident requiring just-in-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	**services under arrangement, and volunteers, consistent with their expected roles.** **(ii) Provide emergency preparedness training at least every 2 years.** **(iii) Maintain documentation of all emergency preparedness training.** **(iv) Demonstrate staff knowledge of emergency procedures.** **(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.**	**General** □ Verify that the hospital's training program provides initial and subsequent (at least every 2 years) emergency preparedness training that is consistent with staff roles during an emergency and is based on the hospital's risk assessment, policies, and procedures, as well as the communication plan. **Note:** *Training is intended for all new and existing staff, individuals providing services under arrangement, and volunteers. It is up to the hospital to decide what level of training each staff member will be required to complete based on an individual's involvement or expected role during an emergency.* **Personnel/Credential File** □ Review a sample of staff training files to verify that staff have received initial and subsequent (at least every 2 years) emergency preparedness training. **Note:** *For ease of demonstrating compliance that the hospital has updated its training program at least every 2 years, hospitals should retain, at a minimum, the past 2 cycles (generally 4 years) of emergency training documentation for both training and exercises.*

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documented by the organization. Note 2: 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.		
EM.16.01.01, EP 2: The 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 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	**§482.15(d)(2) (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:** **(i) Participate in a full-scale exercise that is community-based every 2 years; or** **(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or** **(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.** **(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:** **(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or** **(B) A mock disaster drill; or** **(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-**	**Interview** □ Ask hospital leaders to describe the participation of managers and staff during scheduled exercises. **Document Review** **General** □ Verify that the hospital has conducted at least 2 annual exercises to test the emergency plan. The hospital is required to conduct a minimum of 2 exercises per year as follows: ▪ One annual exercise must be a full-scale community- or facility-based functional exercise. ▪ The other annual exercise can be of choice, which may be a full-scale community based or a facility-based functional exercise, or the exercise may be a mock drill, tabletop exercise, or workshop. **Note:** *If the hospital experiences a real emergency that requires activation of its emergency plan, the hospital is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.* □ Ask to see documentation of the exercises conducted by the hospital which may include but is not limited to the exercise plan, the after-action report, and any additional documentation used by the hospital to support the exercise.

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hospital provides documentation that it activated its emergency operations plan. Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises. **EM.17.01.01, EP 1:** The multidisciplinary committee that oversees the emergency management program reviews and evaluates all exercises and actual emergency or disaster incidents. The committee reviews after-action reports (AARs), identifies opportunities for improvement, and recommends actions to take to improve the emergency management program. The AARs and improvement plans are documented. Note 1: The review and evaluation addresses 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 actual emergency or disaster incident. The report summarizes what took place during the event, analyzes the actions taken by participants, and provides areas needing improvement. **EM.17.01.01, EP 3:** The 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	**relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.** **(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.**	**Note:** *Hospitals are to retain, at a minimum, the past 2 cycles (generally 2 years for inpatient providers) of emergency testing exercise documentation.* □ Ask to see documentation of the hospital's efforts to identify a full-scale community-based exercise if it did not participate in one (that is, date, staff and agencies contacted, and reasons for the inability to participate). □ Verify documentation of the hospital's analysis and response to the annual exercises and how the hospital updated its emergency program based on this analysis.

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- Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program		
EM.12.02.09, EP 1: The 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 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. **EM.12.02.09, EP 2:** The 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	**§482.15(e) Condition for Participation:** **(e)** Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. **§482.15(e)(1) Emergency generator location.** The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12–2, TIA 12–3, TIA 12–4, TIA 12–5, and TIA 12–6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12–1, TIA 12–2, TIA 12–3, and TIA 12–4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. **482.15(e)(2) Emergency generator inspection and testing.** The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.	**Document Review** **General** □ Verify that the hospital has the required emergency and standby power systems to meet the requirements of its emergency plan and corresponding policies and procedures. □ Verify that the hospital's emergency plan for "shelter in place" and evacuation plans include its emergency power supply systems or plans to maintain safe operations while sheltering in place. □ Verify that hospitals under construction or with existing buildings being renovated have a written plan to relocate the emergency power supply system (EPSS) by the time construction is completed. □ Verify that hospitals with permanently attached generators evaluate and maintain their on-site fuel source in accordance with NFPA 110 and have a plan for how to keep the generator operational during an emergency, unless they plan to evacuate.

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following: - If part of a health care system, coordinating within the system to request resources - Coordinating with local supply chains or vendors - Coordinating with local, state, or federal agencies for additional resources - Coordinating with regional health care coalitions for additional resources - Managing donations (such as food, water, equipment, materials) Note: High priority should be given to resources that are known to deplete quickly and are extremely competitive to acquire and replenish (such as fuel, oxygen, personal protective equipment, ventilators, intravenous fluids, antiviral and antibiotic medications). **EM.12.02.11, EP 1:** The 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. **EM.12.02.11, EP 2:** The 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.	**482.15(e)(3) Emergency generator fuel.** [Hospitals, CAHs and LTC facilities] that maintain an on-site 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.	

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
EM.12.02.11, EP 3: The hospital's plan for managing utilities describes in writing alternative means for providing essential or critical utilities, such as water supply, emergency power supply systems, fuel storage tanks, and emergency generators. **PE.03.01.01, EP 3:** The 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: For hospitals that use Joint Commission accreditation for deemed status purposes: 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 hospitals. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: 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 hospital, but only if the waiver will not adversely affect the		

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
health and safety of the patients. Note 4: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity. **PE.04.01.01, EP 1:** The 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 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, EP 3:** The hospital meets the emergency power system and generator		

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
requirements found in NFPA 99-2012 Health Care Facilities Code, NFPA 110-2010 Standard for Emergency and Standby Power Systems, and NFPA 101-2012 Life Safety Code requirements.		
EM.09.01.01, EP 2: If the 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 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 hospital's unique circumstances, patient population, and services offered - Each separately certified 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 hospital within the health care system - Unified and integrated emergency plan - Integrated policies and procedures - Coordinated communication plan - Training and testing program	**§482.15(f) Integrated healthcare systems.** **If a [facility] is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the [facility] may choose to participate in the healthcare system's coordinated emergency preparedness program.** **If elected, the unified and integrated emergency preparedness program must-[do all of the following:]** **(1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.** **(2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered.** **(3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance [with the program].** **(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and**	**Interview** □ If the hospital has opted to participate in its health care system's unified and integrated emergency preparedness program, ask hospital leaders to describe how the program is updated based on changes within the health care system, such as when facilities enter or leave the system. **Document Review** **General** □ Verify whether the hospital has opted to be part of its health care system's unified and integrated emergency preparedness program. Note: *This is optional for separately certified hospitals.* □ If the hospital has opted to participate in its health care system's unified and integrated emergency preparedness program, ask to see documentation of its inclusion in the program. ▪ Verify that the hospital was actively involved in the development of the unified emergency preparedness program. ▪ Verify that the hospital was actively involved in the review of program requirements and updates. ▪ Ask to see a copy of the integrated and unified emergency preparedness program and all required components (emergency plan, policies and procedures, communication plan, training and testing program).

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
EM.11.01.01, EP 3: The 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 hospital and its ability to provide services. The findings are documented. **EM.11.01.01, EP 4:** The hospital uses its prioritized hazards from the hazard vulnerability analysis to identify and implement mitigation and preparedness actions to increase the resilience of the hospital and helps reduce disruption of essential services or functions. **EM.12.01.01, EP 2:** The hospital's emergency operations plan identifies the patient population(s) that it will serve, including at-risk populations, and the types of services it would have the ability to provide in an emergency or disaster event. Note: At-risk populations such as the elderly, dialysis patients, or persons with physical or mental disabilities may have additional needs to be addressed during an emergency or disaster incident, such as medical care, communication, transportation, supervision, and maintaining independence. **EM.12.01.01, EP 6:** The 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	**(4) of this section. The unified and integrated emergency plan must also be based on and include the following:** **(i) A documented community-based risk assessment, utilizing an all-hazards approach.** **(ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.**	

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
officials' efforts to leverage support and resources and to provide an integrated response during an emergency or disaster incident. **EM.13.01.01, EP 1:** The 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 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 hospital will continue to perform its essential business functions to deliver essential or critical services. Essential business functions to consider include administrative/vital records, information technology, financial services, security systems, communications/telecommunications, and building operations to support essential and critical services that cannot be deferred during an emergency; these activities must be performed continuously or resumed quickly following a disruption. **EM.13.01.01, EP 2:** The 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		

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
providing essential services include use of off-site locations, space maintained by another organization, existing facilities or space, telework (remote work), or telehealth. **EM.13.01.01, EP 3:** The hospital has a written order of succession plan that identifies who is authorized to assume a particular leadership or management role when that person(s) is unable to fulfill their function or perform their duties. **EM.13.01.01, EP 4:** The hospital has a written delegation of authority plan that provides the individual(s) with the legal authorization to act on behalf of the 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 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.		

HOSPITAL COMPLIANCE EVALUATION TOOLS

CMS A-Tag Summary Review Sheet – Deemed Hospital Medical Record Review

Introduction to Medical Record Reviews

- Review a **sample of active and closed** medical records for completeness and accuracy in accordance with Federal and State laws and regulations and hospital policy.
- The sample should be 10 percent of the average daily census and be no less than 30 records.
- Within the sample, select **at least one patient from each nursing unit** (e.g., med/surg, ICU, OB, pediatrics, specialty units, etc.). In addition to the inpatient sample, **select a sample of outpatients** in order to determine compliance in outpatient departments, services, and locations. The **sample size may be expanded as needed to assess the hospital's compliance with the CoPs**.
- **Request** patient care **policies** and other supporting documents **prior to** reviewing medical records.

Reference	Admission – Registration – Patient Rights
482.13(a)(1)	➢ **Records of Medicare beneficiaries** contain a signed and dated standardized notice, "An Important Message from Medicare" (IM) provided to inpatients within 2 days of the admission. For patients whose discharge occurred more than 2 days after the initial IM notice was issued, determine whether the hospital provided another copy of the IM to the patient prior to discharge in a timely manner.
482.13(b)(3)	➢ **Advanced directives** – record contains documentation that notice of the hospital's advance directives policy was provided at the time of admission or registration; document in a prominent part of the patient's medical record whether or not the patient has executed an advance directive; if yes, a copy of the patient's advance directive is in the medical record.
482.13(b)(4)	➢ **Patient asked (unless incapacitated) about notifying** family and physician about inpatient admission; if the patient was incapacitated at the time of admission record documents what steps were taken to identify a family member or representative and the patient's physician.
482.13(h)(1)	➢ Patient informed of **visitation rights**; records contain documentation that the required notice was provided
	Informed Consent:
482.24(c)(4)(v)	➢ **Properly executed informed consent forms** for **procedures and treatments** specified by the medical staff, or by Federal or State law if applicable, to require written patient consent. (The medical record must contain a document recording the patient's informed consent for those procedures and treatments that have been specified as requiring informed consent). A properly executed informed consent form contains the following minimum elements: Name of the hospital…, Name of the specific procedure…, Name of the responsible practitioner…, Statement that the procedure or treatment, including the anticipated benefits, material risks, and alternative therapies, was explained to the patient…, Signature of the patient…, Date and time the informed consent form is signed by the patient…

	○ If there is applicable State law governing the content of the informed consent form, then the hospital's form must comply with those requirements.
482.51(b)(2)	➢ A properly executed informed consent **form for the operation must be in the patient's chart before surgery**, except in emergencies
Reference	**Care Documentation**
	Justification for Admission:
482.24(c)(4)(ii)	➢ **Admitting diagnosis**
482.24(c)	➢ Medical record information **justifies admission and continued hospitalization**, supports the diagnosis, and describes patient's progress and response to medications, services (interventions, care, treatments).
482.24(c)(1)	➢ Medical record entries are **legible, complete, dated, timed & authenticated** - consistent with policy/procedure
482.24(c)(3)(iv)	➢ **Pre-printed or electronic standing orders,** order sets, and protocols are dated, timed, and authenticated promptly in the medical record
482.24(c)(4)(iv)	➢ Documentation of **complications, healthcare associated infections (HAI's) and unfavorable** reactions to drugs **and anesthesia**
	Admission Note or H&P
482.24(c)(4)(i)(A)	➢ A **medical history and physical examination** completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, and except as provided under paragraph (c)(4)(i)(C) of this section. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.
482.24(c)(4)(i)(B)	➢ An **updated examination** of the patient, including any changes in the patient's condition, when the medical history and physical examination are completed within 30 days before admission or registration, and except as provided under paragraph (c)(4)(i)(C) of this section. Documentation of the updated examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.
482.24(c)(4)(i)(C)	➢ An **assessment of the patient (in lieu of** the requirements of paragraphs (c)(4)(i)(A) and (B) of this section) completed and documented after registration, but prior to surgery or a procedure requiring anesthesia services, when the patient is receiving specific outpatient surgical or procedural services and when the medical staff has chosen to develop and maintain a policy that identifies, in accordance with the requirements at §482.22(c)(5)(v), specific patients as not requiring a comprehensive medical history and physical examination, or any update to it, prior to specific outpatient surgical or procedural services.

	Surgical or procedure requiring anesthesia services H&P
482.51(b)(1)(i)	➢ **Prior to surgery or a procedure requiring anesthesia** services and except in the case of emergencies: A **medical history and physical examination** must be completed and documented no more than 30 days before or 24 hours after admission or registration, and except as provided under paragraph (b)(1)(iii) of this section.
482.51(b)(1)(ii)	➢ **Prior to surgery or a procedure requiring anesthesia** services and except in the case of emergencies: An **updated examination** of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration when the medical history and physical examination are completed within 30 days before admission or registration, and except as provided under paragraph (b)(1)(iii) of this section.
482.51(b)(1)(iii)	➢ **Prior to surgery or a procedure requiring anesthesia** services and except in the case of emergencies: An **assessment of the patient must** be completed and documented after registration (in lieu of the requirements of paragraphs (b)(1)(i) and (ii) of this section) when the patient is receiving specific outpatient surgical or procedural services and when the medical staff has chosen to develop and maintain a policy that identifies, in accordance with the requirements at § 482.22(c)(5)(v), specific patients as not requiring a comprehensive medical history and physical examination, or any update to it, prior to specific outpatient surgical or procedural services.
	Monitoring of Care:
482.24(c)(4)(vi)	➢ The medical record **must contain**: all practitioners' orders, nursing notes, reports of treatment, medication records, radiology, and laboratory reports, and vital signs and other information necessary to monitor the patient's condition
482.26(b)(4)	o **Orders radiologic services**
482.26(d)(1)	o **Radiologist signs reports of interpretation**
482.28(b)(2)	o **Orders for patient diets**
482.53(d)(2)	o **Nuclear med interpretation** of tests signed and dated
482.57(b)(4)	o **Respiratory care orders**
482.24(c)(2)	➢ **All orders, including verbal orders, are dated, timed, and authenticated.** The receiver of a verbal order must date, time, and sign the verbal order in accordance with hospital policy
482.28(b)(1), (b)(2)	➢ **Nutritional needs** – monitoring the dietary intake and nutritional status of patients identified as having special nutritional needs; diet orders prescribed by the practitioner, a qualified dietician, or qualified nutrition professional.

Reference	Intervention Documentation
	Anesthesia:
482.52(b)(1)	➢ **Pre-anesthesia eval** within 48 hours prior to surgery or anesthesia
482.52(b)(2)	➢ **Intraoperative anesthesia** record or report
482.52(b)(3)	➢ **Post anesthesia eval** no later than 48 hours after surgery or anesthesia
	Procedure:
482.51(b)(6)	➢ An **operative report** describing techniques, findings, and tissues removed or altered must be written or dictated immediately following surgery and signed by the surgeon
	Consults:
482.24(c)(4)(iii)	➢ **Results of all consultative evaluations** of the patient and appropriate findings **by clinical and other staff** involved in the care of the patient.
	Medication:
	➢ Review a sample of patient health records to determine:
482.23(c)(1)(i) &(ii)	o if medication administration conformed to an authorized practitioner's order (that is, there is an order from an authorized practitioner, or an applicable standing order, and that the correct medication was **administered to the right patient at the right dose via the correct route**) and if the **timing of administration complied with the hospital's policies and procedures**.
482.23(c)(2)	o All drugs and biologicals must be **administered by, or under supervision of, nursing or** other personnel…..
482.23(c)(3)	o Orders for drugs and biologicals are documented and signed by any practitioner who is authorized…. Influenza and pneumococcal vaccines may be administered per physician-approved hospital policy after an assessment of contraindications…
482.23(c)(4)	➢ Review a sample of medical records of patients who received **blood transfusions or IV medications**.

	○ Are blood transfusions and IV medications administered in accordance with state law and approved medical staff policies and procedures? ○ Are blood transfusions and IV medications administered by personnel who are working within their scope of practice in accordance with state law and approved medical staff policies?
482.23(c)(6)(i)(E)	➢ Documentation of self-administration of hospital issued medication as reported by patient
482.23(c)(6)(ii)(E)	➢ Documentation of self-administration of medication brought in by patient as reported by patient
	Blood Products:
482.27 (b)(6)(iii)	➢ Documentation of notification of or attempts to notify patient of potentially infectious blood.
482.27(b)(7)(ii)	➢ If hospital unable to locate patient, it documents in the medical record the extenuating circumstances that caused notification to exceed 12 weeks.

	Restraints:
482.13(e)(8)(i)	➢ **Orders for restraint or seclusion** used for the management of violent or self-destructive behavior may only be renewed in accordance with the following limits for up to a total of 24 hours: (A) 4 hours for adults 18 years of age or older; (B) 2 hours for children and adolescents 9 to 17 years of age; or (C) 1 hour for children under 9 years of age;
482.13(e)(16)(i-v)	➢ **Documentation** of the following when restraints or seclusion is used: (i)The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior; (ii) A description of the patient's behavior and the intervention used; (iii) Alternatives or other less restrictive interventions attempted (as applicable); (iv) The patient's condition or symptom(s) that warranted the use of the restraint or seclusion; (v) The patient's response to the intervention(s) used, including the rationale for continued use of the intervention
482.13(e)(12) (e)(12)(i); 482.12(e)(12)(ii) 482.13(e)(14)	➢ **Face-to-face** evaluation **within 1 hour** after the initiation of restraint or seclusion is used for the management of violent or self-destructive behavior by a— (A) Physician or other licensed practitioner (B) Registered nurse who has been trained in accordance with the requirements in 482.13(f) **Documentation of the face-to-face** evaluation includes the following: (A) The patient's immediate situation; (B) The patient's reaction to the intervention; (C) The patient's medical and behavioral condition; and (D) The need to continue or terminate the restraint or seclusion. o **Documentation of consultation** with the attending physician or other LP when the 1-hour face-to-face evaluation was conducted by a trained RN (as soon as possible in accordance with hospital policy)
482.13(g)(3)(i) and (ii)	➢ Medical record includes the **date and time death associated with use of restraint or seclusion** was reported to CMS or recorded in the internal log or other system

Deemed Hospital Medical Record Review

Reference	Discharge Planning, Evaluation, Post Hospital Needs
	Care Plans (nursing or interdisciplinary)
482.13(b)(1)	➢ Confirm that there is evidence that the patient or their representative was included or proactively involved in the development and implementation of their plan of care.
482.23(b)(4)	➢ For each plan reviewed, verify the following with respect to the nursing care component: • Was the plan initiated as soon as possible after admission for each patient? • Does the plan describe and reflect patient goals as part of the patient's nursing care assessment and, as appropriate, physiological and psychosocial factors and patient discharge planning? • Is the plan consistent with the medical care plan of the practitioner responsible for the care of the patient? • Is there evidence of reassessment of the patient's nursing care needs and response to nursing interventions and, as applicable, revisions to the plan? • Was the plan implemented in a timely manner?
	Case Manager and/or Social Work Notes
482.43(a)(1)	➢ Discharge planning in early stage of hospitalization to ensure appropriate arrangements for post-hospital care will be made before discharge
482.43(a)(2)	➢ Discharge planning evaluation – eval of pt needing post-hospital services and determination of the availability of services
482.43(a)(3) & (a)(5)	➢ Discharge planning evaluation and plan – by, or under the supervision of a RN, social worker, or other qualified personnel; the discharge planning evaluation results are included in the medical record
482.43(a)(3)	➢ Discharge planning evaluation results discussion– with the patient or representative and communication documented in the medical record
482.43(a)(6)	➢ Reassess discharge plan
482.43(d)(1)(i) &(iii)	➢ Document in the record that the list of HHAs, SNFs, IRFs, or LTCHs was presented to the patient or to the patient's representative. (Note: disclosable financial interests if they exist must be stated on the list provided to the patient)
482.43(d)(1)(ii)	➢ Patients enrolled in managed care organizations made aware of the need to verify which providers or suppliers are in network
482.43(b)	➢ Necessary medical information is forwarded to next provider(s) of care
482.24(c)(4)(vii)	➢ Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care. (including final diagnosis)
482.24(c)(4)(viii)	➢ Final diagnosis with completion of medical records within 30 days following discharge.

Ambulatory Health Care Occupancy LSC and HCFC Evaluation Tool

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

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

K-tag	Code Requirement	CoP	TJC EP	Comments
SECTION 1 – GENERAL REQUIREMENTS				
K100	**General Requirements – Other** Any LSC Section 20.1 and 21.1 General Requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01** The hospital/CAH addresses life safety from fire. **EP 3** The hospital/CAH meets the applicable provisions of the Life Safety Code (NFPA 101: 2012 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4).	
K111	**Building Rehabilitation** ***Repair, Renovation, Modification, or Reconstruction*** Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: Requirements of Chapter 21fire Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6. 20.1.1.4.3, 21.1.1.4.3, 43.1.2.1 ***Change of Use or Change of Occupancy*** Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 20.1.1.4.2 or 21.1.1.4.2. 20.1.1.4.2, 21.1.1.4.2, 43.1.2.2 (43.7) ***Additions*** Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01** The hospital/CAH addresses building safety and facility management. **EP 1** The hospital/CAH meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2,	

K-tag	Code Requirement	CoP	TJC EP	Comments
	barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. 20.1.1.4.1, 21.1.1.4.1.1, 4.6.5, 4.6.7, 43.1.2.3 (43.8)			
K131	**Multiple Occupancies – Sections of Ambulatory Health Care Facilities** Multiple occupancies shall be in accordance with 6.1.14. Sections of ambulatory health care facilities shall be permitted to be classified as other occupancies, provided they meet both of the following: • The occupancy is not intended to serve ambulatory health care occupants for treatment or customary access • They are separated from the ambulatory health care occupancy by a 1 hour fire resistance rating Ambulatory health care facilities shall be separated from other tenants and occupancies and shall meet all of the following: • Walls have not less than 1 hour fire resistance rating and extend from floor slab to roof slab • Doors are constructed of not less than 1-3/4 inches thick, solid-bonded wood core or equivalent and is equipped with positive latches. • Doors are self-closing and are kept in the closed position, except when in use. • Windows in the barriers are of fixed fire window assemblies per 8.3. Per regulation, ASCs are classified as Ambulatory Health Care Occupancies, regardless of the number of patients served. 20.1.3.2, 21.1.3.3, 20.3.7.1, 21.3.7.1,42 CFR 416.44	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

<table>
<tr><th>K-tag</th><th>Code Requirement</th><th>CoP</th><th>TJC EP</th><th>Comments</th></tr>
<tr><td>K161</td><td>Building Construction Type and Height
Building construction type and stories meet Table 20.1.6.1 or Table 21.1.6.1, respectively.
<table>
<tr><td></td><td></td><td>Construction Type</td><td></td></tr>
<tr><td>1</td><td></td><td>I (442), I (332), II (222), II (111), III (211), IV (2HH),
V (111)</td><td>Any number of stories non-sprinklered or sprinklered</td></tr>
<tr><td>2</td><td></td><td>II (000), III (200), V (000)</td><td>One story non-sprinklered
Any number of stories sprinklered</td></tr>
</table>
Any level below the level of exit discharge shall be separated by Type II (111), Type III (211), or Type V (111) construction unless both of the following are met:
1. Such levels are under the control of the ambulatory healthcare occupancy.
2. Hazardous spaces are protected per section 8.7.
Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 20.3.5 or 21.3.5, respectively)
Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.
20.1.6.1, 20.1.6.2, 21.1.6.1, 21.1.6.2</td><td>HAP 482.41(b)(1)(i)
CAH 485.623(c)(1)(i)</td><td>PE.03.01.01, EP 3</td><td></td></tr>
<tr><td>K163</td><td>Interior Nonbearing Wall Construction
Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials.
Interior nonbearing walls required to have a minimum 2-hour fire resistance rating are permitted to be fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures.
20.1.6.3, 20.1.6.4, 21.1.6.3, 21.1.6.4</td><td>HAP 482.41(b)(1)(i)
CAH 485.623(c)(1)(i)</td><td>PE.03.01.01, EP 3</td><td></td></tr>
</table>

K-tag	Code Requirement	CoP	TJC EP	Comments
SECTION 2 – MEANS OF EGRESS REQUIREMENTS				
K200	**Means of Egress Requirements – Other** Any LSC Section 20.2 and 21.2 Means of Egress requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K211	**Means of Egress – General** Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 20/21.2.2 through 20/21.2.11. 20.2.1, 21.2.1, 7.1.10.1	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K222	**Egress Doors** Special locking arrangements are in accordance with section 7.2.1.6 ☐ DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. ☐ ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. ☐ ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 20.2.2.2, 21.2.2.2, 7.2.1.6.1 through 7.2.1.6.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K223	**Doors with Self-Closing Devices** Doors required to be self-closing are permitted to be held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment, entire facility, and all stair enclosure doors upon activation of: • Required manual fire alarm system; and • Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and • Automatic sprinkler system, if installed; and • Loss of power. 20.2.2.4, 20.2.2.5, 21.2.2.4, 21.2.2.5	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K231	**Means of Egress Capacity** The capacity of required means of egress is in accordance with 7.3. 20.2.3.1, 21.2.3.1, 38.2.3, 39.2.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K232	**Aisle, Corridor or Ramp Width** The clear width of any corridor or passageway required for egress shall be not less than 44 inches wide. Where a corridor is 6 feet wide, projections of not more than 6 inches from the corridor wall above the handrail height are permitted for alcohol-based hand rub dispensers. 20.2.3.2, 20.2.3.3, 21.2.3.2, 21.2.3.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K233	**Clear Width of Exit and Exit Access Doors** **2012 EXISTING** Doors in the means of egress from diagnostic or treatment areas, such as x-ray, surgical, or physical therapy, shall provide a clear width of not less than 32 inches, unless the doors are existing 34 inch wide doors. 21.2.3.4 **2012 NEW** Doors in the means of egress from diagnostic or treatment areas, such as x-ray, surgical, or physical therapy, shall provide a clear width of not less than 32 inches. 20.2.3.4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K241	Number of Exits – Story and Compartment 2012 EXISTING Single means of egress is allowed from a mezzanine or balcony if one of the following exist: 1. Common path of travel is under 100 feet if in a sprinklered building. 2. Common path of travel 75 feet if in a non-sprinklered building. 3. Common path of travel is not limited if occupant load is under 30. Not less than 2 exits, as described in 38.2.2, are remotely located for each fire section or patient care area of the building and are accessible from each smoke compartment. Patient care suites larger than 2500 square feet have 2 exits remotely located from each other. Egress from smoke compartments, if installed, shall be permitted through adjacent compartments provided the egress does not return through the compartment of fire origin. 21.2.3.1 through 21.2.3.5, 7.4.1.1, 7.4.1.3 through 7.4.1.6 2012 NEW Meets the requirements of section 7.4. Not less than 2 exits, as described in 38.2.2, are remotely located for each fire section or patient care area of the building and are accessible from each smoke compartment. Patient care suites larger than 2500 square feet have 2 exits remotely located from each other. Egress from smoke compartments, if installed, shall be permitted through adjacent compartments provided the egress does not return through the compartment of fire origin. 20.2.4.1 through 20.2.4.5, 7.4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K251	Dead-End Corridors and Common Path of Travel 2012 EXISTING Dead end corridors shall not exceed 50 feet. Common path of travel is no more 75 feet, and no more than	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	TJC EP	Comments
	100 feet sprinklered story. Common path of travel is not limited in single tenant space with an occupant load not exceeding 30 persons. 21.2.5, 39.2.5.2 **2012 NEW** Dead-end corridors are no more than 50 feet in sprinklered buildings, and no more than 20 feet in non-sprinklered buildings. Common path of travel is no more 75 feet, and no more than 100 feet in sprinklered buildings or single tenant space with an occupant load not exceeding 30 persons. 20.2.5, 38.2.5.2, 38.2.5.3			
K261	**Travel Distance to Exits** Travel distance between any point in a room and an exit is 150 feet or 200 feet in sprinklered buildings. 20.2.6, 21.2.6	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K271	**Discharge from Exits** Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes inelevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 07-38. 20.2.7, 21.2.7, 38.2.7, 39.2.7, 7.7	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K281	**Illumination of Means of Egress** Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 20.2.8, 21.2.8, 7.8	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K291	**Emergency Lighting** Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 20.2.9.1, 21.2.9.1, 7.9	HAP 482.41(a)(1) HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1** **PE.04.01.03, EP 1** The hospital/CAH has	

K-tag	Code Requirement	CoP	TJC EP	Comments
		PE.04.01.03, EP 1 applies to CAH but is not linked to a CAH CoP	emergency power and lighting in, at a minimum, the following areas: • Operating rooms • Recovery rooms • Intensive care • Emergency rooms • Stairwells Battery lamps and flashlights are available in all other areas not serviced by the emergency power supply source.	
K292	**Life Support Means of Egress** Where general anesthesia or life-support equipment is used, each ambulatory health care facility shall be provided with an essential electric system in accordance with NFPA 99. (N/A if life support equipment is for emergency purposes only.) 20.2.9.2, 21.2.9.2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i) HAP 482.41(c) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K293	**Exit Signage** Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 20.2.10, 21.2.10, 7.10	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i) HAP 482.41(c) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
SECTION 3 - PROTECTION				
K300	**Protection – Other** Any LSC Section 20.3 and 21.3 Protection requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K311	**Vertical Openings – Enclosure** **2012 EXISTING** Vertical openings shall be enclosed or protected per 8.6, unless one of the following conditions exist: 1. Unenclosed vertical openings per 8.6.9.1 are permitted.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	2. Unenclosed openings which do not serve as a required means of egress are permitted. 3. Exit access stairs may be unenclosed if they meet the following conditions: Two stories or less a. Building is protected throughout by a supervised sprinkler system per 9.7.1.1(1). b. Total travel distance to outside does not exceed 100 feet. Three stories or less a. Occupant load per story does not exceed 15 people. b. Building is sprinkler protected throughout per 9.7.1.1(1). c. Building contains an automatic smoke detection system per 9.6. d. Activation of the sprinkler system or smoke detection system notifies all occupants of the building. e. Total travel distance to outside does not exceed 100 feet. Floors that are below the street level and are used for storage or any use other than a business occupancy, shall not have any unprotected openings to the business occupancy floors. 21.3.1, 39.3.1.1, 39.3.1.2 2012 NEW Vertical openings shall be enclosed or protected per 8.6, unless one of the following conditions exist: 1. Unenclosed vertical openings per 8.6.9.1 are permitted. 2. Exit access stairs may be unenclosed if they meet the 2 conditions: a. Building is sprinkler protected throughout. b. Total travel distance to outside does not exceed 100 feet. Floors that are below the street level and are used for storage or any use other than a business occupancy, shall not have any unprotected openings to the business			

K-tag	Code Requirement	CoP	TJC EP	Comments
	occupancy floors. 20.3.1, 38.3.1.1, 38.3.1.2			
K321	**Hazardous Areas – Enclosure** Hazardous areas must meet one of the following: ☐ Contain 1-hour rated enclosure when non-sprinklered ☐ Sprinkler-protected with smoke resistive separation ☐ Severe hazard locations contain sprinkler protection and 1 hour separation with 3/4 hour rated self-closing doors 20.3.2, 21.3.2, 38.3.2, 38.3.2.2, 39.3.2.1, 39.3.2.2, 8.7	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K322	**Laboratories** Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard are protected by 1-hour fire resistance-rated separation, automatic sprinkler system, and are in accordance with 8.7 and with NFPA 99. Laboratories not considered a severe hazard are protected as hazardous areas (see K321). Laboratories using chemicals are in accordance with NFPA 45, *Standard on Fire Protection for Laboratories Using Chemicals*. Gas appliances are of appropriate design and installed in accordance with NFPA 54. Shutoff valves are marked to identify material they control. Devices requiring medical grade oxygen from the piped distribution system meet the requirements under 11.4.2.2 (NFPA 99). 20.3.2.2, 21.3.2.2 9.3.1.2, 11.4.3.2, 15.4 (NFPA 99)	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i) HAP 482.41(c) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K323	**Anesthetizing Locations** Areas designated for administration of general anesthesia (i.e., inhalation anesthetics) are in accordance with 8.7 and NFPA 99. Zone valves are: located immediately outside each life-support, critical care, and anesthetizing location of moderate sedation, deep sedation, or general anesthesia for medical gas or vacuum; readily accessible in an emergency; and arranged so shutting off any one anesthetizing location will not affect others. Area alarm panels are provided to monitor all medical gas, medical- surgical vacuum, and piped WAGD systems. Panels are at locations that provide for surveillance, indicate medical gas pressure decreases of 20 percent and vacuum decreases of 12-inch gauge HgV, and provide visual and audible indication. Alarm sensors are installed either on the source side of individual room zone valve box assemblies or on the patient/use side of each of the individual zone box valve assemblies. The EES critical branch supplies power for task illumination, fixed equipment, select receptacles, and select power circuits, and EES equipment system supplies power to ventilation system. Heating, cooling, and ventilation are in accordance with ASHRAE 170. Medical supply and equipment manufacturer's instructions for use are considered before reducing humidity levels to those allowed by ASHRAE, per S&C 13-58. 20.3.2.3, 21.3.2.3, NFPA 99 5.1.4.8.7, 5.1.4.8.7.2, 5.1.9.3.4, 6.4.2.2.4.2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i) HAP 482.41(c) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K324	**Cooking Facilities** Commercial cooking equipment shall be installed per NFPA 96 unless used for food warming or limited cooking. 20.3.2.4, 20.3.2.5, 21.3.2.4, 21.3.2.5, 9.2.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	The hospital maintains fire safety equipment and fire safety building features by inspecting the following: - Any automatic fire-extinguishing system in the kitchen every 6 months Note: For automatic kitchen fire-extinguishing systems, see NFPA 96-2011: 11.2.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	
K325	**Alcohol Based Hand Rub Dispenser (ABHR)** ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: • Corridor is at least 6 feet wide. • Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols. • Dispensers shall have a minimum of four foot horizontal spacing. • Not more than an aggregate of 10 gallons of fluid or 1135 ouncesof aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room. • Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30. • Dispensers are not installed within 1 inch of an ignition source. • If floor is carpeted, the building is fully sprinkler protected.. • ABHR does not exceed 95 percent alcohol. • Operation of the dispenser shall comply with Section 20.3.2.6(11) or 21.3.2.6(11). • ABHR is protected against inappropriate access. 20.3.2.6, 21.3.2.6, 8.7.3.1, CFR 416.44	HAP 482.41(b)(7) CAH 485.623(c)(5)	**PE.03.01.01** The hospital/CAH addresses life safety from fire. **EP 7** When the hospital/CAH installs alcohol-based hand rub dispensers, it installs the dispensers in a manner that protects against inappropriate access.	
K331	**Interior Wall and Ceiling Finish** **2012 EXISTING** Interior wall and ceiling finishes in exits and exit access corridors shall have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	All other areas may be class C rated material. Indicate flame spread rating(s) walls. _ _ 20.3.3, 21.3.3, 38.3.3, 39.3.3, 10.2			
K332	**Interior Floor Finish** **2012 NEW (N/A for 2012 EXISTING)** Interior floor finish in exit enclosures must meet 10.2 and be Class I or Class II. All other areas must meet 10.2.7.1 or 10.2.7.2. Indicate rating(s) for floors 20.3.3, 21.3.3, 38.3.3, 39.3.3, 10.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K341	**Fire Alarm System – Installation** A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, *National Electric Code,* and NFPA 72, *National Fire Alarm Code* to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring, or other transmission paths are monitored for integrity. 20.3.4.2.1, 21.3.4.1, 9.6	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K342	**Fire Alarm System – Initiation** Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit and 200 ft travel distance is not exceeded. 20.3.4.2, 21.3.4.2, 9.6.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K343	**Fire Alarm – Notification** **2012 EXISTING** A positive alarm sequence in accordance with 9.6.3.4 is permitted. Occupant notification is provided automatically, without delay, in accordance with 9.6.3. Fire department notification is accomplished automatically per 9.6.4. Smoke detection devices or systems equipped with reconfirmation	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	features shall not be required to automatically notify the fire department, unless the alarm condition is reconfirmed within 120 seconds (2 minutes) 21.3.4.3 through 21.3.4.3.2.2, 9.6.3, 9.6.4 **2012 NEW** A positive alarm sequence in accordance with 9.6.3.4 is permitted. Occupant notification is provided automatically, without delay, in accordance with 9.6.3. Fire department notification is accomplished automatically per 9.6.4. 20.3.4.3 through 20.3.4.3.2.1, 9.6.3, 9.6.4			
K344	**Fire Alarm – Control Functions** The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 20.3.4.4, 21.3.4.4	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K345	**Fire Alarm System – Testing and Maintenance** A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, *National Electric Code,* and NFPA 72, *National Fire Alarm and Signaling Code.* Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	
	The hospital maintains fire safety equipment and fire safety building features by testing the following every 12 months: - Duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors on the inventory - Visual and audible fire alarms (including speakers and door-releasing devices on the inventory) - Fire alarm equipment on the inventory for notifying off-site responders - Automatic smoke-detection shutdown devices for air-handling equipment Note: For additional guidance on duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors; visual and audible fire alarms; and fire alarm equipment, see NFPA 72-2010: Table 14.4.5; 17.14.	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	TJC EP	Comments
K346	**Fire Alarm – Out of Service** Fire alarms that are out of service for 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.9.6.1.6	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K351	**Sprinkler System – Installation** Sprinkler systems (if installed) are installed per NFPA 13. Where more than two sprinklers are installed in a single area forprotection, waterflow devices shall be provided to sound the building fire alarm system or to notify a constantly attended location such as a PBX, security office, or emergency room. 20.3.5.1, 20.3.5.2, 21.3.5.1, 21.3.5.2, 9.7.1.2, 9.7, NFPA 13	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K353	**Sprinkler System – Maintenance and Testing** Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, *Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.* Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	
	The hospital maintains fire safety equipment and fire safety building features by testing the following based on the identified timeframes: - Supervisory signal devices on the inventory, quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices; semiannually for valve supervisory switches; and annually for other supervisory initiating devices Note: For supervisory signal devices, water storage tanks and associated water storage equipment do not require testing. For additional guidance on performing tests, see NFPA 72-	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	TJC EP	Comments
	2010: Table 14.4.5. The hospital maintains fire safety equipment and fire safety building features by testing the following every 12 months: - For automatic sprinkler systems, main drains at system low point or at all system risers - For automatic sprinkler systems, fire pumps under flow(fire pump supervisory signals for “pump running” and “pump power loss”) Note: For automatic sprinkler systems, main drains, and system risers, see NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1. Note 3: For automatic sprinkler system fire pumps, see NFPA 25-2011: 8.3.3; 8.3.3.4. The hospital maintains fire safety equipment and fire safety building features by testing the following based on the identified timeframes: - Vane-type and pressure-type water flow devices every 6 months - For automatic sprinkler systems, electric motor-driven fire pumps monthly and diesel engine-driven fire pumps every week under no-flow conditions - Hydrostatic and water flow for standpipe systems every 5 years - Automatic fire extinguishing systems (carbon dioxide systems every 12 months, halon systems every 6 months, other special systems per NFPA standards and manufacturer’s recommendations) - Hydrostatic tests on standpipe occupant hoses 5 years after installation and every 3 years thereafter Note 1: For vane-type and pressure-type water flow devices, mechanical water flow devices (including but not limited to water motor gongs) should be tested quarterly. (For full text, refer to NFPA 25-2011: Table 5.1.1.2). For additional guidance also see NFPA 72-2010: Table 14.4.5. Note 2: For hydrostatic tests on standpipe occupant hoses, see NFPA 1962-2008: Chapter 7 and NFPA 25-2011: Chapter 6 The hospital maintains fire safety equipment and fire safety building features by inspecting the following:			

K-tag	Code Requirement	CoP	TJC EP	Comments
	- For automatic sprinkler systems, all fire department water supply connections every quarter Note: For automatic sprinkler systems, see NFPA 25-2011: 13.7; Table 13.1.1.2.			
K354	**Sprinkler System – Out of Service** Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 9.7.5, 15.5.2 (NFPA 25)	HAP 482.41(b)(8)(i) HAP 482.41(b)(8)(ii) CAH 485.623(c)(6)(i) CAH 485.623(c)(6)(ii)	**PE.03.01.01** The hospital/CAH addresses life safety from fire. **EP 8** When a sprinkler system is shut down for more than 10 hours, the critical access hospital either evacuates the building or portion of the building affected by the system outage until the system is back in service or establishes a fire watch until the system is back in service.	
K355	**Portable Fire Extinguishers** Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, *Standard for Portable Fire Extinguishers.* 20.3.5.3, 21.3.5.3, 9.7.4.1, NFPA 10	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
	The hospital maintains fire safety equipment and fire safety building features by inspecting the following: - Portable fire extinguishers at least monthly (this includes recharging every 12 months) Note 3: For portable fire extinguishers, there are many ways to document the inspections, such as using bar-coding equipment, using check marks on a tag, or using an inventory. Inspections involve a visual check to determine correct type of and clear and unobstructed access to a fire extinguisher, in addition to a check for broken parts and full charge. For additional guidance on inspection of fire extinguishers, see NFPA 10-2010: 7.1.2; 7.2.2; 7.2.4; 7.3.1.	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	TJC EP	Comments
K362	**Corridors – Construction of Walls** 2012 NEW (Indicate N/A for 2012 EXISTING) Where access to exits is provided by corridors, such corridors shall be separated from use areas by a minimum 1-hour fire barrier constructed per section 8.3, unless one of the following exists: 1. Where exits are available from an open floor area 2. Where the entire space is a single tenant 3. Where the building is protected throughout by an approved automatic sprinkler system installed per 9.7.1.1(1) If the walls have a fire resistance rating, give the rating. 20.3.6.1, 38.3.6.1, 38.3.6.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K364	**Corridor - Openings** 2012 NEW (Indicate N/A for 2012 EXISTING) Miscellaneous openings, such as mail slots, pharmacy/laboratory/cashier pass-through windows, shall be permitted to be installed in vision panels or doors without special protection provided that they meet both of the following: 1) The aggregate opening does not exceed 20 square inches. 2) The opening is installed at or below half the distance from the floor to the ceiling. If the room is protected throughout by an automatic sprinkler system. The aggregate opening shall not exceed 80 square inches. 20.3.6.2.1, 20.3.6.2.2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K371	**Subdivision of Building Spaces – Smoke Compartments** Smoke compartments do not exceed 25,000 square feet in size. Every story shall be divided into not less than 2 smoke compartments unless one of the following conditions occur: ☐ Facility is less than 5,000 square feet protected by an approved smoke detection system. ☐ Facility is less than 10,000 square feet	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	protected by an approved, supervised sprinkler system per 9.7. ☐ Adjoining occupancy is used as a smoke compartment if all of the following are met: a. Separating wall is 1 hour fire resistive rated. b. Doors in the 1 hour rated wall at 1-3/4 inches thick. c. Doors in the 1 hour rated wall are self-closing. d. Windows in the 1 hour rated wall are fixed fire window assemblies per 8.3. e. The ambulatory health care facility is less than 22,500 square feet. f. Access from the ambulatory health care facility is unrestricted to another occupancy. 20.3.7.2, 21.3.7.2			
K372	**Subdivision of Building Spaces – Smoke Barrier Construction** **2012 EXISTING** Smoke barriers shall be constructed to a ½ hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 21.3.7.5, 21.3.7.6, 8.5 **2012 NEW** Smoke barriers shall be constructed to provide at least a 1-hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 20.3.7.5, 20.3.7.6, 8.5	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
	The hospital maintains fire safety equipment and fire safety building features by testing the following based on the identified timeframes: - Fire and smoke dampers 1 year after installation and at least every 6 years thereafter to verify they fully close Note: For operation of fire and smoke dampers, see NFPA	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	TJC EP	Comments
	90A-2012: 5.4.8; NFPA 80-2010: 19.4; NFPA 105-2010: 6.5.			
K374	**Subdivision of Building Spaces – Smoke Barrier Doors** **2012 EXISTING** Smoke barrier doors shall be a minimum of 1-3/4 inches thick, solid-bonded wood core or equivalent with self-closing or automatic-closing devices in accordance with 21.2.2.4. Latching hardware is not required. Doors are not required to swing in the direction of egress travel. 21.3.7.9, 21.3.7.10 **2012 NEW** Smoke barrier doors shall be a minimum of 1-3/4 inches thick, solid-bonded wood core or equivalent with self-closing or automatic-closing devices in accordance with 21.2.2.4. Latching hardware is not required. Doors are required to swing in the direction of egress travel. Rabbets, bevels, or astragals are at meeting edges, and stops are at the head and sides of door frames. Center mullions are prohibited in smoke barrier door openings. 20.3.7.9, 20.3.7.10, 20.3.7.13, 20.3.7.14	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K379	**Smoke Barrier Door Glazing** 2012 NEW (Indicate N/A for 2012 EXISTING) Cross-corridor swinging doors or cross corridor horizontal-sliding doors, contain a vision panel consisting of fire-rated glazing in approved frames in each door. Vision panels in any other door in the smoke barrier, if provided, shall be fire-rated glazing in approved frames. 20.3.7.11, 20.3.7.12, 21.3.7.7, 8.3	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
SECTION 4 – SPECIAL PROVISIONS				
K400	**Special Provisions – Other** Any LSC Section 20.4 and 21.4 Special Provisions requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K421	**High-Rise Buildings** **2012 EXISTING** High-rise buildings are protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.1.1(1), or an engineered life safety system complying with 39.4.2.1(2). 21.4, 39.4.2 **2012 NEW** High-rise buildings comply with section 11.8. 20.4, 38.4.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
SECTION 5 – BUILDING SERVICES				
K500	**Building Services – Other** Any LSC Section 20.5 and 21.5 Building Services requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K511	**Utilities – Gas and Electric** Equipment using gas or related gas piping complies with NFPA 54, *National Fuel Gas Code*, electrical wiring and equipment complies with NFPA 70, *National Electric Code*. Existing installations can continue in service provided no hazard to life. 20.5.1, 21.5.1, 9.1.1, 9.1.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K521	**HVAC** Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 20.5.2.1, 21.5.2.1, 9.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K522	**HVAC – Any Heating Device** Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: • is chimney or vent connected.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	• takes air for combustion from outside. • provides for a combustion system separate from occupied area atmosphere. 20.5.2.2, 20.5.2.2.1, 21.5.2.2, 21.5.2.2.1			
K523	**HVAC – Suspended Unit Heaters** Suspended unit heaters are permitted provided the following are met: • Not located in means of egress or in patient rooms. • Located high enough to be out of reach of people in the area. • Has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. 20.5.2.2.2, 21.5.2.2.2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K531	**Elevators** **2012 EXISTING** Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, *Safety Code for Elevators and Escalators.* Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 21.5.3, 9.4.2, 9.4.3 **2012 NEW** Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, *Safety Code for Elevators and Escalators.* Firefighter's Service is operated monthly with a written record. New elevators	HAP 482.41(b)(1)(i) HAP 482.41(d)(2) CAH 485.623(c)(1)(i) CAH 485.623(b)(1)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 2**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	conform to ASME/ANSI A17.1, *Safety Code for Elevators and Escalators,* including Firefighter's Service Requirements. (Includes firefighter's Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 20.5.3, 9.4.2, 9.4.3			
K532	**Escalators, Dumbwaiters, and Moving Walks** Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. (Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters, includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.) 20.5.3, 21.5.3, 9.4	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K541	**Rubbish Chutes, Incinerators, and Laundry Chutes** **2012 EXISTING** Rubbish chutes are installed per section 9.5: ☐ Walls, partitions, and inlet openings meet the requirements of 8.3. ☐ Doors of chutes open to a room designed exclusively for accessing the chute opening. ☐ Room used for accessing the chute opening(s) are separated from other spaces per 8.7. ☐ Chutes shall be permitted to open into rooms not exceeding 400 cubic feet in size if the room is sprinkler protected and the room is not used for storage. **OR** Existing installations having properly enclosed and maintained chute openings shall be permitted to have inlets open to a corridor or normally occupied space. 21.5.4, 9.5, NFPA 82 **2012 NEW**	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	Rubbish chutes are installed per section 9.5: ☐ Walls, partitions, and inlet openings meet the requirements of 8.3. ☐ Doors of chutes open to a room designed exclusively for accessing the chute opening. ☐ Room used for accessing the chute opening(s) are separated from other spaces per 8.7. ☐ Chutes shall be permitted to open into rooms not exceeding 400 cubic feet in size if the room is sprinkler protected and the room is not used for storage. ☐ Maintenance and installation are per NFPA 82. 20.5.4, 9.5, NFPA 82			
SECTION 7 – OPERATING FEATURES				
K700	**Operating Features – Other** Any LSC Section 20.7 and 21.7 Operating Features requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K711	**Evacuation and Relocation Plan** There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 20/21.7.2.1.2 and provides for all of the fire safety plan components per 20/21.7.2.2. 20.7.1.1 through 20.7.1.3, 20.7.1.8 through 20.7.2.3.3 21.7.1.1 through 20.7.1.3, 21.7.1.8 through 20.7.2.3.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K712	**Fire Drills** Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 20.7.1.4 through 20.7.1.7, 21.7.1.4 through 21.7.1.7 ***Varying conditions means: Fire drills vary by at least one hour for each shift from quarter to quarter through four consecutive quarters	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K741	**Smoking Regulations** Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 20.7.4, 21.7.4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K751	**Draperies, Curtains, and Loosely Hanging Fabrics** Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies at showers and baths. 20.7.5.1 through 20.7.5.3, 21.7.5.1 through 21.7.5.3	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K752	**Upholstered Furniture and Mattresses** Newly introduced upholstered furniture meets Class I or char length, and heat release criteria in accordance with 10.3.2.1 and 10.3.3, unless the building is fully sprinklered. Newly introduced mattresses shall meet char length and heat release criteria in accordance with 10.3.2.2 and 10.3.4, unless the building is fully sprinklered. Upholstered furniture and mattresses belonging to nursing home residents do not have to meet these requirements as all nursing homes are required to be fully sprinklered. Newly introduced upholstered furniture and mattresses means purchased on or after the LSC final rule effective date. 20.7.5.2, 20.7.5.3, 21.7.5.2, 21.7.5.3	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K753	**Combustible Decorations** Combustible decorations shall be prohibited unless one of the following is met: • Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. • Decorations meet NFPA 701. • Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. • The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 20.7.5.4, 21.7.5.4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K754	**Soiled Linen and Trash Containers** Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. 20.7.5.5, 21.7.5.5			
K761	**Maintenance, Inspection & Testing - Doors** Fire doors assemblies are inspected and tested annually in accordance with NFPA 80 *Standard for Fire Doors and Other Opening Protectives*. Fire doors that are not located in required fire barriers, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspection and testing have an understanding of the operating components of the doors. Written records of inspection and testing are maintained and are available for review. 20.7.6, 21.7.6, 8.3.3.1 (LSC), 5.2. 5.2.3 (NFPA 80)	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01, EP 2**	
	The hospital maintains fire safety equipment and fire safety building features by testing the following every 12 months: - Sliding and rolling fire doors, smoke barrier sliding or rolling doors, and sliding and rolling fire doors in corridor walls and partitions for proper operation and full closure - Fire door assemblies (inspection and testing) Note 5: For fire doors and smoke barrier doors, see NFPA 80-2010: 5.2.14.3; NFPA 105-2010: 5.2.1; 5.2.2. Note 6: For fire door assemblies, nonrated doors, including corridor doors to patient care rooms and smoke barrier doors, are not subject to the annual inspection and testing requirements of either NFPA 80 or NFPA 105. For hospitals that use Joint Commission accreditation for deemed status purposes: Nonrated doors should be routinely inspected and maintained in accordance with the facility maintenance program. For additional guidance on testing of door assemblies, see NFPA 101-2012: 7.2.1.5.10.1; 7.2.1.5.11; 7.2.1.15; NFPA 80-2010: 4.8.4; 5.2.1; 5.2.3; 5.2.4; 5.2.6; 5.2.7; 6.3.1.7; NFPA 105-2010: 5.2.1. The critical access hospital maintains fire safety equipment	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	TJC EP	Comments
	and fire safety building features by inspecting the following: - Fire door assemblies annually by a qualified individual (testing begins with a pre-test visual inspection and includes both sides of the opening)			
K771	**Engineer Smoke Control Systems** When installed, engineered smoke control systems are tested in accordance with established engineering principles. Test documentation is maintained on the premises. 20.7.7.1 through 20.7.7.3, 21.7.7.1 through 21.7.7.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K781	**Portable Space Heaters** Portable space heating devices shall be prohibited in all health care occupancies. Unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 20.7.8, 21.7.8	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K791	**Construction, Repair, and Improvement Operations** Construction, repair, and improvement operations shall comply with 4.6.10. Any means of egress in any area undergoing construction, repair, or improvements shall be inspected daily to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241. 20.7.9.1, 20.7.9.2, 21.7.9.1, 21.7.9.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
	The hospital does not remove or minimize an existing life safety feature when such feature is a requirement for new construction. Existing life safety features, if not required by the Life Safety Code, can be either maintained or removed. (For full text, refer to NFPA 101-2012: 4.6.12.2; 4.6.12.3; 18/19.7.9)	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
PART II – HEALTH CARE FACILITIES CODE REQUIREMENTS				

K-tag	Code Requirement	CoP	TJC EP	Comments
K900	**Health Care Facilities Code - Other** Any NFPA 99 requirements (excluding Chapter 7, 8, 12, and 13) that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Health Care Facilities Code or NFPA standard citation, should be included in the finding.	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K901	**Fundamentals – Building System Categories** Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K902	**Gas and Vacuum Piped Systems – Other** Any NFPA 99 Chapter 5 Gas and Vacuum Systems requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding. Chapter 5 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K903	**Gas and Vacuum Piped Systems – Categories** Medical gas, medical air, surgical vacuum, WAGD, and air supply systems are designated: ☐ Category 1. Systems in which failure is likely to cause major injury or death. ☐ Category 2. Systems in which failure is likely to cause minor injury. ☐ Category 3. Systems in which failure is not likely to cause injury but can cause discomfort. Deep sedation and general anesthesia are not to be administered using a Category 3 medical gas system. 5.1.1.1, 5.2.1, 5.3.1.1, 5.3.1.5 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K904	**Gas and Vacuum Piped Systems – Warning Systems** All master, area, and local alarm systems used for medical gas and vacuum systems comply with appropriate Category warning system requirements, as applicable. 5.1.9, 5.2.9, 5.3.6.2.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K905	**Gas and Vacuum Piped Systems – Central Supply System Identification and Labeling** Containers, cylinders and tanks are designed, fabricated, tested, and marked in accordance with 5.1.3.1.1 through 5.1.3.1.7. Locations containing only oxygen or medical air have doors labeled with "Medical Gases, NO Smoking or Open Flame". Locations containing other gases have doors labeled "Positive Pressure Gases, NO Smoking or Open Flame, Room May Have Insufficient Oxygen, Open Door and Allow Room to Ventilate Before Opening." 5.1.3.1, 5.2.3.1, 5.3.10 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K906	**Gas and Vacuum Piped Systems – Central Supply System Operations** Adaptors or conversion fittings are prohibited. Cylinders are handled in accordance with 11.6.2. Only cylinders, reusable shipping containers, and their accessories are stored in rooms containing central supply systems or cylinders. No flammable materials are stored with cylinders. Cryogenic liquid storage units intended to supply the facility are not used to transfill. Cylinders are kept away from sources of heat. Valve protection caps are secured in place, if supplied, unless cylinder is in use. Cylinders are not stored in tightly closed spaces. Cylinders in use and storage are prevented from exceeding 130°F, and nitrous oxide and carbon dioxide cylinders are prevented from reaching temperatures lower than manufacture recommendations or 20°F. Full or empty cylinders, when not connected, are stored in locations complying with 5.1.3.3.2 through 5.1.3.3.3, and are not stored in enclosures containing motor-driven machinery, unless for instrument air reserve headers. 5.1.3.2, 5.1.3.3.17, 5.1.3.3.1.8, 5.1.3.3.4, 5.2.3.2, 5.2.3.3, 5.3.6.20.4, 5.6.20.5, 5.3.6.20.7, 5.3.6.20.8, 5.3.6.20.9 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K907	**Gas and Vacuum Piped Systems – Maintenance Program** Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations.	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses building safety and facility management. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	TJC EP	Comments
	Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99)			
K908	**Gas and Vacuum Piped Systems – Inspection and Testing Operations** The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99)	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01, EP 2**	
K909	**Gas and Vacuum Piped Systems – Information and Warning Signs** Piping is jued by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (Table 5.1.11), and operating pressure if other than standard. Labels are at intervals not more than 20 feet, are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency. 5.1.14.3, 5.1.11.1, 5.1.11.2, 5.2.11, 5.3.13.3, 5.3.11 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K910	**Gas and Vacuum Piped Systems – Modifications** Whenever modifications are made that breach the pipeline, any necessary installer and verification test specified in 5.1.2 is conducted on the downstream portion of the medical gas piping system. Permanent records of all tests required by system verification tests are maintained. 5.1.14.4.1, 5.1.14.4.6, 5.2.13, 5.3.13.4.3 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K911	**Electrical Systems – Other** Any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding. Chapter 6 (NFPA 99)	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K912	**Electrical Systems – Receptacles** Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, playrooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K913	**Electrical Systems – Wet Procedure Locations** Operating rooms are considered wet procedure locations, unless otherwise determined by a risk assessment conducted by the facility governing body. Operating rooms defined as wet locations are protected by either isolated power or ground-fault circuit interrupters. A written record of the risk assessment is maintained and available for inspection. 6.3.2.2.8.4, 6.3.2.2.8.7, 6.4.4.2	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K914	**Electrical Systems – Maintenance and Testing** Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of ≤ 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals ≤ 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01, EP 2**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)			
K915	**Electrical Systems – Essential Electric System Categories** ☐ Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. ☐ General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. ☐ Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1 1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K916	**Electrical Systems – Essential Electric System Alarm Annunciator** A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K917	**Electrical Systems – Essential Electric System Receptacles** Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

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

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

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

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

K-tag	Code Requirement	CoP	TJC EP	Comments
	11.5.2.1 (NFPA 99)			
K927	**Gas Equipment – Transfilling Cylinders** Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, *Transfilling of High-Pressure Gaseous Oxygen Used for Respiration*. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K928	**Gas Equipment – Labeling Equipment and Cylinders** Equipment listed for use in oxygen-enriched atmospheres are so labeled. Oxygen metering equipment and pressure reducing regulators are labeled "OXYGEN-USE NO OIL". Flowmeters, pressure reducing regulators, and oxygen-dispensing apparatus are clearly and permanently labeled designating the gases for which they are intended. Oxygen-metering equipment, pressure reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier. Cylinders and containers are labeled in accordance with CGA C-7. Color coding is not utilized as the primary method of determining cylinder or container contents. All labeling is durable and withstands cleaning or disinfecting. 11.5.3.1 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K929	**Gas Equipment – Precautions for Handling Oxygen Cylinders and Manifolds** Handling of oxygen cylinders and manifolds is based on CGA G-4, Oxygen. Oxygen cylinders, containers, and associated equipment are protected from contact with oil and grease, from contamination, protected from damage, and handled with care in accordance with precautions provided under 11.6.2.1 through 11.6.2.4 (NFPA 99). 11.6.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

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

K-tag	Code Requirement	CoP	TJC EP	Comments
	○ policies and procedures are established outlining safety precautions related to the use of flammable germicide or antiseptic use. Procedures are established for operating room emergencies including alarm activation, evacuation, equipment shutdown, and control operations. Emergency procedures include the control of chemical spills, and extinguishment of drapery, clothing and equipment fires. Training is provided to new OR personnel (including surgeons), continuing educationis provided, incidents are reviewed monthly, and procedures are reviewed annually. 15.13 (NFPA 99) ***The preoperative time-out is addressed by the clinical surveyor.			
	The hospital labels utility system controls to facilitate partial or complete emergency shutdowns. Note 1: Examples of utility system controls that should be labeled are utility source valves, utility system main switches and valves, and individual circuits in an electrical distribution panel. Note 2: For example, the fire alarm system's circuit is clearly labeled as Fire Alarm Circuit; the disconnect method (that is, the circuit breaker) is marked in red; and access is restricted to authorized personnel. Information regarding the dedicated branch circuit for the fire alarm panel is located in the control unit. For additional guidance, see NFPA 101-2012: 18/19.3.4.1; 9.6.1.3; NFPA 72-2010: 10.5.5.2.	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

Fire Drill Matrix

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

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

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

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

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

1st	
2nd	
3rd	

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

Hospital Physical Environment Document List & Review Tool

Revised - Effective: 4/20/2024

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

Please conduct during Facility Orientation.

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

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

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

Please conduct after Facility Orientation, during Document Review activity.

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

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Q1 Semi	Q2	Q3 Semi	Q4 Annual
	C	NC	NA	IOU						
PE.04.01.01					**Fire Protection and Suppression Testing and Inspection**					
EP 2					NFPA 72-2010: Table 14.4.5 NFPA 25-2011: Table 5.1.1.2					
					Tamper switches NFPA 72-2010: Table 14.4.5	Semiannual				
EP 2					Duct, heat, smoke detectors, and manual fire alarm boxes NFPA 72-2010: Table 14.4.5; 17.14	Annually				
EP 2					Notification devices (audible & visual), and door-releasing devices NFPA 72-2010: Table 14.4.5	Annually				
EP 2					Emergency services notification transmission equipment NFPA 72-2010: Table 14.4.5	Annually				
EP 2					Electric motor-driven fire pumps tested under no-flow conditions NFPA 25-2011: 8.3.1; 8.3.2	Monthly				
					Diesel-engine-driven fire pumps tested under no-flow conditions NFPA 25-2011: 8.3.1; 8.3.2	Weekly				
EP 2					Sprinkler systems main drain tests on all risers NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1	Annually				
EP 2					Fire department connections inspected (Fire hose connections N/A) NFPA 25-2011: 13.7; Table 13.1.1.2	Quarterly				
EP 2					Fire pump(s) tested – under flow Fire pump supervisory signals for pump running and pump power loss tested NFPA 25-2011: 8.3.3; 8.3.3.4	Annually				
EP 2					Standpipe flow test every 5 years	5 years				

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Q1 Semi	Q2	Q3 Semi	Q4 Annual
PE.04.01.01					**Fire Protection and Suppression Testing and Inspection**					
					NFPA 25-2011: 6.3.1; 6.3.2; Table 6.1.1.2					
EP 2					Kitchen suppression semi-annual testing NFPA 96-2011: 11.2	Semiannual				
EP 2					Carbon dioxide systems tested NFPA 12-2011:4.8.3.2	Annually				
					Halon systems NFPA 12A-2009: 6.1	Semiannual				
					Other special systems per National Fire Protection Association standards and manufacturers' recommendations NFPA 11-2010; NFPA 16-2011; NFPA 17-2009; NFPA 17A-2009					
EP 2					Portable fire extinguishers inspected monthly NFPA 10-2010: 7.2.2; 7.2.4	Monthly				
EP 2					Portable fire extinguishers maintained annually NFPA 10-2010: 7.1.2; 7.2.2; 7.2.4; 7.3.1	Annually				
EP 2					Fire hoses hydro tested 5 years after install; every 3 years thereafter NFPA 1962-2008: Chapter 7 and NFPA 25-2011: Chapter 6	5 years / 3 years				
EP 2					Smoke and fire dampers tested to verify full closure NFPA 90A-2012: 5.4.8; NFPA 80-2010: 19.4; NFPA 105-2010: 6.5	1 year after install				
						At least every 6 years thereafter				
EP 2					Smoke detection shutdown devices for HVAC tested NFPA 90A-2012: 6.4.1	Annually				
EP 2					All horizontal and vertical roller and slider doors tested	Annually				

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

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
PE.03.01.01 EP 3 and PE.04.01.01 EP 1					**Emergency Power Systems are Maintained and Tested**			
EP 3 or EP1					At least monthly performs functional test of emergency lighting systems and exit signs	Monthly		

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
PE.03.01.01 EP 3 and PE.04.01.01 EP 1					Emergency Power Systems are Maintained and Tested			
					required for egress and task lighting for a minimum duration of 30 seconds, along with a visual inspection of other exit signs NFPA 101-2012: 7.9.3; 7.10.9; NFPA 99-2012: 6.3.2.2.11.5			
EP 3 or EP1					Every 12 months performs functional test of battery powered lights on the inventory required for egress and exit signs for a duration of 1 ½ hours For new construction, renovation, or modernization battery-powered lighting in locations where deep sedation and general anesthesia are administered is tested annually for 30 minutes with test results and completion dates documented NFPA 101-2012: 7.9.3; 7.10.9; NFPA 99-2012: 6.3.2.2.11.5	Annually		
EP 3 or EP1					Functional test of Level 1 SEPSS, monthly; Level 2 SEPSS, quarterly, for 5 minutes or as specified for its class Annual test at full load for 60% of full duration of its class NFPA 111-2010: 8.4	Monthly Quarterly Annually		
					Note 1: Non-SEPSS tested per manufacturer's specifications	Per Mfr.		
					Note 2: Level 1 SEPSS defined for critical areas and equipment			
					Note 3: Class defines minimum time which SEPSS is designed to operate at rated load without recharging			
EP 3 or EP1					Emergency power supply system (EPSS) inspected weekly, including all associated components and batteries NFPA 110-2010: 8.3.1; 8.3.3; 8.3.4; 8.4.1	Weekly		

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

STANDARD - EPs	See Legend				Document / Requirement	THIS MAY BE SCORED AS CONDITIONAL OR STANDARD			Testing Dates
	C	NC	NA	IOU			Yes	No	
PE.04.01.01					**Medical Gas and Vacuum Systems are Inspected and Tested**				
EP 3					**Test, inspect and** maintain critical components of piped medical gas and vacuum systems, waste anesthetic gas disposal (WAGD), and support gas systems on the inventory. Inventory of critical components includes at least all source subsystems, control valves, alarms, manufactured assemblies containing patient gases, and inlets and outlets with activities, dates and results documented No prescribed frequency; recommend risk assessment if < annual NFPA 99-2012: 5.1.14.2; 5.1.15; 5.2.14; 5.3.13	Per policy			
EPs 1, 3					Location of and signage for bulk oxygen systems NFPA 99-2012: 5.1.3.5.12	On Bldg. Tour			
EPs 1, 3					Emergency oxygen supply connection NFPA 99-2012: 5.1.3.5.13	On Bldg. Tour			
EPs 1, 3					Review medical gas installation/modification/breech certification results for cross connection, purity, correct gas, and pressure NFPA 99-2012: 5.1.2; 5.1.4; 5.1.14.4.1; 5.1.14.4.6; 5.2.13	As applicable			
EP 1					Medical gas supply and zone valves are accessible and clearly labeled NFPA 99-2012: Table 5.1.11 NFPA 99-2012: 5.1.4; 5.1.11.1; 5.1.11.2; 5.1.14.3; 5.2.11; 5.3.13.3; 5.3.11	On Bldg. Tour			
EP 1					Handling, transfer, storage, labeling, transfilling of cylinders NFPA 99-2012: 11.5.3.1; 11.6.1; 11.6.2; 11.6.5; 11.7.3	Per policy			

STANDARD - EPs	See Legend				Document / Requirement	THIS MAY BE SCORED AS CONDITIONAL OR STANDARD			Testing Dates
	C	NC	NA	IOU			Yes	No	
PE.04.01.01					Medical Gas and Vacuum Systems are Inspected and Tested				
COMMENTS:									

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Q1	Q2	Q3	Q4 Annual
	C	NC	NA	IOU						
PE.03.01.01					Fire Drills					
EP 3					Fire drills once per shift per quarter in health care occupancies; Quarterly in each building defined as ambulatory health care occupancy (If available, please provide five quarters of fire drill data) NFPA 101-2012: 18/19: 7.1.7	Quarterly				
EP 3					Fire drills every 12 months from date of last drill: Business Occupancies	Annually				
EP 3					When quarterly fire drills are required, ALL are unannounced • Drills held at unexpected times and under varying conditions – at least one hour apart for each shift from quarter to quarter through four consecutive quarters • Drills include transmission of fire alarm signal and simulation of emergency fire conditions NFPA 101-2012: 18/19: 7.1.7; 7.1; 7.2; 7.3	Quarterly (See fire drill matrix)				
PE.04.01.01 EP 1					Fire exit drills for operating rooms/surgical suites. NFPA 99-2012: 15.13.3.10.3	Annually				

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

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

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

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Yes	No
PE.04.01.01					Management of Medical Equipment Risks		
EP 2					Non-deemed status requirement: Maintains either a written inventory of all medical equipment or a written inventory of selected equipment categorized		

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

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

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
PE.04.01.01					Medical equipment inspection, testing and maintenance			
EP 1, 2					All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99-2012: Chapter 14.			
COMMENTS:								

STANDARD - EPs	See Legend C	NC	NA	IOU	Document / Requirement	Frequency	Yes	No / Missing Date
PE.04.01.01					Utility system Inspection, testing and maintenance			
EP 2					High-risk utility system components on the inventory with completion date and results of activities documented Note 1: A high-risk utility system includes components for which there is a risk of serious injury or even death to a patient or staff member should it fail, which includes life-support equipment. Note 2: Required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components must have a 100% completion rate.			
EP 2					Infection control utility system components on the inventory with completion date and results of activities documented Note 1: Required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components must have a 100% completion rate.			
EP2					Non-high-risk utility system components on the inventory with completion date and results of activities documented			
EP 2					Line isolation monitors (LIM), if installed, are tested at least monthly by actuating the LIM test switch. For LIM circuits with automated self-testing, a manual test is performance at least annually.			

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
PE.04.01.01					**Utility system Inspection, testing and maintenance**			
					NFPA 99-2012: 6.3.2; 6.3.3; 6.3.3.3.2; 6.3.4			
COMMENTS:								

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
NPG.11.01.01 NPG.02.04.01					**The hospital manages security risks.**			
EP 2					The hospital has written procedures to follow in the event of a security incident, including an infant or pediatric abduction.			
EP 3					The hospital conducts an annual worksite analysis related to its workplace violence prevention program. The hospital takes actions to mitigate or resolve the workplace violence safety and security risks based upon findings from the analysis. Note: A worksite analysis includes a proactive analysis of the worksite, an investigation of the hospital's workplace violence incidents, and an analysis of how the program's policies and procedures, training, education, and environmental design reflect best practices and conform to applicable laws and regulations.			
COMMENTS:								

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
NPG.11.01.01					The hospital collects information to monitor conditions in the environment.			
EP 1					EP 1 (current EC.4.1.1 EP 1) The hospital develops and implements processes for monitoring, internally reporting, and investigating the following: - Injuries to patients or others within the hospital's facilities - Occupational illnesses and staff injuries - Incidents of damage to its property or the property of others - Safety and security incidents involving patients, staff, or others within its facilities, including those related to workplace violence - Hazardous materials and waste spills and exposures - Fire safety management problems, deficiencies, and failures - Medical or laboratory equipment management problems, failures, and use errors - Utility systems management problems, failures, or use errors			

STANDARD - EPs	See Legend				Document / Requirement	Addressed in policy?		Implemented as required?	
	C	NC	NA	IOU		Yes	No	Yes	No
PE.03.02.01					Interim Life Safety Measures (ILSM)				
EP 1					ILSM policy identifying when and to what extent ILSM implemented				
PE.03.01.01 EP 8 and PE.03.02.01EP 2					Alarms out of service 4 or more hours in 24 hours or sprinklers out of service more than 10 hours in 24 hours in an occupied building - Fire watch / Fire Dept. notification NFPA 101-2012: 9.6.1.6; 9.7.6; NFPA 25-2011: 15.5.2				
EP 3					Signs for alternate exits posted				
EP 4					Daily inspection of routes of egress (See also 19.7.9.2 RE: daily inspections)				
EP 5					Temporary but equivalent systems while system is impaired				
EP 6					Additional firefighting equipment provided				
EP 7					Smoke tight non-combustible temporary barriers				

STANDARD - EPs	See Legend				Document / Requirement	Addressed in policy?		Implemented as required?	
	C	NC	NA	IOU		Yes	No	Yes	No
PE.03.02.01					Interim Life Safety Measures (ILSM)				
EP 8					Increased surveillance implemented				
EP 9					Storage and debris removal				
EP 10					Additional training on firefighting equipment				
EP 11					Additional fire drill per shift per quarter				
EP 12					Temporary systems tested and inspected monthly				
EP 13					Additional training on building deficiencies, construction hazards, temp measures				
EP 14					Training for impaired structural or impaired compartment fire safety features				
EP 15					Other ILSM's				
COMMENTS:									

NOTE: Please complete the following during building tour

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

Health Care Occupancy LSC and HCFC Evaluation Tool

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

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

K-tag	Code Requirement	CoP	TJC EP	Comments
SECTION 1 – GENERAL REQUIREMENTS				
K100	**General Requirements – Other** Any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01** The hospital/CAH addresses life safety from fire. **EP 3** The hospital/CAH meets the applicable provisions of the Life Safety Code (NFPA 101: 2012 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4).	
K111	**Building Rehabilitation** ***Repair, Renovation, Modification, or Reconstruction*** Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: Requirements of Chapter 18 and 19. Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6. 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 ***Change of Use or Change of Occupancy*** Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2. 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7) ***Additions*** Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01** The hospital/CAH addresses building safety and facility management. **EP 1** The hospital/CAH meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2,	

K-tag	Code Requirement	CoP	TJC EP	Comments
	having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2-hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8)			
K112	**Sprinkler Requirements for Major Rehabilitation** If a non-sprinklered smoke compartment has undergone major rehabilitation the automatic sprinkler requirements of 18.3.5 have been applied to the smoke compartment. In cases where the building is not protected throughout by a sprinkler system, the requirements of 18.4.3.2, 18.4.3.3, and 18.4.3.8 are also met. Note: Major rehabilitation involves the modification of more than 50 percent, or more than 4500 ft^2 of the area of the smoke compartment. 18.1.1.4.3.3, 19.1.1.4.3.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K131	**Multiple Occupancies – Sections of Health Care Facilities** Sections of health care facilities classified as other occupancies meet all of the following: • They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. • They are separated from areas of health care occupancies by construction having a minimum two-hour fire resistance rating in accordance with Chapter 8. • The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

<table>
<tr><th>K-tag</th><th>Code Requirement</th><th>CoP</th><th>TJC EP</th><th>Comments</th></tr>
<tr><td>K132</td><td>Multiple Occupancies – Contiguous Non-Health Care Occupancies
Non-health care occupancies that are located immediately next to a Health Care Occupancy but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than two-hour fire resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.4.1, 19.1.3.4.1</td><td>HAP 482.41(b)(1)(i)
CAH 485.623(c)(1)(i)</td><td>PE.03.01.01, EP 3</td><td></td></tr>
<tr><td>K133</td><td>Multiple Occupancies – Construction Type
Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a two-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows:
The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1.
The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters.
18.1.3.5, 19.1.3.5, 8.2.1.3</td><td>HAP 482.41(b)(1)(i)
CAH 485.623(c)(1)(i)</td><td>PE.03.01.01, EP 3</td><td></td></tr>
<tr><td>K161</td><td>Building Construction Type and Height
2012 EXISTING
Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7, 19.1.6.4, 19.1.6.5<table><tr><td></td><td></td><td>Construction Type</td><td></td></tr><tr><td>1</td><td></td><td>I (442), I (332), II (222)</td><td>Any number of stories non-sprinklered or sprinklered</td></tr><tr><td>2</td><td></td><td>II (111)</td><td>One story non-sprinklered Maximum 3 stories sprinklered</td></tr><tr><td>3</td><td></td><td>II (000)</td><td></td></tr></table></td><td>HAP 482.41(b)(1)(i)
CAH 485.623(c)(1)(i)</td><td>PE.03.01.01, EP 3</td><td>Determine type of building construction and where you would be able to confirm by direct observation the structure and building materials used in constructing the building (exposed areas above the ceilings or vertical pipe shafts may provide insight).

Visit areas where you can confirm by direct</td></tr>
</table>

K-tag	Code Requirement	CoP	TJC EP	Comments

4		III (211)	Not allowed non-sprinklered Maximum 2 stories sprinklered
5		IV (2HH)	
6		V (111)	
7		III (200)	Not allowed non-sprinklered Maximum 1 story sprinklered
8		V (000)	

Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)

2012 NEW

Building construction type and stories meets Table 18.1.6.1, unless otherwise permitted by 18.1.6.2 through 18.1.6.7 18.1.6.4, 18.1.6.5

		Construction Type	
1		I (442), I (332), II (222)	Not allowed non-sprinklered Any number of stories sprinklered
2		II (111)	Not allowed non-sprinklered Maximum 3 stories sprinklered
3		II (000)	Not allowed non-sprinklered Maximum 1 story sprinklered
4		III (211)	
5		IV (2HH)	
6		V (111)	
7		III (200)	Not allowed non-sprinklered
8		V (000)	

Sprinklered stories must be sprinklered throughout by an approved supervised automatic system in accordance with section 9.7. (See 18.3.5)

observation the structure and building materials used in constructing the building (exposed areas above the ceilings or vertical pipe shafts may provide insight).

K-tag	Code Requirement	CoP	TJC EP	Comments
K162	**Roofing Systems Involving Combustibles** **2012 EXISTING** Buildings of Type I (442), Type I (332), Type II (222), or Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following: 1. roof covering meets Class C requirements. 2. roof is separated from occupied building portions with a noncombustible floor assembly using not less than 2½ inches concrete or gypsum fill. 3. attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. 19.1.6.2*, ASTM E108, ANSI/UL 790 **2012 NEW** Buildings of Type I (442), Type I (332), Type II (222), Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following: 1. roof covering meets Class A requirements. 2. roof is separated from occupied building portions with 2-hour fire resistive noncombustible floor assembly using not less than 2½ inches concrete or gypsum fill. 3. the structural elements supporting the rated floor assembly meet the required fire resistance rating of the building. 18.1.6.2, ASTM E108, ANSI/UL 790	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K163	**Interior Nonbearing Wall Construction** Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls required to have a minimum 2-hour fire resistance rating are permitted to be fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. 18.1.6.4, 18.1.6.5, 19.1.6.4, 19.1.6.5	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
SECTION 2 – MEANS OF EGRESS REQUIREMENTS				

K-tag	Code Requirement	CoP	TJC EP	Comments
K200	**Means of Egress Requirements – Other** Any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K211	**Means of Egress – General** Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K221	**Patient Sleeping Room Doors** Locks on patient sleeping room doors are not permitted unless the key- locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K222	**Egress Doors** Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: ☐ CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 ☐ SPECIAL NEEDS LOCKINGARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 ☐ DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ☐ ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ☐ ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
K223	**Doors with Self-Closing Devices** Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: • Required manual fire alarm system; and • Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and • Automatic sprinkler system, if installed; and	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	• Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8			
K224	**Horizontal-Sliding Doors** Horizontal-sliding doors permitted by 7.2.1.14 that are not automatic-closing are limited to a single leaf and shall have a latch or other mechanism to ensure the door will not rebound. Horizontal-sliding doors serving an occupant load fewer than 10 shall be permitted, providing all of the following criteria are met: • Area served by the door has no high hazard contents. • Door is operable from either side without special knowledge oreffort. • Force required to operate the door in the direction of travel is ≤ 30 lbf to set the door in motion and ≤ 15 lbf to close or open to the required width. • Assembly is appropriately fire rated, and where rated, is self-or automatic-closing by smoke detection per 7.2.1.8, and installed per NFPA 80. • Where required to latch, the door has a latch or other mechanism to ensure the door will not rebound. 18.2.2.2.10, 19.2.2.2.10	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K225	**Stairways and Smokeproof Enclosures** Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K226	**Horizontal Exits** Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K227	**Ramps and Other Exits** Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K231	**Means of Egress Capacity** The capacity of required means of egress is in accordance with 7.3. 18.2.3.1, 19.2.3.1	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K232	**Aisle, Corridor or Ramp Width** **2012 EXISTING** The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of non-ambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 **2012 NEW** The width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet, except as modified by the 18.2.3.4 or 18.2.3.5 exceptions. 18.2.3.4, 18.2.3.5	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K233	**Clear Width of Exit and Exit Access Doors** **2012 EXISTING** Exit access doors and exit doors are of the swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. 19.2.3.6, 19.2.3.7 **2012 NEW** Exit access doors and exit doors are of the swinging type and are at least 41.5 inches in clear width. In psychiatric hospitals or limited care facilities, doors are at least 32 inches wide. Doors	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	not subject to patient use, in exit stairway enclosures, or serving newborn nurseries shall be no less than 32 inches in clear width. If using a pair of doors, the doors shall be provided with a rabbet, bevel, or astragal at the meeting edge, at least one of the doors shall provide 32 inches in clear width, and the inactive leaf of the pair shall be secured with automatic flush bolts. 18.2.3.6, 18.2.3.7			
K241	**Number of Exits – Story and Compartment** Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K251	**Dead-End Corridors and Common Path of Travel** **2012 EXISTING** Dead-end corridors shall not exceed 30 feet. Existing dead-end corridors greater than 30 feet shall be permitted to be continued to be used if it is impractical and unfeasible to alter them. 19.2.5.2 **2012 NEW** Dead-end corridors shall not exceed 30 feet. Common path of travel shall not exceed 100 feet. 18.2.5.2, 18.2.5.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K252	**Number of Exits – Corridors** Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K253	**Number of Exits – Patient Sleeping and Non-Sleeping Rooms** Patient sleeping rooms of more than 1,000 square feet or nonsleeping rooms of more than 2,500 square feet have at least two exit access doors remotely located from each other. 18.2.5.5.1, 18.2.5.5.2, 19.2.5.5.1, 19.2.5.5.2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K254	**Corridor Access** All habitable rooms not within suites have a door leading directly outside to grade or have a door leading to an exit access corridor. Patient sleeping rooms with less than eight patient beds may have one room intervening to reach an exit access corridor provided the intervening room is equipped with an approved automatic smoke detection system. 18.2.5.6.1 through 18.2.5.6.4, 19.2.5.6.1 through 19.2.5.6.4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K255	**Suite Separation, Hazardous Content, and Subdivision** All suites are separated from the remainder of the building (including from other suites) by construction meeting the separation provisions for corridor construction (18.3.6.2-18.3.6.5 or 19.3.6.2-19.3.6.5). Existing approved barriers shall be allowed to continue to be used provided they limit the transfer of smoke. Intervening rooms have no hazardous areas and hazardous areas within suites comply with 18/19.2.5.7.1.3. Subdivision of suites shall be by noncombustible or limited-combustible construction. 18.2.5.7.1.2 through 18.2.5.7.1.4, 19.2.5.7.1.2, 19.2.5.7.1.3, 19.2.5.7.1.4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K256	**Sleeping Suites** Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where ≥ 2 exits are required, one exit access door may be to a stairway, passageway or to the exterior. Suites shall be provided with constant staff supervision. Staff shall have direct visual supervision of patient sleeping rooms, from a constantly attended location or the room shall be provided with an automatic smoke detection system. Suites more than 1,000 ft² shall have 2 or more remote exits. One means of egress from the suite shall be to a corridor and one may be into an adjacent suite separated in accordance with corridor requirements. Suites shall not exceed the following size limitations: • 5,000 square feet if the suite is not fully smoke detected or fully sprinklered. • 7,500 square feet if the suite is either fully smoke detected or fully sprinklered. • 10,000 square feet if the suite is both fully smoke	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	detected and fully sprinklered and the sleeping rooms have direct supervision from a constantly attended location. Travel distance between any point in a suite to exit access shall not exceed 100 feet and distance to an exit shall not exceed 150 feet (200 feet if building is fully sprinklered). 18.2.5.7.2, 19.2.5.7.2			
K257	**Non-Sleeping Suites** Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where ≥ 2 exits are required, one exit access door may be to a stairway, passageway or to the exterior. Suites more than 2,500 ft² shall have 2 or more remote exits. One means of egress from the suite shall be to a corridor and one may be into an adjacent suite separated in accordance with corridor requirements. Suites shall not exceed 10,000 ft². Travel distance between any point in a suite to exit access shall not exceed 100 feet and distance to an exit shall not exceed 150 feet (200 feet if building is fully sprinklered). 18.2.5.7.3, 19.2.5.7.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K261	**Travel Distance to Exits** Travel distance (excluding suites) to exits are measured in accordance with 7.6. • From any point in the room or suite to exit less than or equal to 150 feet (less than or equal to 200 feet if the building is fully sprinklered). • Point in a room-to-room door less than or equal to 50feet. 18.2.6, 19.2.6	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K271	**Discharge from Exits** Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes inelevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K281	**Illumination of Means of Egress** Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K291	**Emergency Lighting** Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1	HAP 482.41(a)(1) HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d) **EP 3 applies to CAH but is not linked to a CAH CoP (Above and beyond requirement)**	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1** **PE.04.01.03, EP 1** The hospital/CAH has emergency power and lighting in, at a minimum, the following areas: • Operating rooms • Recovery rooms • Intensive care • Emergency rooms • Stairwells Battery lamps and flashlights are available in all other areas not serviced by the emergency power supply source.	
K292	**Life Support Means of Egress** **2012 NEW** (INDICATE N/A FOR EXISTING) Buildings equipped with or requiring the use of life support systems (electro- mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the life safety branch of the electrical system described in NFPA 99. (Indicate N/A if life support equipment is for emergency purposes only.) 18.2.9.2, 18.2.10.5	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i) HAP 482.41(c) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K293	**Exit Signage** **2012 EXISTING** Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i) HAP 482.41(c) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	(Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) **2012 NEW** Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1			
SECTION 3 - PROTECTION				
K300	**Protection – Other** Any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K311	**Vertical Openings – Enclosure** **2012 EXISTING** Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1-hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 **2012 NEW** Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 2 hours connecting four or more stories. (1- hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.6.7. 18.3.1 through 18.3.1.5	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K321	**Hazardous Areas – Enclosure** **2012 EXISTING** Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with ¾ hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic- closing and permitted to have	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

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<tr><th>K-tag</th><th>Code Requirement</th><th>CoP</th><th>TJC EP</th><th>Comments</th></tr>
<tr><td></td><td>nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.
Describe the floor and zone locations of hazardous areas that are deficient.
19.3.2.1, 19.3.5.9

<table>
<tr><th>Area</th><th>Automatic Sprinkler</th><th>Separation</th><th>N/A</th></tr>
<tr><td>a. Boiler and Fuel-Fired Heater Rooms</td><td></td><td></td><td></td></tr>
<tr><td>b. Laundries (larger than 100 sq. ft.)</td><td></td><td></td><td></td></tr>
<tr><td>c. Repair, Maintenance, and Paint Shops</td><td></td><td></td><td></td></tr>
<tr><td>d. Soiled Linen Rooms (exceeding 64 gal.)</td><td></td><td></td><td></td></tr>
<tr><td>e. Trash Collection Rooms (exceeding 64 gal.)</td><td></td><td></td><td></td></tr>
<tr><td>f. Combustible Storage Rooms/Spaces (over 50 sq. ft.)</td><td></td><td></td><td></td></tr>
<tr><td>g. Laboratories (if classified as Severe Hazard - see K322)</td><td></td><td></td><td></td></tr>
</table>

2012 NEW
Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a ¾ hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self- closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4.
Describe the floor and zone locations of hazardous areas that are deficient.
18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7</td><td></td><td></td><td></td></tr>
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<tr><td>K322</td><td>Laboratories
Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard are protected by 1-hour fire resistance-rated separation, automatic sprinkler system, and are in accordance with 8.7 and with NFPA 99.
Laboratories not considered a severe hazard are protected as hazardous areas (see K321).
Laboratories using chemicals are in accordance with NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals.
Gas appliances are of appropriate design and installed in accordance with NFPA 54. Shutoff valves are marked to identify material they control.
Devices requiring medical grade oxygen from the piped distribution system meet the requirements under 11.4.2.2 (NFPA 99).
18.3.2.2, 19.3.2.2, 8.7, 8.7.4.1 (LSC)
9.3.1.2, 11.4.3.2, 15.4 (NFPA 99)</td><td>HAP 482.41(b)(1)(i)
CAH 485.623(c)(1)(i)

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

PE.04.01.01, EP 1</td><td></td></tr>
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K-tag	Code Requirement	CoP	TJC EP	Comments
K323	**Anesthetizing Locations** Areas designated for administration of general anesthesia (i.e., inhalation anesthetics) are in accordance with 8.7 and NFPA 99. Zone valves are: located immediately outside each life-support, critical care, and anesthetizing location of moderate sedation, deep sedation, or general anesthesia for medical gas or vacuum; readily accessible in an emergency; and arranged so shutting off any one anesthetizing location will not affect others. Area alarm panels are provided to monitor all medical gas, medical- surgical vacuum, and piped WAGD systems. Panels are at locations that provide for surveillance, indicate medical gas pressure decreases of 20 percent and vacuum decreases of 12-inch gauge HgV, and provide visual and audible indication. Alarm sensors are installed either on the source side of individual room zone valve box assemblies or on the patient/use side of each of the individual zone box valve assemblies. The EES critical branch supplies power for task illumination, fixed equipment, select receptacles, and select power circuits, and EES equipment system supplies power to ventilation system. Heating, cooling, and ventilation are in accordance with ASHRAE 170. Medical supply and equipment manufacturer's instructions for use are considered before reducing humidity levels to those allowed by ASHRAE, per S&C 13-58. 18.3.2.3, 19.3.2.3 (LSC) 5.1.4.8.7, 5.1.4.8.7.2, 5.1.9.3, 5.1.9.3.4, 6.4.2.2.4.2 (NFPA 99)	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i) HAP 482.41(c) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K324	**Cooking Facilities** Cooking equipment is protected in accordance with NFPA 96, *Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations*, unless: • residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. • cooking facilities open to the corridor in smoke	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or • cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			
	The hospital maintains fire safety equipment and fire safety building features by inspecting the following: - Any automatic fire-extinguishing system in the kitchen every 6 months Note: For automatic kitchen fire-extinguishing systems, see NFPA 96-2011: 11.2.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	
K325	**Alcohol Based Hand Rub Dispenser (ABHR)** ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: • Corridor is at least 6 feet wide. • Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols. • Dispensers shall have a minimum of four foot horizontal spacing. • Not more than an aggregate of 10 gallons of fluid or 1135 ounces of aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room. • Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30. • Dispensers are not installed within 1 inch of an ignition source. • Dispensers over carpeted floors are in sprinklered smoke compartments. • ABHR does not exceed 95 percent alcohol. • Operation of the dispenser shall comply with Section	HAP 482.41(b)(7) CAH 485.623(c)(5)	**PE.03.01.01** The hospital/CAH addresses life safety from fire. **EP 7** When the hospital/CAH installs alcohol-based hand rub dispensers, it installs the dispensers in a manner that protects against inappropriate access.	

K-tag	Code Requirement	CoP	TJC EP	Comments
	18.3.2.6(11) or 19.3.2.6(11). • ABHR is protected against inappropriate access. 18.3.2.6, 19.3.2.6,			
K331	**Interior Wall and Ceiling Finish** **2012 EXISTING** Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 **2012 NEW** Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions and columns have a flame spread rating of Class A. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. Individual rooms not exceeding four persons may have a Class A or B finish. Lower half of corridor walls, not exceeding 4 feet in height, may have a Class A or B flame spread rating. 10.2, 18.3.3.1, 18.3.3.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K332	**Interior Floor Finish** **2012 NEW (N/A for 2012 EXISTING)** Interior finishes shall comply with 10.2. Floor finishes in exit enclosures and exit access corridors and spaces not separated by walls that resist the passage of smoke shall be Class I or II. 18.3.3.3.1, 18.3.3.3.2, 18.3.3.3.3, 10.2, 10.2.7.1, 10.2.7.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K341	**Fire Alarm System – Installation** A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, *National Electric Code,* and NFPA 72, *National Fire Alarm Code* to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	power extenders, and supervising station transmitting equipment. Fire alarm system wiring, or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8			
K342	**Fire Alarm System – Initiation** Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K343	**Fire Alarm – Notification** **2012 EXISTING** Positive alarm sequence in accordance with 9.6.3.4 are permitted in buildings protected throughout by a sprinkler system. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. 19.3.4.3, 19.3.4.3.1, 19.3.4.3.2, 9.6.4, 9.7.1.1(1) **2012 NEW** Positive alarm sequence in accordance with 9.6.3.4 are permitted. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. Annunciation and annunciation zoning for fire alarm and sprinklers shall be provided by audible and visual indicators and zones shall not be larger than 22,500 square feet per zone.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	18.3.4.3 through 18.3.4.3.3, 9.6.4			
K344	**Fire Alarm – Control Functions** The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 18.3.4.4, 19.3.4.4, 9.6.1, 9.6.5, NFPA 72	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K345	**Fire Alarm System – Testing and Maintenance** A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, *National Electric Code,* and NFPA 72, *National Fire Alarm and Signaling Code.* Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	
	The hospital maintains fire safety equipment and fire safety building features by testing the following every 12 months: - Duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors on the inventory - Visual and audible fire alarms (including speakers and door-releasing devices on the inventory) - Fire alarm equipment on the inventory for notifying off-site responders - Automatic smoke-detection shutdown devices for air-handling equipment Note: For additional guidance on duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors; visual and audible fire alarms; and fire alarm equipment, see NFPA 72-2010: Table 14.4.5; 17.14.	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	
K346	**Fire Alarm – Out of Service** Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	9.6.1.6			
K347	**Smoke Detection** **2012 EXISTING** Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 **2012 NEW** Smoke detection systems are provided in spaces open to corridors as required by 18.3.6.1 In nursing homes, an automatic smoke detection system is installed in the corridors of all smoke compartments containing resident sleeping rooms, unless the resident sleeping rooms have: • smoke detection, or • automatic door closing devices with integral smoke detectors on the room side that provide occupant notification. Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.2, 18.3.4.5.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K351	**Sprinkler System – Installation** **2012 EXISTING** Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, *Standard for the Installation of Sprinkler Systems.* In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft^2 and sprinkler coverage covers the closet footprint as required by NFPA 13, *Standard for Installation of Sprinkler*	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) **2012 NEW** Buildings are to be protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, *Standard for the Installation of Sprinkler Systems.* In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where State and local regulations prohibit sprinklers. Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft^2 and sprinkler coverage covers the closet footprint as required by NFPA 13, *Standard for Installation of Sprinkler Systems.* 18.3.5.1, 18.3.5.4, 18.3.5.5, 18.3.5.6, 9.7, 9.7.1.1(1), 18.3.5.10			
K352	**Sprinkler System – Supervisory Signals** Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, *National Fire Alarm and Signaling Code,* and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
	The hospital maintains fire safety equipment and fire safety building features by testing the following based on the identified timeframes: - Supervisory signal devices on the inventory, quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices; semiannually for valve supervisory switches; and annually for other	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	TJC EP	Comments
	supervisory initiating devices Note: For supervisory signal devices, water storage tanks and associated water storage equipment do not require testing. For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5.			
K353	**Sprinkler System – Maintenance and Testing** Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, *Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.* Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	
	The hospital maintains fire safety equipment and fire safety building features by testing the following every 12 months: - For automatic sprinkler systems, main drains at system low point or at all system risers - For automatic sprinkler systems, fire pumps under flow (fire pump supervisory signals for “pump running” and “pump power loss”) Note: For automatic sprinkler systems, main drains, and system risers, see NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1. Note 3: For automatic sprinkler system fire pumps, see NFPA 25-2011: 8.3.3; 8.3.3.4. The hospital maintains fire safety equipment and fire safety building features by testing the following based on the identified timeframes: - Vane-type and pressure-type water flow devices every 6 months - For automatic sprinkler systems, electric motor-driven fire pumps monthly and diesel engine-driven fire pumps every week under no-flow conditions - Hydrostatic and water flow for standpipe systems every 5 years - Automatic fire extinguishing systems (carbon dioxide systems every 12 months, halon systems every 6 months, other special systems per NFPA standards and manufacturer’s recommendations) - Hydrostatic tests on standpipe occupant hoses 5 years after installation and every 3 years thereafter Note 1: For vane-type and pressure-type water flow devices,	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	TJC EP	Comments
	mechanical water flow devices (including but not limited to water motor gongs) should be tested quarterly. (For full text, refer to NFPA 25-2011: Table 5.1.1.2). For additional guidance also see NFPA 72-2010: Table 14.4.5. Note 2: For hydrostatic tests on standpipe occupant hoses, see NFPA 1962-2008: Chapter 7 and NFPA 25-2011: Chapter 6 The hospital maintains fire safety equipment and fire safety building features by inspecting the following: - For automatic sprinkler systems, all fire department water supply connections every quarter Note: For automatic sprinkler systems, see NFPA 25-2011: 13.7; Table 13.1.1.2.			
K354	**Sprinkler System – Out of Service** Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)	HAP 482.41(b)(8)(i) HAP 482.41(b)(8)(ii) CAH 485.623(c)(6)(i) CAH 485.623(c)(6)(ii)	**PE.03.01.01** The hospital/CAH addresses life safety from fire. **EP 8** When a sprinkler system is shut down for more than 10 hours, the critical access hospital either evacuates the building or portion of the building affected by the system outage until the system is back in service or establishes a fire watch until the system is back in service.	
K355	**Portable Fire Extinguishers** Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, *Standard for Portable Fire Extinguishers.* 18.3.5.12, 19.3.5.12, NFPA 10	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
	The hospital maintains fire safety equipment and fire safety building features by inspecting the following: - Portable fire extinguishers at least monthly (this includes recharging every 12 months) Note 3: For portable fire extinguishers, there are many ways to	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential	

K-tag	Code Requirement	CoP	TJC EP	Comments
	document the inspections, such as using bar-coding equipment, using check marks on a tag, or using an inventory. Inspections involve a visual check to determine correct type of and clear and unobstructed access to a fire extinguisher, in addition to a check for broken parts and full charge. For additional guidance on inspection of fire extinguishers, see NFPA 10-2010: 7.1.2; 7.2.2; 7.2.4; 7.3.1.		equipment in safe operating condition.	
K361	**Corridors – Areas Open to Corridor** Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K362	**Corridors – Construction of Walls** **2012 EXISTING** Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. 19.3.6.2, 19.3.6.2.7 **2012 NEW** Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K363	**Corridor – Doors** **2012 EXISTING** Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1¾ inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i) Score corridor door issues not addressed by highlighted text using these CoPs at PE.04.01.01 EP 5.	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5lbf is applied, whether or not power is applied. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 **2012 NEW** Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5lbf is applied, whether or not power is applied. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485	Score issues related to yellow highlighted text at PE.04.01.01 EP 10 using the below CoPs: HAP 482.41(b)(1)(ii) CAH 485.623(c)(1)(ii)	**PE.03.01.01, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes: Regardless of the provisions of the Life Safety Code, corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited on these doors.	
K364	**Corridor – Openings** Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 in^2 and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 in^2. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3			
K371	**Subdivision of Building Spaces – Smoke Compartments** **2012 EXISTING** Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 **2012 NEW** Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. Smoke subdivision requirements do not apply to any of the stories or areas described in 18.3.7.2. 18.3.7.1, 18.3.7.2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K372	**Subdivision of Building Spaces – Smoke Barrier Construction** **2012 EXISTING** Smoke barriers shall be constructed to a ½ hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1)	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	2012 NEW Smoke barriers shall be constructed to provide at least a 1-hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3			
	The hospital maintains fire safety equipment and fire safety building features by testing the following based on the identified timeframes: - Fire and smoke dampers 1 year after installation and at least every 6 years thereafter to verify they fully close Note: For operation of fire and smoke dampers, see NFPA 90A-2012: 5.4.8; NFPA 80-2010: 19.4; NFPA 105-2010: 6.5.	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	
K373	**Subdivision of Building Spaces – Accumulation Space** Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.5.1, 18.3.7.5.2, 19.3.7.5.1, 19.3.7.5.2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K374	**Subdivision of Building Spaces – Smoke Barrier Doors** **2012 EXISTING** Doors in smoke barriers are 1¾-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 in for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 **2012 NEW** Doors in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded core wood. Required clear widths are provided per 18.3.7.6(4) and (5). Nonrated protective plates of unlimited height are permitted. Horizontal- sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	in an opposite direction. Doors shall be self-closing and rabbets, bevels, or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.6, 18.3.7.7, 18.3.7.8			
K379	**Smoke Barrier Door Glazing** **2012 EXISTING** Openings in smoke barrier doors shall be fire-rated glazing or wired glass panels in steel frames. 19.3.7.6, 19.3.7.6.2, 8.5 **2012 NEW** Windows in smoke barrier doors shall be installed in each cross corridor swinging or horizontal-sliding door protected by fire-rated glazing or by wired glass panels in approved frames. 18.3.7.9	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K381	**Sleeping Room Outside Windows and Doors** Every patient sleeping room has an outside window or outside door. In new occupancies, sill height does not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows. Newborn nurseries and rooms intended for occupancy less than 24 hours have no outside window or door requirements. Window sills in special nursing care areas (e.g., ICU, CCU, hemodialysis, neonatal) do not exceed 60 inches above the floor. 42 CFR 403, 418, 460, 482, 483, and 485 (in CoPs)	HAP 482.41(b)(9) HAP 482.41(b)(9)(i) HAP 482.41(b)(9)(ii) CAH 485.623(c)(7) CAH 485.623(c)(7)(i) CAH 485.623(c)(7)(ii)	PE.03.01.01 The hospital addresses life safety from fire. **EP 9** Buildings have an outside window or outside door in every sleeping room, and for any building constructed after July 5, 2016, the sill height does not exceed 36 inches above the floor. Note 1: Windows in atrium walls are considered outside windows for the purposes of this requirement. Note 2: The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours.	

K-tag	Code Requirement	CoP	TJC EP	Comments
			Note 3: The sill height in special nursing care areas of new occupancies does not exceed 60 inches.	
SECTION 4 – SPECIAL PROVISIONS				
K400	**Special Provisions – Other** Any LSC Section 18.4 and 19.4 Special Provisions requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K421	**High-Rise Buildings** **2012 EXISTING** High-rise buildings are protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7 within 12 years of LSC final rule effective date. 19.4.2 **2012 NEW** High-rise buildings comply with section 11.8. 18.4.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
SECTION 5 – BUILDING SERVICES				
K500	**Building Services – Other** Any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K511	**Utilities – Gas and Electric** Equipment using gas or related gas piping complies with NFPA 54, *National Fuel Gas Code*, electrical wiring and equipment complies with NFPA 70, *National Electric Code*. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K521	**HVAC** Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K522	**HVAC – Any Heating Device** Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: • is chimney or vent connected. • takes air for combustion from outside. • provides for a combustion system separate from occupied area atmosphere. 18.5.2.2, 19.5.2.2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K523	**HVAC – Suspended Unit Heaters** Suspended unit heaters are permitted provided the following are met: • Not located in means of egress or in patient rooms. • Located high enough to be out of reach of people in the area. • Has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. 18.5.2.3(1), 19.5.2.3(1)	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K524	**HVAC – Direct-Vent Gas Fireplaces** Direct-vent gas fireplaces, as defined in NFPA 54, inside of all smoke compartments containing patient sleeping areas comply with the requirements of 18.5.2.3(2), 19.5.2.3(2). 18.5.2.3(2), 19.5.2.3(2), NFPA 54	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K525	**HVAC – Solid Fuel-Burning Fireplaces** Solid fuel-burning fireplaces are permitted in other than patient sleeping areas provided: • Areas are separated by 1-hour fire resistance construction.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	• Fireplace complies with 9.2.2. • Fireplace enclosure resists breakage up to 650°F and has heat- tempered glass. Room has supervised CO detection per 9.8. 18.5.2.3(3) and 19.5.2.3(3)			
K531	**Elevators** **2012 EXISTING** Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, *Safety Code for Elevators and Escalators.* Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 **2012 NEW** Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, *Safety Code for Elevators and Escalators.* Firefighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, *Safety Code for Elevators and Escalators,* including Firefighter's Service Requirements. (Includes firefighter's Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 18.5.3, 9.4.2, 9.4.3	HAP 482.41(b)(1)(i) HAP 482.41(d)(2) CAH 485.623(c)(1)(i) CAH 485.623(b)(1)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 2**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K532	**Escalators, Dumbwaiters, and Moving Walks** **2012 EXISTING** Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* (Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters, includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.) 19.5.3, 9.4.2.2 **2012 NEW** Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. 18.5.3, 9.4.2.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K541	**Rubbish Chutes, Incinerators, and Laundry Chutes** **2012 EXISTING** (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 **2012 NEW**	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	Rubbish chutes, incinerators, and laundry chutes shall comply with the provisions of Section 9.5, unless otherwise specified in 18.5.4.2. • The fire resistance rating of chute charging room shall not be required to exceed 1-hour. • Any rubbish chute or linen chute shall be provided with automatic extinguishing protection in accordance with Section 9.7. • Chutes shall discharge into a trash collection room used for no other purpose and shall be protected in accordance with 8.7. 18.5.4.2, 8.7, 9.5, 9.7, NFPA 82			
SECTION 7 – OPERATING FEATURES				
K700	**Operating Features – Other** Any LSC Section 18.7 and 19.7 Operating Features requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K711	**Evacuation and Relocation Plan** There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.7.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K712	**Fire Drills** Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 ***Varying conditions means: Fire drills vary by at least one hour for each shift from quarter to quarter through four consecutive quarters			
K741	**Smoking Regulations** Smoking regulations shall be adopted and shall include not less than the following provisions: (7) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (8) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (9) Smoking by patients classified as not responsible shall be prohibited. (10) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (11) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (12) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K751	**Draperies, Curtains, and Loosely Hanging Fabrics** Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1			
K752	**Upholstered Furniture and Mattresses** Newly introduced upholstered furniture meets Class I or char length, and heat release criteria in accordance with 10.3.2.1 and 10.3.3, unless the building is fully sprinklered. Newly introduced mattresses shall meet char length and heat release criteria in accordance with 10.3.2.2 and 10.3.4, unless the building is fully sprinklered. Upholstered furniture and mattresses belonging to nursing home residents do not have to meet these requirements as all nursing homes are required to be fully sprinklered. Newly introduced upholstered furniture and mattresses means purchased on or after the LSC final rule effective date. 18.7.5.2, 18.7.5.4, 19.7.5.2, 19.7.5.4	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K753	**Combustible Decorations** Combustible decorations shall be prohibited unless one of the following is met: • Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. • Decorations meet NFPA 701. • Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. • Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). • The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 18.7.5.6, 19.7.5.6	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K761	**Maintenance, Inspection & Testing - Doors** Fire doors assemblies are inspected and tested annually in accordance with NFPA 80 *Standard for Fire Doors and*	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01, EP 2**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	Other Opening Protectives. Fire doors that are not located in required fire barriers, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspection and testing have an understanding of the operating components of the doors. Written records of inspection and testing are maintained and are available for review. 18.7.6, 19.7.6, 8.3.3.1 (LSC), 5.2, 5.2.3 (NFPA 80)			
	The hospital maintains fire safety equipment and fire safety building features by testing the following every 12 months: - Sliding and rolling fire doors, smoke barrier sliding or rolling doors, and sliding and rolling fire doors in corridor walls and partitions for proper operation and full closure - Fire door assemblies (inspection and testing) Note 5: For fire doors and smoke barrier doors, see NFPA 80-2010: 5.2.14.3; NFPA 105-2010: 5.2.1; 5.2.2. Note 6: For fire door assemblies, nonrated doors, including corridor doors to patient care rooms and smoke barrier doors, are not subject to the annual inspection and testing requirements of either NFPA 80 or NFPA 105. For hospitals that use Joint Commission accreditation for deemed status purposes: Nonrated doors should be routinely inspected and maintained in accordance with the facility maintenance program. For additional guidance on testing of door assemblies, see NFPA 101-2012: 7.2.1.5.10.1; 7.2.1.5.11; 7.2.1.15; NFPA 80-2010: 4.8.4; 5.2.1; 5.2.3; 5.2.4; 5.2.6; 5.2.7; 6.3.1.7; NFPA 105-2010: 5.2.1. The hospital maintains fire safety equipment and fire safety building features by inspecting the following: - Fire door assemblies annually by a qualified individual (testing begins with a pre-test visual inspection and includes both sides of the opening)	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses life safety from fire. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	TJC EP	Comments
K754	**Soiled Linen and Trash Containers** Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is ≤ 96 gal. unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K771	**Engineer Smoke Control Systems** **2012 EXISTING** When installed, engineered smoke control systems are tested in accordance with established engineering principles. Test documentation is maintained on the premises. 19.7.7 **2012 NEW** When installed, engineered smoke control systems are tested in accordance with NFPA 92, *Standard for Smoke Control Systems*. Test documentation is maintained on the premises. 18.7.7	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP 3**	
K781	**Portable Space Heaters** Portable space heating devices shall be prohibited in all health care occupancies. Unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	**PE.03.01.01, EP3**	
K791	**Construction, Repair, and Improvement Operations** Construction, repair, and improvement operations shall comply with 4.6.10. Any means of egress in any area undergoing construction, repair, or improvements shall be inspected daily to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241. 18.7.9, 19.7.9, 4.6.10, 7.1.10.1	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	The hospital does not remove or minimize an existing life safety feature when such feature is a requirement for new construction. Existing life safety features, if not required by the Life Safety Code, can be either maintained or removed. (For full text, refer to NFPA 101-2012: 4.6.12.2; 4.6.12.3; 18/19.7.9)	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
PART II – HEALTH CARE FACILITIES CODE REQUIREMENTS				
K900	**Health Care Facilities Code - Other** Any NFPA 99 requirements (excluding Chapter 7, 8, 12, and 13) that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Health Care Facilities Code or NFPA standard citation, should be included in the finding.	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K901	**Fundamentals – Building System Categories** Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K902	**Gas and Vacuum Piped Systems – Other** Any NFPA 99 Chapter 5 Gas and Vacuum Systems requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding. Chapter 5 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K903	**Gas and Vacuum Piped Systems – Categories** Medical gas, medical air, surgical vacuum, WAGD, and air supply systems are designated: ☐ Category 1. Systems in which failure is likely to cause major injury or death. ☐ Category 2. Systems in which failure is likely to cause minor injury. ☐ Category 3. Systems in which failure is not likely to cause injury but can cause discomfort. Deep sedation and general anesthesia are not to be	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	administered using a Category 3 medical gas system. 5.1.1.1, 5.2.1, 5.3.1.1, 5.3.1.5 (NFPA 99)			
K904	**Gas and Vacuum Piped Systems – Warning Systems** All master, area, and local alarm systems used for medical gas and vacuum systems comply with appropriate Category warning system requirements, as applicable. 5.1.9, 5.2.9, 5.3.6.2.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K905	**Gas and Vacuum Piped Systems – Central Supply System Identification and Labeling** Containers, cylinders and tanks are designed, fabricated, tested, and marked in accordance with 5.1.3.1.1 through 5.1.3.1.7. Locations containing only oxygen or medical air have doors labeled with "Medical Gases, NO Smoking or Open Flame". Locations containing other gases have doors labeled "Positive Pressure Gases, NO Smoking or Open Flame, Room May Have Insufficient Oxygen, Open Door and Allow Room to Ventilate Before Opening." 5.1.3.1, 5.2.3.1, 5.3.10 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K906	**Gas and Vacuum Piped Systems – Central Supply System Operations** Adaptors or conversion fittings are prohibited. Cylinders are handled in accordance with 11.6.2. Only cylinders, reusable shipping containers, and their accessories are stored in rooms containing central supply systems or cylinders. No flammable materials are stored with cylinders. Cryogenic liquid storage units intended to supply the facility are not used to transfill. Cylinders are kept away from sources of heat. Valve protection caps are secured in place, if supplied, unless cylinder is in use. Cylinders are not stored in tightly closed spaces. Cylinders in use and storage are prevented from exceeding 130°F, and nitrous oxide and carbon dioxide cylinders are prevented from reaching temperatures lower than manufacture recommendations or 20°F. Full or empty cylinders, when not connected, are stored in locations complying with 5.1.3.3.2 through 5.1.3.3.3, and are not stored in enclosures containing motor-driven machinery, unless for instrument air reserve headers.	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	5.1.3.2, 5.1.3.3.17, 5.1.3.3.1.8, 5.1.3.3.4, 5.2.3.2, 5.2.3.3, 5.3.6.20.4, 5.6.20.5, 5.3.6.20.7, 5.3.6.20.8, 5.3.6.20.9 (NFPA 99)			
K907	**Gas and Vacuum Piped Systems – Maintenance Program** Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99)	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01** The hospital/CAH addresses building safety and facility management. **EP 2** The hospital/CAH maintains essential equipment in safe operating condition.	
K908	**Gas and Vacuum Piped Systems – Inspection and Testing Operations** The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99)	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01, EP 2**	
K909	**Gas and Vacuum Piped Systems – Information and Warning Signs** Piping is labeled by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (Table 5.1.11), and operating pressure if other than standard. Labels are at intervals not more than 20 feet, are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency. 5.1.14.3, 5.1.11.1, 5.1.11.2, 5.2.11, 5.3.13.3, 5.3.11 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K910	**Gas and Vacuum Piped Systems – Modifications** Whenever modifications are made that breach the pipeline, any necessary installer and verification test specified in 5.1.2 is conducted on the downstream portion of the medical gas piping system. Permanent records of all tests required by system verification tests are maintained. 5.1.14.4.1, 5.1.14.4.6, 5.2.13, 5.3.13.4.3 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K911	**Electrical Systems – Other** Any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.03.01.01, EP 3** **PE.04.01.01, EP 1**	
K912	**Electrical Systems – Receptacles** Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, playrooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K913	**Electrical Systems – Wet Procedure Locations** Operating rooms are considered wet procedure locations, unless otherwise determined by a risk assessment conducted by the facility governing body. Operating rooms defined as wet locations are protected by either isolated power or ground-fault circuit interrupters. A written record of the risk assessment is maintained and available for inspection. 6.3.2.2.8.4, 6.3.2.2.8.7, 6.4.4.2	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K914	**Electrical Systems – Maintenance and Testing** Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01, EP 2**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of ≤ 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals ≤ 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)			
K915	**Electrical Systems – Essential Electric System Categories** ☐ Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. ☐ General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. ☐ Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1 1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K916	**Electrical Systems – Essential Electric System Alarm Annunciator** A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K917	**Electrical Systems – Essential Electric System Receptacles** Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K918	**Electrical Systems – Essential Electric System Maintenance and Testing** The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20–40-day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01, EP 2**	
K919	**Electrical Equipment – Other** Any NFPA 99 Chapter 10, *Electrical Equipment*, requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	**PE.04.01.01, EP 1** **PE.03.01.01, EP 3**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K920	**Electrical Equipment – Power Cords and Extension Cords** Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non- PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K921	**Electrical Equipment – Testing and Maintenance Requirements** The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient care-related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuing training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01, EP 2**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K922	**Gas Equipment – Other** Any NFPA 99 Chapter 11 Gas Equipment requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding. Chapter 11 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K923	**Gas Equipment – Cylinder and Container Storage** **≥ 3,000 cubic feet** Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. **> 300 but <3,000 cubic feet** Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. **≤ 300 cubic feet** In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of ≤ 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING". Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K924	**Gas Equipment – Testing and Maintenance Requirements** Anesthesia apparatus are tested at the final path to patient after any adjustment, modification or repair. Before the apparatus is returned to service, each connection is checked to verify proper gas and an oxygen analyzer is used to verify oxygen concentration. Defective equipment is immediately removed from service. Areas designated for servicing of oxygen equipment are clean and free of oil, grease, or other flammables. Manufacturer service manuals are used to maintain equipment and a scheduled maintenance program is followed. 11.4.1.3, 11.5.1.3, 11.6.2.5, 11.6.2.6 (NFPA 99)	HAP 482.41(d)(2) CAH 485.623(b)(1)	**PE.04.01.01, EP 2**	
K925	**Gas Equipment – Respiratory Therapy Sources of Ignition** Smoking materials are removed from patients receiving respiratory therapy. When a nasal cannula is delivering oxygen outside of a patient's room, no sources of ignition are within in the site of intentional expulsion (1-foot). When other oxygen deliver equipment is used or oxygen is delivered inside a patient's room, no sources of ignition are within the area are of administration (15-feet). Solid fuel-burning appliances is not in the area of administration. Nonmedical appliances with hot surfaces or sparking mechanisms are not within oxygen-delivery equipment or site of intentional expulsion. 11.5.1.1, TIA 12-6 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K926	**Gas Equipment – Qualifications and Training of Personnel** Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K927	**Gas Equipment – Transfilling Cylinders** Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, *Transfilling of High-Pressure Gaseous Oxygen Used for Respiration*. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
	containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)			
K928	**Gas Equipment – Labeling Equipment and Cylinders** Equipment listed for use in oxygen-enriched atmospheres are so labeled. Oxygen metering equipment and pressure reducing regulators are labeled "OXYGEN-USE NO OIL". Flowmeters, pressure reducing regulators, and oxygen-dispensing apparatus are clearly and permanently labeled designating the gases for which they are intended. Oxygen-metering equipment, pressure reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier. Cylinders and containers are labeled in accordance with CGA C-7. Color coding is not utilized as the primary method of determining cylinder or container contents. All labeling is durable and withstands cleaning or disinfecting. 11.5.3.1 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K929	**Gas Equipment – Precautions for Handling Oxygen Cylinders and Manifolds** Handling of oxygen cylinders and manifolds is based on CGA G-4, Oxygen. Oxygen cylinders, containers, and associated equipment are protected from contact with oil and grease, from contamination, protected from damage, and handled with care in accordance with precautions provided under 11.6.2.1 through 11.6.2.4 (NFPA 99). 11.6.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K930	**Gas Equipment – Liquid Oxygen Equipment** The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

K-tag	Code Requirement	CoP	TJC EP	Comments
K931	**Hyperbaric Facilities** All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99. Chapter 14 (NFPA 99)	HAP 482.41(d)(2) HAP 482.41(c) CAH 485.623(b)(1) CAH 485.623(d)	**PE.04.01.01, EP 1** **PE.04.01.01, EP 2**	
K932	**Features of Fire Protection – Other** Any NFPA 99 Chapter 15 Features of Fire Protection requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding. Chapter 15 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	
K933	**Features of Fire Protection – Fire Loss Prevention in Operating Rooms** Periodic evaluations are made of hazards that could be encountered during surgical procedures, and fire prevention procedures are established. When flammable germicides or antiseptics are employed during surgeries utilizing electrosurgery, cautery or lasers: • packaging is non-flammable. • applicators are in unit doses. • Preoperative "time-out" is conducted prior the initiation of any surgical procedure to verify: o application site is dry prior to draping and use of surgical equipment. o pooling of solution has not occurred or has been corrected. o solution-soaked materials have been removed from the OR prior to draping and use of surgical devices. o policies and procedures are established outlining safety precautions related to the use of flammable germicide or antiseptic use. Procedures are established for operating room emergencies including alarm activation, evacuation, equipment shutdown, and control operations. Emergency procedures include the control of chemical spills, and extinguishment of drapery,	HAP 482.41(c) CAH 485.623(d)	**PE.04.01.01, EP 1**	

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

Kitchen Tracer Survey Guide – Hospital and Critical Access Hospital

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

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

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

PHYSICAL ENVIRONMENT					
YES	**NO**		**YES**	**NO**	
☐	☐	Are areas kept clean? PE.01.01.01 EP 3 (HAP 482.41(a)) (CAH 485.623(b)(4)	☐	☐	Is the area free of any signs of **pests**? If there are pests, has the organization taken steps to address the issue? PE.01.01.01 EP 3 (HAP 482.41(a)) (CAH 485.623(b)(4))
☐	☐	**Kitchen equipment**; is it in safe operating condition? If there is an issue, does the staff have a plan to address it? *Manufacturer's recommended periodic maintenance schedule or an acceptable Alternate Equipment Management (AEM) program should be followed.* PE.04.01.01 EP 2 (HAP 482.41(d)(2)) (CAH 485.623(b)(1)	☐	☐	Are **Cookware/dishware/Dishes/ Utensils** stored in a clean, dry location? *There is no requirement for a solid bottom shelf for storage of food or cooking equipment. Use of solid bottom shelving is **an example** of a strategy that would be used.* Clean items are managed as per local/state food code, e.g., protected from contamination, such as splash, dust or other contaminants. The HCO determines how items will be protected in accordance with food code. IC.06.01.01 EP 3 (HAP 482.42(a)(3)) (CAH 485.640(a)(3))

☐	☐	Is **garbage/refuse** properly disposed of? PE.02.01.01 EP 6 (HAP 482.41(b)(4)) (CAH 485.623(b)(2))	☐	☐	Are **wet wiping cloths** stored in an approved sanitizing solution & washed daily? IC.06.01.01 EP 3 (HAP 482.42(a)(3)) (CAH 485.640(a)(3))
☐	☐	Are sinks clear from items that can be contaminated from splashes? *e.g., paper-wrapped straws* IC.06.01.01 EP 3 (HAP 482.42(a)(3)) (CAH 485.640(a)(3))	☐	☐	Are **food carts** cleaned & sanitized *after every meal.* IC.06.01.01 EP 3 (HAP 482.42(a)(3)) (CAH 485.640(a)(3))
			Advanced: You can ask a question regarding pest control services that have been accomplished.		

REFRIGERATOR					
YES	**NO**		**YES**	**NO**	
☐	☐	**Refrigerator temps:** have they been monitored? (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)	☐	☐	Is **uncooked food** (chicken or other meat) stored away from cooked food to prevent contamination? *e.g., not stored over cooked food* (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)
☐	☐	Is frequency of **temp checks & limits** (41° or lower) maintained as per policy? (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)	☐	☐	Is **prepared food** covered & labeled with expiration date? (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)
☐	☐	Is there a process if the temp is inadequate? *If possible,* (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)	☐	☐	Are **open containers** labeled with expiration date? (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)
☐	☐	Is **food stored** away from soiled areas & rust? (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)	☐	☐	Are there any **expired items** (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)
			☐	☐	Is the **locking mechanism** on the door in proper working condition? PE.04.01.01 EP 2 (HAP 482.41(d)(2)) (CAH 485.623(b)(1)
☐	☐	Is **food stored** to allow for ventilation? (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)	☐	☐	Is staff aware of how to use **safety process/mechanisms** in an emergency? (HAP HR.11.01.01, EP 1, 482.28(a)(3)) (CAH HR.11.01.01 EP 1)

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

FOOD PREP ASSESSMENT - Interview			
YES	NO		
☐	☐	**Foodborne illness:** does the organization take prevention measures? Question if cases have occurred/been resolved. IC.06.01.01 EP 3 (HAP 482.42(a)(3)) (CAH 485.640(a)(3)	**Advanced: Ask about ladle size & how to determine appropriate proportions.**
☐	☐	**Sick employees or those with open wounds**; is there a procedure for them? PC.12.01.11 EP 1 (open wounds observed) (HAP 482.28(b)(1)) (CAH 485.635(a)(3)(vi)) **or** IC.06.01.01 EP 5 (to manage employees with acute illnesses that may be transmitted in the workplace) (HAP 482.42(a)(3)) (CAH 485.640(a)(3))	**Advanced: Conduct HAZMAT tracer for corrosive lime-a-way used for decalcifying automated dishwashers. Assess adequacy of eyewash station, PPE usage, SDS, staff knowledge, etc.**
☐	☐	**Thawing food**; is there a process? *Validate the staff is following the process during observation. Food should not be thawing at room temperature & can be thawed under cold running water or the refrigerator.* (HAP NPG.12.01.01, EP 8, 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)	

FOOD PREP ASSESSMENT - Observation					
YES	NO		YES	NO	
☐	☐	**Hand hygiene during food prep**; is staff using proper practices to prevent contamination of food and food surfaces, *e.g., washing after touching face or hair* IC.06.01.01 EP 3 (HAP 482.42(a)(3)) (CAH 485.640(a)(3)	☐	☐	Monitor **food temp checks** for hot, cold and pre-cooked items undergoing the cooling process. *Food should be cooled to 70° within 2 hours & to 41° within 4 & total cooling time should not exceed 6 hours.* (HAP NPG.12.01.01, EP 8; 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)
☐	☐	Is **hand washing facilities** separate from the ones used for food prep? PE.01.01.01 EP 1 (HAP 482.41(a)) (CAH 485.623(a))	☐	☐	Review **temp logs** – did staff maintain logs for each service during food prep? Is the process for monitoring temps in alignment with food code? *Temps are usually logged at start, midpoint & end if meal service is extended. Ensure adequate process for Potentially Hazardous Foods (PHF) and Time/Temp Controlled for Safety (TCS) Foods* (HAP NPG.12.01.01, EP 8; 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)
☐	☐	**Gloves**: do staff use when appropriate to prevent contamination? *e.g., handling raw meat or ready-to-eat foods*? (HAP NPG.12.01.01, EP 8; 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)			
☐	☐	**Hair nets**; are all staff members wearing? (HAP NPG.12.01.01, EP 8; 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)	**Final cooking temps** should be as follows: (HAP NPG.12.01.01, EP 8; 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)		
☐	☐	**Cutting boards/prep surfaces**; are they cleaned and sanitized properly to avoid contamination? E.g., one for meat, one for veggies & sanitized between uses IC.06.01.01 EP 3 (HAP 482.42(a)(3)) (CAH 485.640(a)(3)) Does the staff use **clean utensils** with bulk foods/ice? (HAP NPG.12.01.01, EP 8; 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	Poultry - 165° Ground meat, ground fish, eggs - 155° Fish & other meat - 145° Precooked, cooled, then reheated - 165° Hot food hold temp - 135° or higher Cold food hold temp - 41° or below
☐	☐	**Evaluate dishwasher temps/chemical monitoring processes** PE.04.01.05 EP 3 (HAP 482.41(d)(2)) (CAH 485.623(b)(1))			

Kitchen Tracer Survey Guide

FREEZER For food storage (HAP NPG.12.01.01, EP 8, 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)					
YES	**NO**		**YES**	**NO**	
☐	☐	**Freezer temps**: have they been monitored?	☐	☐	Is the freezer free of any ice buildup? PE.04.01.05 EP 2 (HAP 482.41(d)(2)) (CAH 485.623(b)(1))
☐	☐	Is frequency of checks & temp limits maintained as per policy? *Temps should ensure that food remains solid.*	☐	☐	Are items labeled appropriately with **expiration dates?** *There should be no expired items*
☐	☐	Is there a process if the temp is inadequate? *If possible, validate the process was followed.*	☐	☐	If there is **pre-cooked food**, is the cooling process sufficient? *See refrigerator note* above
☐	☐	Is food stored away from soiled areas & rust?	☐	☐	Is the **locking mechanism** on the door in proper working condition? PE.04.01.01, EP 2 (HAP 482.41(d)(2)) (CAH 485.623(b)(1))
☐	☐	Is food stored to allow for ventilation?	☐	☐	Is there a process/mechanism in place to prevent staff from being locked in? Can the mechanism be accessed, and is it in working order? *It shouldn't be blocked or have any ice buildup.*
☐	☐	Is the freezer free from any signs of **freezer burn/food discoloration**?			
☐	☐	Are **raw foods** stored properly? *There should be no signs of them dripping on other foods.*	☐	☐	Is staff aware of how to use safety process/mechanism in emergency? HR.11.01.01 EP 1

To be Completed by Life Safety Code Surveyor

LIFE SAFETY					
YES	**NO**		**YES**	**NO**	
☐	☐	Is the kitchen in good repair? e.g., lack of broken floor tiles, delamination, flaking walls, etc. PE.01.01.01 EP 1 (HAP 482.41(a)) (CAH 485.623(a))	☐	☐	Are the **gaskets** intact for kitchen entry/delivery doors to prevent entry from pests? PE.01.01.01 EP 1 (HAP 482.41(a)) (CAH 485.623(a))
☐	☐	Do **sprinkler heads** have adequate **18"** clearance? *Ensure racks perpendicular to walls do not encroach 18" open space for sprinklers. NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.1.1; NFPA 13-2010: 8.5.5.2; 8.5.5.2.1; 8.5.5.3* PE.03.01.01 EP 3 (HAP 482.41(b)(2)) (CAH 485.623(c)(1)(i))	☐	☐	**Eyewash/shower station**; if required, is it in good working order & located away from hazards? PE.02.01.01 EP 4
			☐	☐	Can staff **access eyewash station** within 10 seconds of hazardous material storage/usage area? PE.02.01.01 EP 4
Evaluate sprinkler head obstructions in BOTH refrigerators & freezers. Be wary of surface mounted fluorescent light fixtures close to sprinkler heads as this does not follow the 18" rule. *Refer to attachment for specific criteria.*			☐	☐	Has the **eyewash inspection log** been kept up to date? PE.02.01.01 EP 4
			☐	☐	**Natural gas**: does the organization use this?
☐	☐	**Soda fountain machine**: is the CO2 secured? PE.04.01.01 EP 1 (HAP 482.41(c)) (CAH 485.623(d))	☐	☐	Is a **gas valve** accessible for emergency shutoff & do staff know its location/operation? PE.02.01.01 EP 4
☐	☐		☐	☐	Is **emergency shutoff valve** properly labeled?

		Are floor drains clear and not backed up? PE.01.01.01 EP 1 (HAP 482.41(a)) (CAH 485.623(a))			PE.02.01.02, EP 4
			☐	☐	**Tethering** – Kitchen appliances are required to have restraints or tethering. NFPA 54-2012, 9.6.1.2 PE.04.01.01 EP 1 (HAP 482.41(c)) (CAH 485.623(d))
☐	☐	**Deep fat fryer**; is there a **K fire extinguisher** within 30'? *NFPA 96–2011 10.10.1; NFPA 10–2010, 6.6.1; 6.6.* PE.04.01.01 EP 1 (HAP 482.41(c)) (CAH 485.623(d))	*Evaluate the hood system*		
			☐	☐	Is the **hood clean** with no grease buildup? *NFPA 96-2011 11.6.2* PE.04.01.01 EP 1 (HAP 482.41(c)) (CAH 485.623(d))
☐	☐	**Deep fat fryer**: is it installed with at least a 16" space between the fryer & surface flames from adjacent cooking equipment? *NFPA 96–2011 12.1.2.4* PE.04.01.01 EP 1 (HAP 482.41(c)) (CAH 485.623(d))	☐	☐	Are the **steel filter baffles** all installed with no gaps & are they in the proper direction? *NFPA 96-2011 6.2.3.1; 6.2.3.5* PE.04.01.01 EP 1 (HAP 482.41(c)) (CAH 485.623(d))
☐	☐	**K fire extinguisher placard** identifying need to activate the fixed suppression (ansul) system before using the extinguisher? *NFPA 96-2011 10.2.2* PE.03.01.01 EP 3 (HAP 482.41(b)(2)) (CAH 485.623(c)(1)(i))	☐	☐	Is **grease producing equipment** located properly under the hood? *NFPA 96-2011 5.2* PE.04.01.01 EP 1 (HAP 482.41(c)) (CAH 485.623(c)(1)(i))
☐	☐	**Suppression system**: does staff know how to use it? *Instructions for manual operations should be conspicuously posted & reviewed by staff. NFPA 96-2011 11.1.4* (HAP PE.03.01.01 EP 4, 482.41(b)(5)) (CAH HR.11.01.01 EP 1)	☐	☐	Are **extinguishing heads** pointed properly toward the cooking surface? PE.03.01.01 EP 3 (HAP 482.41(b)(2)) (CAH 485.623(c)(1)(i))
			☐	☐	**Electrical panels**; are they clear from obstruction? *There should be 36"* PE.04.01.01 EP 1 (HAP 482.41(c)) (CAH 485.623(d))
☐	☐	**Compressed gas cylinders**: are they properly secured? *NFPA 99-2012 11.3; 11.6.2.3* PE.04.01.01 EP 1 (HAP 482.41(c)) (CAH 485.623(d))	☐	☐	**Fire Evacuation & Relocation Plan**; is the staff knowledgeable? *NFPA 101-2012: 18/19.7.1; 7.2 (HAP* PE.03.01.01 EP 4, 482.41(b)(5)) (CAH HR.11.01.01 EP 1)

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The Joint Commission™

Infection Prevention and Control Program Assessment Tool

Required Documents and Data

- Assessment of infection risks

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

- Results of infection control surveillance

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

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

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

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

Table: Elements of Compliance and Scoring Guidance

Elements of Compliance	Standard(s)/EP(s)
Infection Prevention and Control Program & Leader(s)	
1. An infection preventionist(s) or infection control professional(s) has been appointed by the hospital governing body, based on the recommendation of the medical staff and nursing leaders, and is qualified through education, training, experience, or certification.	NPG.12.01.01 EP 12
2. The hospital defines the qualifications for the infection preventionist(s) or infection control professional(s), which may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control).	HR.11.02.01 EP 1

3. The infection preventionist(s)/infection control professional(s) perform the following activities in collaboration with all departments, programs, and areas involved in infection prevention and control activities: a. Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines b. Documentation of the infection prevention and control program and its surveillance, prevention, and control activities c. Competency-based training and education of hospital staff, including medical staff and, as applicable, personnel providing contracted services on infection prevention and control policies and procedures and their application	IC.04.01.01 EP 2

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

1. The governing body ensures that the infection prevention and control program is operational and resourced to carry out and track its activities through the following: a. Resources must be adequate to accomplish the tasks required for the infection prevention and control program. This includes the following: i. Allocating human resources to mitigate infection risks and prevent transmission of infections (for example, nursing and environmental services staffing must be adequate to carry out infection prevention and control activities). ii. Allocating material resources to mitigate infection risks and prevent transmission of infections, such as information technology, laboratory services, equipment, and supplies. iii. Allocating sufficient information resources to guide program activities, such as access to local, state, and federal public health authorities' advisories and alerts (for example, the CDC's Health Alert Network [HAN]; FDA alerts); access to manufacturers' instructions for use; access to any standards and guidelines required by applicable regulation and the guidelines and consensus standards chosen by the hospital to inform policies and procedures (for example, guidelines and standards from ASHRAE, FGI, SHEA, AAMI, AORN, APIC Text, etc.)	IC.05.01.01 EP 1
b. The governing body is ultimately accountable for the implementation, success, and sustainability of the program activities, while the medical director, nurse executive, and administrative leaders provide additional leadership support for the program. c. Hospital policies address the roles and responsibilities for infection prevention and control program within the hospital and how the various hospital committees and departments interface with the infection prevention and control program (for example, how to report infectious/communicable disease issues to the infection prevention and control program).	
2. The hospital's governing body ensures that the problems identified by the infection prevention and control program are addressed in collaboration with the hospital's quality assessment and performance improvement (QAPI) leaders, and other leaders (for example, the medical director, nurse executive, and administrative leaders) as evidenced by thefollowing: a. The hospital's QAPI program addresses problems identified by the infection control leader(s). b. The hospital leaders, including the CEO, the medical staff leader, and the nurse executive, monitor adherence to corrective action plans, assess the effectiveness of actions taken, and verify the implementation of revised corrective actions as needed. c. The hospital's governing body, the medical staff leader, the nurse executive, and administrative leaders must ensure that staff in-service training programs address problems identified through the infection prevention and control program.	IC.05.01.01 EP 2

3. **For hospitals that use Joint Commission accreditation for deemed status purposes:** If a hospital is part of a hospital system consisting of separately certified hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member hospitals after determining that such a decision is in accordance with applicable law and regulation. The system governing body is responsible and accountable for making certain that each of its separately certified hospitals meet all of the requirements at 42 CFR 482.42(d). Each separately certified hospital subject to the system governing body demonstrates that the unified and integrated infection prevention and control program and the antibiotic stewardship program have the following characteristics: - Structured in a manner that accounts for each member hospital's unique circumstances and any significant differences in patient populations and services offered at each hospital - Establish and implement policies and procedures to make certain that the needs and concerns of each separately certified hospital, regardless of practice or location, are given due consideration - Have mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed - A qualified individual(s) with expertise in infection prevention and control and in antibiotic stewardship has been designated at the hospital as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to hospital staff	LD.11.01.01 EP 10
Program Policies and Procedures	
1. The hospital's infection prevention and control program has written policies and procedures to guide its activities and methods for preventing and controlling the transmission of infections within the hospital and between the hospital and other institutions and settings. The policies and procedures are in accordance with the following hierarchy of references: - Applicable law and regulation. Note: Relevant federal, state, and local law and regulations include but are not limited to the Centers for Medicare & Medicaid Services Conditions of Participation, the Food and Drug Administration (FDA) regulations for reprocessing single-use medical devices; Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens Standard 29 CFR 1910.1030, Personal Protective Equipment Standard 29 CFR 1910.132, and Respiratory Protection Standard 29 CFR	IC.04.01.01 EP 3

1910.134; health care worker vaccination laws; state and local public health authorities' requirements for reporting of communicable diseases and outbreaks; and state and local regulatory requirements for biohazardous or regulated medical waste generators. - Manufacturers' instructions for use. - Nationally recognized evidence-based guidelines and standards of practice, including The Centers for Disease Control and Prevention (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, or, in the absence of such guidelines, expert consensus or best practices. The guidelines are documented within the policies and procedures. Note 1: For full details on CDC Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, refer to https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html. Note 2: The hospital determines which evidence-based guidelines, expert recommendations, or best practices, or a combination thereof, it adopts in its policies and procedures.	
2. The hospital's policies and procedures for cleaning, disinfection, and sterilization of reusable medical and surgical devices and equipment address the following: - Cleaning, disinfection, and sterilization of reusable medical and surgical devices in accordance with the Spaulding classification system and manufacturers' instructions Note: The Spaulding classification system classifies medical and surgical devices as critical, semicritical, or noncritical based on risk to the patient from contamination on a device and establishes the levels of germicidal activity (sterilization, high-level disinfection, intermediate and low-level disinfection) to be used for the three classes of devices. - The use of EPA-registered disinfectants for noncritical devices and equipment according to the directions on the product labeling, including, but not limited to, indication, specified use-dilution, contact time, and method of application - The use of FDA-approved liquid sterilants for the processing of critical devices and high-level disinfectants for the processing of semicritical devices in accordance with the FDA-cleared label and device manufacturers' instructions - Required documentation for device reprocessing cycles, including but not limited to sterilizer cycle logs, the frequency of chemical and biological testing, and the results of testing for appropriate concentration for chemicals used in high- level disinfection - Resolution of conflicts or discrepancies between a medical device manufacturer's instructions and manufacturers' instructions for automated high-level disinfection or sterilization equipment - Criteria and the process for the use of immediate-use steam sterilization - Actions to take in the event of a reprocessing error or failure identified either prior to the release of the reprocessed item(s) or after the reprocessed item(s) was used or stored for later use Note: Depending on the nature of the incident, examples of actions may include quarantine of the sterilizer, recall of item(s), stakeholder notification, patient notification, surveillance, and follow-up.	IC.04.01.01 EP 4
Risk Assessment	

1. The hospital identifies risks for infection, contamination, and exposure that pose a risk to patients and staff to prioritize program activities, including the following: a. The hospital includes risks from organisms with a propensity for transmission within health care facilities based on published reports and the occurrence of clusters of patients (for example, norovirus, respiratory syncytial virus ([RSV]), influenza, measles, and organisms with antimicrobial resistance such as Carbapenem-resistant Enterobacterales ([CRE]), *Candida auris*).	NPG.05.01.01, EP 1

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

1. The hospital provides job-specific training and education on infection prevention and control. The staff's records confirm completion of education and training. Note 1: Job-specific means that education and training are consistent with or tailored to the performed roles and responsibilities. For example, environmental services staff must be trained in the methods and procedures for surface disinfection. Note 2: The training and education must include the practical applications of infection prevention and control guidelines, policies, and procedures.	HR.11.03.01 EP 1
2. The hospital provides training to staff expected to have contact with blood or other potentially infectious material on the blood borne pathogen standards upon hire, at regular intervals, and as needed.	HR.11.03.01 EP 1
3. The hospital staff receive training in the following: a. When personal protective equipment (PPE) is necessary b. What PPE is necessary	HR.11.03.01 EP 1

c. How to properly don, doff, adjust, and wear PPE	
4. The hospital defines and assesses staff competency in infection prevention and control. Note: Competency-based training must be job-specific. For example, the staff in the sterile processing department must demonstrate competencies in the methods and procedures of sterilization, and the staff in areas that perform high-level disinfection must demonstrate competencies in the methods and procedures for high-level disinfection.	HR.11.04.01 EP 1
5. The hospital develops and implements education and training and assesses competencies for the staff who will implement protocols for high-consequence infectious diseases or special pathogens.	NPG.05.02.01, EP 2
Outbreak Management	
1. There is a process in place for reporting to public health authorities when the transmission of infection occurs; this process is consistent with state and local public health authority requirements for identification, reporting, and containing communicable diseases and outbreaks.	IC.06.01.01 EP 4
2. The hospital implements its policies and procedures for infectious disease outbreaks, including the following: - Implementing infection prevention and control activities when an outbreak is first recognized by internal surveillance or public health authorities - Reporting an outbreak in accordance with state and local public health authorities' requirements - Implementing outbreak investigation - Communicating information necessary to prevent further transmission of the infection among patients, visitors, and staff, as appropriate	IC.06.01.01 EP 4
Standard Precautions: Hand Hygiene Note: The hospital policies and procedures on hand hygiene are in accordance with either the current Centers for Disease Control and Prevention (CDC) and/or the current World Health Organization (WHO) hand hygiene guidelines, including the following:	
1. Implement a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) and/or the current World Health Organization (WHO) hand hygiene guidelines.	NPG.05.03.01 EP 1
2. Set goals for improving compliance with hand hygiene guidelines.	NPG.05.03.01 EP 1
3. Improve compliance with hand hygiene guidelines based on established goals.	NPG.05.03.01 EP 1
4. Supplies necessary for adherence to hand hygiene (such as alcohol-based hand rub, soap, water, and a sink) are readily accessible in all areas where patient care is being delivered including but not limited to patient care areas and food and medication preparation areas.	IC.06.01.01 EP 3
5. Alcohol-based hand rub is readily accessible and placed in appropriate locations where it can be accessed by the staff, patients, and visitors. The locations may include the following: a. Entrances to patient rooms b. At the bedside c. Staff workstations d. Other convenient locations	IC.06.01.01 EP 3
6. Hospital staff use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient b. Before performing an aseptic task (for example, placing an indwelling device) or handling invasive medical devices c. Before moving from work on a soiled body site to a clean body site on the same patient d. After touching a patient or the patient's immediate environment e. After contact with blood, body fluids or contaminated surfaces f. Immediately after glove removal	IC.06.01.01 EP 3

7. Hospital staff perform hand hygiene using soap and water when hands are visibly soiled (for example, blood, body fluids) or after caring for a patient with known or suspected *C. difficile* or norovirus during an outbreak. Note: In all other situations, alcohol-based hand rub is preferred.	IC.06.01.01 EP 3
8. Hospital staff do not wear artificial fingernails and/or extenders when having direct contact with patients in accordance with hospital policy. Note: If following the *CDC Guideline for Hand Hygiene in Health-Care Settings*: when having direct contact with patients at high risk of infection (for example, those in intensive care units or ORs). If following the *WHO Guidelines on Hand Hygiene*: when having direct contact with patients.	IC.06.01.01 EP 3
Standard Precautions: Environmental Cleaning and Disinfection Note: Environmental cleaning and disinfection is performed in accordance with hospital policies and procedures to maximize prevention of infection and communicable disease including the following:	
1. The hospital implements routine and targeted cleaning of environmental surfaces as indicated by the level of patient contact and degree of soiling, including the following: a. Surfaces in the patient care environment and areas are cleaned and disinfected on a regular basis, using an EPA- registered disinfectant. Note: High-touch surfaces (for example, bed rails, over-bed table, bedside commode, lavatory surfaces in patient bathrooms) are cleaned and disinfected more frequently than minimal-touch surfaces. b. Spills of blood or other potentially infectious materials are promptly cleaned and decontaminated, using appropriate EPA-registered hospital disinfectants.	IC.06.01.01 EP 3
2. Cleaners and disinfectants, including disposable wipes, are used in accordance with manufacturers' instructions (for example, dilution, storage, shelf-life, contact time).	IC.06.01.01 EP 3
3. Mop heads and cleaning cloths are laundered at least daily using appropriate laundry techniques (for example, following manufacturers' instructions when laundering microfiber items).	IC.06.01.01 EP 3
4. The hospital has established and follows a schedule for areas/equipment (for example, refrigerators, ice machines, eye wash stations, scrub sinks) to be cleaned regularly.	IC.06.01.01 EP 3
5. After a patient vacates a room and before the bed linens and towels are replaced, all potentially contaminated surfaces in the room are thoroughly cleaned and disinfected.	IC.06.01.01 EP 3
6. Undamaged hospital bed mattress covers are cleaned and disinfected according to manufacturers' instructions. Any damaged, worn, or visibly stained hospital bed mattress or mattress covers are removed from service and cleaned, disinfected, refurbished, or discarded in accordance with manufacturers' instructions and hospital procedures.	IC.06.01.01 EP 3
Standard Precautions: Injection and Sharps Safety Note: Injection practices and sharps safety and disposal are performed in accordance with The Centers for Disease Control and Prevention (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings and hospital policies and procedures to maximize prevention of infection and communicable disease including the following:	
1. Injections are prepared using aseptic technique in an area that has been cleaned and separated from potential sources of contamination (for example, visible blood, body fluids, sinks or other water sources).	IC.06.01.01 EP 3
2. Single-dose or single-use vials, ampules, bags or bottles of parenteral solution, fluid infusion or administration sets (for example, intravenous tubing) are used for one patient only.	IC.06.01.01 EP 3

3. Diaphragms of medication vials are disinfected before inserting a device into the vial.	IC.06.01.01 EP 3

4. Needles and syringes are used for one patient only (this includes manufactured prefilled syringes and cartridge devices such as insulin pens).	IC.06.01.01 EP 3
5. The same lancing/fingerstick device is not used for more than one individual, even if the lancet is changed.	IC.06.01.01 EP 3
6. If multidose vials are used for more than one patient, medication vials do not enter the immediate patient treatment area (for example, operating room, patient room, anesthesia carts). Note: If multi-dose vials enter the immediate patient treatment area, they must be dedicated for single patient use and discarded immediately after use.	IC.06.01.01 EP 3
7. Immediately or as soon as possible after use, contaminated sharps are discarded in puncture-resistant, leakproof (on the sides and bottom) sharps containers, and sharps containers are replaced when the fill line is reached.	IC.06.01.01 EP 3
Standard Precautions: Risk Assessment with Appropriate Use of Personal Protective Equipment Note: Appropriate personal protective equipment (PPE) is used in accordance with hospital policies and procedures to maximize prevention of infection and communicable disease including the following:	
1. Staff have immediate access to PPE and are able to select, put on, remove, and dispose of PPE in a manner that protects themselves, the patient, and others.	IC.06.01.01 EP 3
2. Gloves are worn when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin, or contaminated equipment could occur. The staff change gloves and perform hand hygiene before moving from a contaminated body site to a clean body site.	IC.06.01.01 EP 3
3. A gown is worn that is appropriate to the task to protect skin and prevent soiling of clothing during procedures and activities that could cause contact with blood, body fluids, secretions, or excretions.	IC.06.01.01 EP 3
4. Protective eyewear and a mask or a face shield are worn to protect the mucous membranes of the eyes, nose and mouth during procedures and activities that could generate splashes or sprays of blood, body fluids, secretions, and excretions. Note: Masks, goggles, face shields, and combinations of each are selected according to the need anticipated by the task performed.	IC.06.01.01 EP 3
5. PPE removal and disposal: PPE, other than respirators, are removed and discarded upon completing a task before leaving the patient's room or care area. If a respirator is used, it should be removed and discarded (or reprocessed if reusable) after leaving the patient room or care area and closing the door. Disposable gloves are removed and discarded upon completion of a task or when soiled during the process of care.	IC.06.01.01 EP 3
6. Face masks (procedure or surgical) are worn by staff who are placing a catheter or injecting materials into the epidural or subdural space (for example, during myelogram, epidural, or spinal anesthesia).	IC.06.01.01 EP 3
Standard Precautions: Minimizing Potential Exposures. **Preparedness for High-Consequence Infectious Diseases or Special Pathogens.**	
1. Respiratory hygiene and cough etiquette instructional signage or handouts are posted and tissues, masks, and hand hygiene supplies available at the points of entry to minimize potential exposures to or transmission of respiratory infection. Note: Points of entry may include the emergency department, urgent care, and ambulatory clinics	IC.06.01.01 EP 3

2. The hospital has developed and implemented protocols for high-consequence infectious diseases or special pathogens. The protocols are readily available for use at the point of care and address the following:	NPG.05.02.01, EP 1

- Identify: Procedures for screening at the points of entry to the hospital for respiratory symptoms, fever, rash, and travel history to identify or initiate evaluation for high-consequence infectious diseases or special pathogens Note: Points of entry may include the emergency department, urgent care, and ambulatory clinics. - Isolate: Procedures for transmission-based precautions - Inform: Procedures for informing public health authorities and key hospital staff - Required personal protective equipment and proper donning and doffing techniques - Infection control procedures to support continued and safe provision of care while the patient is in isolation and to reduce exposure among staff, patients, and visitors using the hierarchy of controls Note: See the Glossary for a definition of hierarchy of controls. - Procedures for waste management and cleaning and disinfecting patient care spaces, surfaces, and equipment	
Standard Precautions: Reprocessing of Reusable Medical Equipment Note: Reprocessing of reusable medical equipment is performed in accordance with the Spaulding classification system, manufacturers' instructions, and hospital policies and procedures.	
1. Only devices labeled as reusable are reprocessed directly by the hospital on-site or offsite via a reprocessing vendor. If the hospital elects to reuse any devices labeled for single use by the manufacturer, these devices are reprocessed by an entity that is registered with the FDA as a third-party reprocessor and cleared by the FDA to reprocess the specific device in question. The hospital has documentation from the third-party reprocessor confirming this is the case.	IC.06.01.01 EP 3
2. Manufacturers' instructions for medical devices and equipment are available to the staff performing reprocessing. The hospital may use posters or other condensed methods to provide critical information to staff performing reprocessing to ensure reprocessing consistent with the instructions for use.	IC.05.01.01 EP 1
3. Reusable non-critical medical equipment (for example, blood glucose meters and other point-of-care devices, blood pressure cuffs, oximeter probes) are cleaned and disinfected according to manufacturers' instructions after each use or when visibly soiled.	IC.06.01.01 EP 3
4. Hydrotherapy equipment (for example, Hubbard tanks, tubs, whirlpools, spas, birthing tanks) are drained, cleaned, and disinfected using an EPA-registered disinfectant according to manufacturers' instructions after each patient use.	IC.06.01.01 EP 3
5. Responsibility for cleaning and disinfection of reusable noncritical patient-care equipment and devices is clearly designated.	IC.06.01.01 EP 3
High-level disinfection:	
6. All reusable semi-critical items receive at least high-level disinfection prior to reuse, in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
7. Flexible endoscopes are inspected for damage and leak tested as part of each reprocessing cycle, in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
8. Items are thoroughly pre-cleaned according to manufacturers' instructions and visually inspected for residual soil prior to high- level disinfection. For instruments with lumens (for example, endoscopes), pre-cleaning of devices must include all channels using cleaning brushes of appropriate size.	IC.06.01.01 EP 3

9. Manufacturers' instructions are followed for the following: a. Enzymatic cleaners or detergents b. Reusable cleaning brushes c. Chemicals used in high-level disinfection, including instructions for preparation, testing for appropriate concentration, and replacement (for example, prior to expiration) Note: The results of testing for appropriate concentration are documented to ensure minimal effective concentration of the active ingredient. d. Disinfection temperatures and length of time e. Device rinsing following high-level disinfection	IC.06.01.01 EP 3

f. If automated reprocessing equipment is used, manufacturers' recommended connectors are used to assure that all endoscope channels are appropriately disinfected.	
10. Devices are dried thoroughly prior to storage/reuse in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
11. After high-level disinfection, devices are stored in a manner that protects them from damage or contamination.	IC.06.01.01 EP 3
12. The hospital has a system in place to identify which endoscope was used on a patient for each procedure.	IC.06.01.01 EP 3
Sterilization:	
13. All reusable critical items are sterilized prior to reuse, in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
14. Items are thoroughly pre-cleaned according to manufacturers' instructions and visually inspected for residual soil prior to sterilization. Note: For instruments with lumens, pre-cleaning of devices must include all channels using cleaning brushes of appropriate size.	IC.06.01.01 EP 3
15. Enzymatic cleaner or detergent is used and discarded according to manufacturers' instructions.	IC.06.01.01 EP 3
16. Cleaning brushes are single-use, disposable items or, if reusable, cleaned and either high-level disinfected or sterilized (per manufacturers' instructions) at least daily.	IC.06.01.01 EP 3
17. After pre-cleaning, items are appropriately wrapped-packaged for sterilization (for example, the package system selected is compatible with the sterilization process being performed, hinged instruments are open, and instruments are disassembled if indicated by the manufacturer).	IC.06.01.01 EP 3
18. The sterilization process is monitored by using a combination of mechanical, chemical, and biological indicators to ensure the effectiveness of the sterilization process. Indicators are used in accordance with the sterilizer or sterilizer accessory (pouch, casket, tray, etc.) manufacturers' instructions.	IC.06.01.01 EP 3
19. For dynamic air removal–type sterilizers (for example, prevacuum steam sterilizers), an air removal test (Bowie-Dick test) is performed each day the sterilizer is used to verify efficacy of air removal in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
20. Sterile packs are labeled with the sterilizer used, the cycle or load number, the date of sterilization, and, if applicable, the expiration date.	IC.06.01.01 EP 3
21. Logs for each sterilizer cycle are current and include results from each load, in accordance with the hospital policies and procedures. Note: For the absence of policies and procedures, score IC.04.01.01 EP 4	IC.06.01.01 EP 3
22. After sterilization, medical devices and instruments are stored so that sterility is not compromised.	IC.06.01.01 EP 3
23. Sterile packages are inspected for integrity and compromised packages are repackaged and reprocessed prior to use.	IC.06.01.01 EP 3
24. If immediate-use* steam sterilization (IUSS) is performed, all of the following criteria are met: a. Work practices ensure proper cleaning and decontamination, inspection, and arrangement of the instruments into the recommended sterilizing trays or other containment devices before sterilization. b. Once clean, the item is placed within a container intended for immediate use. c. The sterilizer cycle and parameters used are selected according to the manufacturers' instructions for use for the device, container, and sterilizer. d. The sterilizer function is monitored with mechanical monitors and chemical and biologic indicators that are validated for use with the sterilization cycle and in accordance with the device and sterilizer manufacturers' instructions. e. The processed item must be transferred immediately*, using aseptic technique, from the sterilizer to the actual point of use, the sterile field in an ongoing surgical procedure. *"Immediate use" is defined as the shortest possible time between a sterilized item's removal from the sterilizer and its aseptic	IC.06.01.01 EP 3

transfer to the sterile field. A sterilized item intended for immediate use is not stored for future use, nor held from one case to another.	

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

6. A NIOSH-approved particulate respirator (N95 or higher) is worn by staff when entering the airborne infection isolation room (AIIR) for patients with confirmed or suspected TB. Hospital policies are followed for other pathogens requiring AIIR.	IC.06.01.01 EP 3
Temporary Invasive Medical Devices for Clinical Management	
1. Staff adhere to invasive medical devices insertion, maintenance, and discontinuation practices, in accordance with hospital policies and procedures. Note: Examples of invasive medical devices include vascular catheters, indwelling urinary catheter, ventilator.	IC.06.01.01 EP 3
2. The hospital follows its policies and procedures for appropriate indications for urinary catheters.	IC.06.01.01 EP 3
3. The hospital promptly removes any intravascular catheter that is no longer essential, in accordance with its policies and procedures. Note: For the absence of policies and procedures, score IC.04.01.01 EP 3.	IC.06.01.01 EP 3

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

Laundry & Linen Note: Laundry is processed in a manner consistent with law and regulation and hospital policies and procedures to maximize prevention of infection and communicable disease including the following:	
1. Soiled textiles/laundry are handled with minimum agitation to avoid contamination of air, surfaces, and persons.	IC.06.01.01 EP 3
2. Soiled laundry is contained in leak-proof bags or containers at the point of use. Note: Hamper covers are not required in patient care areas.	IC.06.01.01 EP 3
3. Healthcare textiles are protected from environmental contamination during transport and storage. Note: Textiles/linens are covered if stored in a clean area in the inpatient unit or may be uncovered if stored in a dedicated clean storage area.	IC.06.01.01 EP 3
4. The receiving area for contaminated textiles is clearly separated from clean laundry areas and is maintained at negative pressure compared with the clean areas of the laundry in accordance with FGI construction standards in effect during the time of facility construction.	PE.04.01.01 EP 3
Dietary Services/Kitchen Note: Practices for the prevention of foodborne infections and diseases are performed in accordance with the federal, state, and local codes, law and regulation on food operations, and hospital policies and procedures.	
1. The hospital has written policies and procedures on sanitary and hand hygiene practices for its dietary services and kitchen staff.	IC.04.01.01 EP 3
2. The hospital provides a clean and sanitary environment in food storage, preparation, serving, and dishware storage areas, consistent with law, regulation, and food sanitation code. Note: Examples may include: a. Cutting boards, prep surfaces, work areas, trays and equipment are cleaned properly to avoid contamination and sanitized between uses. b. Different cutting boards/prep surfaces are used for meat, vegetables, and other food items. c. Handwashing sinks are available. d. Sinks are clear of items that can be contaminated by splashes. e. Raw food and ingredients are prepared and stored in a manner that prevents cross contamination with other foods (for example, to avoid dripping, liquid pooling, splashing). f. Dishes and utensils are air dried and stored in a manner that prevents cross contamination. g. Food carts are sanitized after every meal. h. Wet wiping cloths are stored in an approved sanitizing solution and washed daily.	IC.06.01.01 EP 3
3. The dietary services and kitchen staff comply with hand hygiene practices.	IC.06.01.01 EP 3
4. The hospital prepares food and nutrition products using proper sanitation and temperature, including the following: a. Food service staff wear hair or beard coverings, in accordance with hospital policies and procedures, b. Food service staff adhere to hand hygiene in accordance with hospital policies and procedures. c. The hospital monitors the food's temperature for hot and cold items during meal service. d. The hospital maintains proper temperature of refrigerated or warmed foods during preparation. e. The hospital follows the proper process for thawing of foods. f. The hospital monitors final cooking temperatures.	CAH NPG.11.04.01 EP 1 HAP NPG.12.01.01, EP 8
5. The hospital stores food and nutrition products, including those brought in by patients or their families, using proper sanitation: a. Food is protected from contamination during storage. b. Food storage areas such as a refrigerator, cupboards, drawers, and bins are not soiled and protected from splashes and free of odors.	CAH NPG.11.04.01 EP 1 HAP NPG.12.01.01, EP 8

6. The hospital manages foodborne outbreak(s) and reports outbreak(s) to public health authorities, in accordance with law and regulation and hospital policies and procedures.	IC.06.01.01 EP 4
Surgical Services Note: Surgical services are performed in accordance with hospital policies and procedures including the following:	
1. Staff perform a surgical scrub before donning sterile gloves for surgical procedures using either an antimicrobial surgical scrub agent or an FDA-approved alcohol-based antiseptic surgical hand rub. After surgical scrub, hands and arms are dried with a sterile towel (if applicable), and sterile surgical gown and gloves are donned in the OR.	IC.06.01.01 EP 3
2. Staff in the surgical area adhere to aseptic and sterile technique.	IC.06.01.01 EP 3
3. Staff and visitors wear surgical attire (e.g., scrubs) and surgical caps/hoods covering all head and facial hair in semi restricted and restricted areas. Note: Restricted areas include ORs, procedure rooms, and the clean core (sterile supply) area. The semi restricted areas include the peripheral support areas of the surgical suite.	IC.06.01.01 EP 3
4. Surgical masks are worn fully covering the mouth and nose by all staff in restricted areas where open sterile supplies or scrubbed staff are located.	IC.06.01.01 EP 3
5. The sterile field is maintained, including the following: • Items used within the sterile field are sterile. • Items introduced into the sterile field are opened, dispensed, and transferred in a manner to maintain sterility. • The sterile field is prepared in the location where it will be used and as close as possible to time of use. • Movement in or around sterile field is done in a manner to maintain sterility.	IC.06.01.01 EP 3
6. Traffic in and out of the OR is kept to a minimum and limited to essential staff.	IC.06.01.01 EP 3
7. All horizontal surfaces (for example, furniture, surgical lights, booms, equipment) are damp dusted before the first procedure of the day using a clean, lint-free cloth and an EPA-registered hospital detergent/disinfectant.	IC.06.01.01 EP 3
8. High-touch environmental surfaces are cleaned and disinfected between patients.	IC.06.01.01 EP 3
9. ORs are terminally cleaned after the last procedure of the day (including weekends) and each 24-hour period during regular work week. Terminal cleaning includes wet-vacuuming or mopping the floor with an EPA-registered disinfectant.	IC.06.01.01 EP 3
10. Anesthesia equipment surfaces that are touched by staff while providing patient care or while handling contaminated items are cleaned and low-level disinfected between use on patients according to manufacturers' instructions.	IC.06.01.01 EP 3
11. Exterior surfaces of anesthesia equipment that are not knowingly contaminated during patient care are terminally low-level disinfected at the end of the day according to manufacturers' instructions.	IC.06.01.01 EP 3
12. Internal components of the anesthesia machine breathing circuit are cleaned per manufacturers' instructions and hospital policies and procedures.	IC.06.01.01 EP 3
13. Reusable noncritical items (for example, blood pressure cuffs, ECG leads, tourniquets, oximeter probes) are cleaned and disinfected between patients.	IC.06.01.01 EP 3

Imaging Document Review Guide

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

1. Facilities and Equipment:

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

    - ☐ CT annual equipment performance evaluation:NPG.13.03.01 EP 6
      Must be documented, done by medical physicist, and include:
        - Image uniformity
        - Slice thickness accuracy
        - Alignment light accuracy
        - Table travel accuracy
        - Radiation beam width
        - High contrast resolution
        - Low contrast resolution
        - Geometric or distance accuracy
        - CT number accuracy and uniformity
        - Artifact evaluation

    - ☐ MRI annual equipment performance evaluation: PE.05.01.01 EP 1
      Must be documented, done by medical physicist or MRI scientist, and include
        - Image uniformity for all coils used clinically
        - Signal to noise ratio (SNR) for all coils used clinically
        - Slice thickness accuracy
        - Slice position accuracy
        - Alignment light accuracy
        - High contrast resolution
        - Low contrast resolution
        - Geometric or distance accuracy
        - Magnetic field homogeneity
        - Artifact evaluation

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

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

    - ☐ Image Acquisition Display Monitor Performance Evaluations for CT, MRI, NM, PET-PE.05.01.01 EP 4
      Must be performed as part of annual equipment performance evaluations and include:

- Maximum and minimum luminance
- Luminance uniformity
- Resolution
- Spatial accuracy

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

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

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

2. Radiation Protection and Radiopharmaceutical Management

   Radiation Protection and Radiopharmaceutical Management
   - Records of radiopharmaceutical receipt and disposition MM.13.1.1 EP 6 for 2026

3. Clinical Policies and Protocols
   - Critical Tests: Written procedures or protocols, and data collected on the timeliness of reporting critical results of tests and diagnostic procedures NPG.01.02.01, EP1

   - CT Protocols: Protocols must be based on current standards of practice and address clinical indication, contrast administration, pediatric or adult, patient size and body habitus, expected radiation dose range. Must include input from interpreting physician, lead imaging technologist, and medical physicist and be reviewed at timeframes established by hospital NPG.13.2.1 EP 3 for 2026

     - MRI Safety: Policies address: claustrophobia, noise protection, metal detection, patient emergencies while in scanner, restricting access to scanner for all people not trained in MRI safety NPG.13.03.01 EP 2 and EP 3

4. Reporting and Performance Improvement
   - Data collected on thermal injuries during MRI NPG.13.04.01 EP 1 for 2026
   - Data collected on incidents and injuries where ferromagnetic objects unintentionally entered MRI scan room NPG.13.04.01 EP 1 for 2026
   - Data collected on incidents where radiation dose (CTDIvol, DLP, SSDE) exceeded the expected range Identified in the imaging protocol NPG.13.04.01 EP 2 for 2026

5. Staff Competencies
   - Credential files for all diagnostic medical physicists who work with CT. NPG.13.1.1 EP 2 for 2026
   - Credential files including certification and annual training on dose optimization for CT techs
   - NPG.13.1.1 EP 3 for 2026Credential files including annual training for all MRI techs on safe MRI practices NPG.13.1.1 EP 4 for 2026

6. Leadership
   - Documentation / Radiology Director: must be a qualified MD or DO. MS.17.01.03, EP 5
     - Documentation / Nuclear Medicine: must be a qualified MD or DO. LD.13.1.7 EP 3 for 2026
     - Documentation / Radiation Safety Officer: must be designated. NPG.13.2.1 EP 1 for 2026
     - Documentation of Medical Staff Approval (usually at Med Exec Comm Meeting) for:

     Qualifications of radiology staff who use equipment and administer procedures MS.16.01.01, EP11

     Nuclear Medicine Director's specifications for the qualifications, training, functions, of nuclear medicine staff MS.16.01.01, EP 12

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

- Reports, including medical record number, documenting contrast dose and radiation dose for 5 recent inpatients. RC.12.01.01, EP 2,
- Reports, including medical record number, documenting fluoroscopy radiation dose for 5 recent inpatients. RC.12.1.1 EP 2

Performance Improvement Evaluation Tool

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

X	Assessment Item	Notes	Joint Commission Standard	HAP CoPs	CAH CoPs & TJC Standards
Data Collection, Analysis, and Improvement for Ongoing Performance Monitoring					
	Operative/other procedures placing patient at risk	- Verify data is collected - Ask hospital if any of these data collection topics have evolved into improvement projects *****Use this information when selecting the performance monitoring data and improvement projects to trace. (See Performance Improvement Tracer guidance below)**	PI.12.01.01, EP1	482.21 (c)(2)	No CoP
	Significant discrepancies between pre-op and post-op diagnosis		PI.12.01.01, EP1	482.21(c)(2)	No CoP
	Use of blood and blood components		PI.12.01.01, EP 1	482.21(c)(2)	No CoP
	Resuscitation results		NPG.01.05.01, EP1	482.21(a)(2)	No CoP
	Patient perception of safety and care		PI.11.01.01 EP2	482.21(b)(1)	No CoP
	MDRO/CLABSI/CAUTI/ SSI		PI.11.01.01, EP 2	482.21(b)(1)	No CoP
	Pain management assessment interventions and effectiveness		NPG.06.03.01 EP1	No CoP	No CoP
	Contract services		LD.13.03.03 EP2	482.12(e) and (e)(1),	485.635(c)(4)(i) and (ii) LD.11.01.03, EP 1
	Patient flow process		NPG.01.03.01, EP1		
	Medication management system		MM.17.01.01, EP 3	482.25(b)(6)	482.25(b)(6)
	Antibiotic stewardship/use		MM.18.01.01 EPs 1, 2, 3, 4, 5 NPG.14.06.01 EPs 1, 2	§482.42, §482.42(b)(4), §482.42(b)(1), §482.42(c)(3)(i), §482.42(c)(3)(ii), §482.42(c)(3)(iii), §482.42(c)(3)(iv), §482.42(c)(1)(ii), §482.42(b)(2)(i), §482.42(b)(2)(ii), §482.42(b)(2)(iii)	485.640 (b)(2)(iii), 485.640(b)(3), 485.640(c)(1)(i) MM.18.01.01, EP 3, 11, &12 MM18.01.01, EP 8-10 IC.05.01.01, EP1
	Hand hygiene		NPG.05.03.01, EP 1	No CoP	No CoP
	Safety Culture Evaluation		NPG.02.03.01 EPs 10, 11	No CoP	No CoP
	Health care disparities		NPG.04.01.01, EP 3-6	No CoP	No CoP
	Compounded sterile preparations quality assurance		MM.15.01.01, EP 6	482.25(b)(1)	MM.15.01.01, EP 6 482.25(b)(1)
Adverse Event, Incident Report Data – There may not be data available, but process must exist to collect, aggregate, analyze/study, and report undesirable event/incident data.					
	Moderate or deep sedation adverse events		PI.12.01.01 EP 1	§482.21(c)(2)	MM.17.01.01, EP 1
	Transfusion reactions (reported and confirmed)		PI.12.01.01 EP 1	§482.21(c)(2)	No CoP
	Significant medication errors		PI.12.01.01 EP 1	§482.21(c)(2)	~~MM.17.01.01, EP 1~~
	Significant adverse drug reactions		PI.12.01.01 EP 1	§482.21(c)(2)	MM.17.01.01, EP 1
	MRI thermal injuries		NPG.13.04.01, EP1	No CoP	No CoP

Performance Improvement Evaluation Tool

X	Assessment Item	Notes	Joint Commission Standard	HAP CoPs	CAH CoPs & TJC Standards
	Ferromagnetic object injuries (MRI room)		NPG.13.04.01, EP1	No CoP	No CoP
	Analysis of sentinel events		PI.11.01.01, EP1 MS.16.03.01, EP2 NPG.02.03.01, EP1 NPG.02.03.01, EP5	482.21(a)(2), (c)(2), (e)(1)	No CoP
	Proactive risk assessment (every 18 months)		NPG.02.03.01 EPs 1-13	482.21(e)(1)	No CoP
	Incident Reporting System		NPG.02.03.01 EPs 1-13	482.13(c)(2), 482.41(d)(2)	
	Radiation dose incidents		NPG.13.04.01, EP2	No CoP	No CoP
Data Analyzed and Actions Taken					
	Deemed only: Medicare quality reporting data used in PI program		PI.11.01.01, EP 2	482.21(b)(1)	485.641(b)(5) PI.11.01.01, EP 1
	Use of system/process failure and proactive risk assessment information		NPG.02.03.01 EPs 1-13	482.21(a)(1), (b)(2)(i), (c)(2), (e)(1)	No CoP
	Uses improvement tools or methodologies		PI.14.01.01, EP 2	No CoP	No CoP
	Analysis of data to identify patterns, trends, variation		LD.11.01.01, EP 8 LD.13.03.01, EP 1 PI.14.01.01, EP 1 PI.12.01.01, EP 4 PI.13.01.01, EP2	482.21, 482.21(a)(2), (b)(2)(i), (e)(1)	485.641, 485.641(d)(2), 485.641(e) LD.13.03.01, EP 1 LD.13.03.01, EP 2 PI.11.01.01, EP 2 PI.14.01.01, EP1
	Use data to identify improvement opportunities		LD.11.01.01, EP 8 LD.13.03.01, EP 1 PI.14.01.01, EP 1 PI.12.01.01, EP 4 PI.12.01.01 EP 1 PI.13.01.01, EP 2	482.21, 482.21(a)(2), (b)(2)(ii), (c)(2), (e)(1)	485.641, 485.641(d)(2), 485.641(e) LD.13.03.01, EP 1 LD.13.03.01, EP 2 PI.11.01.01, EP 2 PI.14.01.01, EP1
	Acts on performance improvement priorities		LD.11.01.01, EP 8 LD.13.03.01, EP 1 PI.14.01.01, EP 1 PI.12.01.01, EP 5 PI.11.01.01, EP 4	482.21, (c)(3), (d)(4)	485.641(e) PI.11.01.01, EP 2 PI.14.01.01, EP1
Improving Performance					
	Acts when does not achieve or sustain improvements		LD.11.01.01, EP 8 LD.13.03.01, EP 1 PI.14.01.01, EP 1 PI.12.01.01, EP 5 PI.12.01.01, EP 3	482.21, (c)(3), (d)(3)	485.641(e) PI.11.01.01, EP 2 PI.14.01.01, EP1
Identifying, Prioritizing, and Planning Performance Improvement Projects					
	Deemed: PI reflects complexity of services		LD.11.01.01, EP 8 LD.13.03.01, EP 1 PI.14.01.01, EP 1	482.21	485.641(b)(1) through (b)(4), 485.641(c) LD.11.01.01, EP 8

Performance Improvement Evaluation Tool

X	Assessment Item	Notes	Joint Commission Standard	HAP CoPs	CAH CoPs & TJC Standards
	PI is hospitalwide		LD.11.01.01, EP 8 LD.13.03.01, EP 1 PI.14.01.01, EP 1	482.21	485.641 LD.13.01.01, EP 1
	- Leaders set priorities for PI - Leaders give priority to high-risk, high- volume, or problem-prone processes - Leaders identify frequency of data collection		LD.11.01.01, EP 8 LD.13.03.01, EP 1 PI.14.01.01, EP 1 LD.13.03.01, EP 2	482.21, 482.21(c)(1)(i) – (iii) 482.21(b)(3)	485.641, 485.641(d)(1) and (d)(3) LD.13.01.01, EP 1, 2
	Leaders set expectations for using data and information to achieve PI goals		LD.11.01.01, EP 8 LD.13.03.01, EP 1 PI.14.01.01, EP 1 PI.11.01.01, EP2 PI.13.01.01, EP 2	482.21, 482.21(a)(1), (b)(2)(i)	485.641, 485.641(e) LD.13.01.01, EP 1
	Leaders review plan for addressing PI priorities annually and update		PI.11.01.01, EP 4	No CoP	No CoP
Sharing of PI Data and Information (e.g., Governing Body, Medical Staff, Patient Safety, Performance Improvement Program)					
	ICP communicates w/antibiotic stewardship and PI program		IC.04.01.01, EP 2,3, and 5 IC.05.01.01, EP 1,2 IC.06.01.01, EP 3 MM.18.01.01. EP 1,3, and 5	482.42, 482.42(c)(1)(ii) 482.42(c)(2)(iii) 482.42(c)(2)(vi)	485.640(c)(1)(ii), 485.640(c)(2)(iii), 485.640(c)(2)(vi) IC.05.01.01, EP 2 MM.18.01.01. EP 3, &5 IC.04.01.01, EP 2
	Antibiotic stewardship program communicates with ICP, leaders, and PI		IC.04.01.01, EP 2,3, and 5 IC.05.01.01, EP 1,2 IC.06.01.01, EP 3 MM.18.01.01. EP 1,3, and 5	482.42, 482.42(c)(1)(ii), 482.42(c)(3)(iii)	485.640, 485.640(c)(1)(ii), 485.640(c)(3)(iii) IC.05.01.01, EP 2 MM.18.01.01. EP 3, &5 IC.04.01.01, EP 2

Performance Improvement (PI) Project Tracer Checklist

Use this tool to trace the selected organization PI project related to improving patient outcomes.

PI Patient Outcomes Project	
Discussion	
How was the project need identified and by who? (quality indicators, dashboards)	
How did you get leadership to make this project a priority?	
What guidance and expectations did leadership establish for the project?	
Review the written plan for the project PI.11.01.01, EP 3 Is the process needing improvement identified? ○ Are there any stakeholder requirements for the project? ○ Are there project goals? ○ What improvement activities are planned? ○ Is the method(s) for measuring performance of the process(es) needing improvement described? ○ What method(s) will be used to analyze performance measure data? ○ Is there a description of how the process(es) will be improved? ○ What method(s) will be used to determine if actions taken to improve the process(es) resulted in improved performance? ○ Are next steps identified in the plan if improvement is not achieved? ○ PI.14.01.01, EP1 or PI. 12.01.01, EP 4? ○ Is there a plan to continue monitoring improved processes for sustainability, and for how long?	

Performance Monitoring and Distinct Quality Indicator Checklist

Use this tool to trace the selected organization performance monitoring and distinct quality indicators related to the following:

- **Infection prevention and control data** (for example, surveillance, CLABSI, CAUTI, hand hygiene, C-diff., other)
- **Medication management data** (for example, antibiotic stewardship, medication error reduction, adverse drug reactions)
- **Other performance monitoring activity** (for example, stroke measures, maternal health measures)

Performance Monitoring and Distinct Quality Indicators			
	IC PI Activity	**MM PI Activity**	**Other Performance Monitoring Activity**
Discussion			
Is the scope of data collection appropriate to the indicator (e.g., indicators related to hand hygiene would require data from multiple units/areas)? **PI.11.01.01 EP 3**, **PI.12.01.01, EP 1, EP 2, EP 4**			
Is the method and frequency of data collection specified? **PI.11.01.01 EP 3**			
Is there evidence that the data are collected in the manner and frequency specified? **PI.11.01.01 EP 3**			
Are data collected aggregated in accordance with the hospital's methodology specified? **PI.13.01.01 EP 1**			
Are the collected data analyzed? **PI.13.01.01 EP 1**			
If the activity/indicator is the type that measures a rate, are rates calculated for points in time and over time, and are comparisons made to performance benchmarks when available? **PI.13.01.01 EP 1**			
When appropriate, are aggregated data broken down into subsets that allow comparison of performance among units/areas of the hospital? **PI.13.01.01 EP 1**			
If data analysis identified opportunities for improvement, is there evidence of actions taken to address them? **PI.13.01.01 EP 1, PI.14.01.01 EP 1**			
Are actions taken evaluated for success? **PI.14.01.01 EP 1**			
If actions taken were not successful, were new actions identified? **PI.14.01.01 EP 1, PI.12.01.01 EP 5**			
If actions taken were successful, did evaluation continue to assess sustained compliance? **PI.12.01.01, EP 5**			

Emergency Management Documentation Review Tool – HAP/CAH

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

Emergency Management Document Review Tool

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

Assessment Item	Applicability	Joint Commission Standards	CMS CoP	Comments
• When procedural changes are made during an event				
Part 5: EM Testing (Exercises)				
☐ Two annual emergency exercises are documented and conducted as follows: ☐ Participation in one operational-based exercise (full-scale community (if avail) or a functional facility-based) ***and*** ☐ One additional exercise of choice operations-based or discussion-based ☐ Has exemption from conducting its next operations-based exercise due to a real event in which the EOP was activated	Applies to all hospitals and CAHs	**EM.16.01.01, EP 2**	HAP 482.15 (d)(2) - (d)(2)(ii)(C) CAH485.625 (d)(2) - (d)(2)(ii)(C)	**Exercise Date(s) #1** **Exercise Date(s) #2** **Additional Exercise Date(s):**
Part 5: EM Program Evaluation				
☐ Documents and reviews of all emergency exercises, emergency or disaster incidents (After-action reports) ☐ Documentation, review, & update of improvement plans, actions taken, and any revisions made to plans/policies and procedures	Applies to all hospitals and CAHs	**EM.17.01.01, EP 1**	HAP 482.15 (d)(2)(iii) CAH485.625 (d)(2)(iii)	**Current Review Date:** _____ **Updated at least every 2 years? (EM.17.01.01, EP 3)** **Yes No**
Part 6: Emergency & Standby Power Systems (may be incorporated with LS document review/LS building tour)				
☐ A written plan for managing essential or critical utilities during an emergency that includes: • Emergency & standby power systems • Emergency generator location • Emergency generator inspection & testing • Emergency generator fuel source	Applies to all hospitals and CAHs	**EM.12.02.09, EPs 1 - 2** **EM.12.02.11, EPs 1–3** **PE.03.01.01, EP 3** **PE.04.01.01, EP 1** **PE.04.01.03, EP 3**	HAP 482.15 (e)(1) - (e)(3) CAH485.625 (e)(1) – (e)(3)	**Current Review Date:** _____ **Updated at least every 2 years? (EM.17.01.01, EP 3)** **Yes No**
Part 7: Unified and Integrated EM Program (if applicable)				
If hospital is part of health care system and chooses to participate in a unified and integrated emergency management program: ☐ Program accounts for the hospital's unique circumstances, patient population, and services offered ☐ Documented community-based & individual facility-based risk assessment ☐ Unified and integrated EOP ☐ Integrated P&Ps	Applies to Hospitals and CAHs that are part of a system that has a unified and integrated EM program	**EM.09.01.01, EPs 2-3** **EM.11.01.01, EPs 3-4** **EM.12.01.01, EPs 1, 2 & 6** **EM.13.01.01,**	HAP482.15 (f), (f)(1) - (f)(5) CAH485.625 (f), (f)(1) - (f)(5)	**Current Review Date:** _____ **Updated at least every 2 years? (EM.17.01.01, EP 3)** **Yes No**

Emergency Management Document Review Tool

Assessment Item	Applicability	Joint Commission Standards	CMS CoP	Comments
☐ Coordinated communication plan ☐ Training and testing program ☐ Reviews and evaluates exercises and emergency events ☐ Documentation of improvement plans, actions taken, revisions to plans/policies and procedures		**EPs 1-4** **EM.15.01.01, EP 1** **EM.16.01.01, EP 1**		
Part 8: Transplant Hospitals (if applicable)				
☐ Protocols address duties and responsibilities of the hospital, transplant program(s), and OPO	Applies to Deemed Hospitals, only	**EM.09.01.01, EP 4**	HAP 482.15 (g), (g)(1) - (g)(2)	**Current Review Date:** _____ **Updated at least every 2 years?** **Yes No**

Workplace Violence Evaluation Tool

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

PRE-SURVEY: Gather and Review

Review all pertinent documents submitted or provided by the organization.

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

TJC Process:

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

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

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

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

Explore during individual tracers and staff/leadership interviews:

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

Surveyor notes:

Standard NPG.11.01.01: The hospital collects information to monitor conditions in the environment
EP 3: The hospital establishes a process(es) for continually monitoring, internally reporting, and investigating the following:
- Injuries to patients or others within the hospital's facilities and grounds

- Occupational illnesses and staff injuries
- Incidents of damage to its property or the property of others
- Safety and security incidents involving patients, staff, or others within its facilities, including those related to workplace violence
- Hazardous materials and waste spills and exposures
- Fire safety management problems, deficiencies, and failures
- Medical or laboratory equipment management problems, failures, and use errors
- Utility systems management problems, failures, or use errors.

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

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

***TJC Process*:**

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

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

Explore during individual tracers and staff/leadership interviews:

Is there evidence that hospital personnel are aware of the process for internally reporting workplace violence incidents? Can they describe what happens after an incident is reported? Have relevant report data been shared with them?

Surveyor notes:

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

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

TJC Process:

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

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

Surveyor notes:

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

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

TJC Process:

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

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

Surveyor notes:

Health Care Equity Evaluation Tool (HAP/CAH)

This is a guide to addressing the Health Care Equity requirements during the survey.

PRE-SURVEY: Gather and Review

Review all pertinent documents submitted or provided by the organization.

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

TJC Process:

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

Explore during interviews with leadership:

- Discuss how the organization has prioritized improving health care equity as a quality and safety issue.

Explore during Individual Tracers and staff/leadership interviews:

- Is there evidence the hospital personnel are aware of the efforts to improve health care equity?

Surveyor notes:

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

TJC Process:

Explore during interviews with leadership:

- Identify the designated individual that is leading the organization's efforts to improve health care equity.
- How was the individual selected?

- What is the scope of the individual's responsibilities?
- If the individual oversees health care equity at multiple locations, how do they coordinate the efforts to address specific health care equity issues at each location?

Surveyor notes:

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

TJC Process:

Explore during interviews with leadership:

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

Explore during Individual Tracers and staff/leadership interviews:

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

Surveyor notes:

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

TJC Process:

Explore during the Organization Quality and Performance Improvement session

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

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

Surveyor notes:

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

TJC Process:

Explore during the combined Organization Quality and Performance Improvement session:

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

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

Surveyor notes:

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

TJC Process:

Explore during the combined Organization Quality and Performance Improvement session:

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

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

Surveyor notes:

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

TJC Process:

Explore during interviews with leadership:

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

Explore during Individual Tracers and staff/leadership interviews:

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

Surveyor notes:

Antibiotic Stewardship Evaluation Tool (HAP/CAH)

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

PRE-SURVEY: Gather and Review

Review all pertinent documents submitted or provided by the organization.

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

TJC Process:

Optimizing the use of antibiotics is a patient safety priority, and antibiotic stewardship programs play a critical role in supporting appropriate antibiotic prescribing practices and reducing antibiotic resistance. The revisions to Standard MM.18.01.01 include a combination of updates to align with federal regulations and recommendations from scientific and professional organizations, editorial changes, additional notes to clarify expectations, and EPs that will now apply to all accredited hospitals (deeming lead-in statements have been deleted).

Explore during interviews with leadership:

- Discuss how the organization supports its antibiotic stewardship program.

Explore during Individual Tracers and staff and leadership interviews:

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

Surveyor notes:

Standard MM.18.01.01: The 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 hospital services provided.

TJC Process:

Explore during interviews with antibiotic stewardship program leadership:

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

Surveyor notes:

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

TJC Process:

Explore during interviews with hospital leadership and the program leader:

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

During the Competency Assessment Session:

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

Surveyor notes:

Standard MM.18.01.01: The hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.
EP 3: The leader(s) of the antibiotic stewardship program is responsible for the following:
-Development and implementation of a 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 hospital's infection prevention and control and QAPI programs, on antibiotic use issues.

-Competency-based training and education of hospital personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the hospital, on the practical applications of antibiotic stewardship guidelines, policies, and procedures.

TJC Process:

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

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

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

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

Surveyor notes:

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

TJC Process:

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

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

Surveyor notes:

Standard MM.18.01.01: The hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.
EP 5: The hospitalwide antibiotic stewardship program:

-Demonstrates coordination among all components of the hospital responsible for antibiotic use and resistance, including, but not limited to, the infection prevention and control program, the quality assessment and performance improvement program, the medical staff, nursing services, and pharmacy services.
-Documents the evidence-based use of antibiotics in all departments and services of the hospital.
-Documents any improvements, including sustained improvements, in proper antibiotic use.

TJC Process:

Explore during Individual Tracer Activity through interviews:

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

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

- Review the hospital's antibiotic stewardship policies and procedures for evidence that the hospital has a process in place for coordination among all components of the hospital responsible for antibiotic use and resistance, including, but not limited to, the antibiotic stewardship program, the infection prevention and control program, the QAPI program, the medical staff, nursing services, and pharmacy services.
- Ask about any improvements in proper antibiotic use that have been achieved and sustained.

Surveyor notes:

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

TJC Process:

Explore during the Organization Quality and Performance Improvement session or individual tracer activity:

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

Surveyor notes:

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

TJC Process:

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

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

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

TJC Process:

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

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

Surveyor notes:

Standard NPG.14.06.01: The hospital has an active antibiotic stewardship program.EP 2: The antibiotic stewardship program monitors the hospital's antibiotic use by analyzing data on days of therapy per 1000 days present or 1000

patient days, or by reporting antibiotic use data to the National Healthcare Safety Network's Antimicrobial Use Option of the Antimicrobial Use and Resistance Module.

TJC Process:

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

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

Surveyor notes:

Hospital National Performance Goals Evaluation Module

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

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

Joint Commission Standards / EPs	Hospital Survey Process
NPG.01.02.01 The hospital reports critical results of tests and diagnostic procedures on a timely basis. **NPG.01.02.01, EP 1** The hospital develops and implements written procedures for managing the critical results of tests and diagnostic procedures that address the following: - The definition of critical results of tests and diagnostic procedures - By whom and to whom critical results of tests and diagnostic procedures are reported - The acceptable length of time between the availability and reporting of critical results of tests and diagnostic procedures **NPG.01.02.01, EP 2** The hospital evaluates the timeliness of reporting the critical results of tests and diagnostic procedures.	**Interview** ☐ Ask the responsible staff about the process for critical results to determine knowledge of processes. **Document Review** ☐ Review policy and procedures related to reporting of critical results of tests and diagnostic procedures. ☐ Review data collected and any PI to ascertain the activities of the hospital. ☐ Review required documentation within patient medical records, according to hospital policy.
NPG.01.03.01 The hospital manages the flow of patients throughout the hospital. **NPG.01.03.01, EP 1** The hospital measures and sets goals for the components of the patient flow process, including the following: - Available supply of patient beds - Throughput of areas where patients receive care, treatment, and services (such as inpatient units, laboratory, operating rooms, telemetry, radiology, and the postanesthesia care unit) - Safety of areas where patients receive care, treatment and services - Efficiency of the nonclinical services that support patient care and treatment (such as housekeeping and transportation) - Access to support services (such as case management and social work) **NPG.01.03.01, EP 2** The hospital measures and sets goals for mitigating and managing the boarding of patients who come through the emergency department. (Refer to NPG.8.01.01, EPs 1 and 2; NPG.01.05.02, EP 1) Note: Boarding is the practice of holding patients in the emergency department or another temporary location after the decision to admit or transfer has been made. The hospital should set its goals with attention to patient acuity and best practice.	**Interview** ☐ Ask staff on different units and services (particularly Emergency Department, med/surge units, OR, radiology, laboratory, housekeeping, transportation) what they consider to be the hospital's most challenging patient flow problem ☐ Query staff regarding the timing of assessments and reassessments and availability of consulting providers (such as for behavioral health, oncology, surgery, neurology, ob/gyn). Inquire about the availability and rounding of qualified mental health staff or consultants. ☐ Query staff regarding frequency of boarding patients with behavioral health emergencies. ☐ Query leadership regarding how they use patient flow dashboards or other reports to monitor performance and manage trends over time. **Document Review** ☐ Review medical records of boarded patients for: ☐ Assessment and reassessments - include as indicated: medical, mental status, and psychiatric assessments, and consideration of suicide risk and prevention (see also PC.03.03.09 regarding restraint and seclusion).

Joint Commission Standards / EPs	Hospital Survey Process
NPG.01.03.01, EP 3 The individuals who manage patient flow processes review measurement results to determine whether goals were achieved, and leaders take action to improve patient flow processes when goals are not achieved. Note: At a minimum, leaders include members of the medical staff and governing body, the chief executive officer and other senior managers, the nurse executive, clinical leaders, and staff members in leadership positions within the organization. (See the Glossary for the definition of leader.)	☐ Care planning process – trace stabilization or therapeutic care, treatment or service; identify any current treatment providers, family members or others with role in care planning. ☐ Continuum of care – evaluate the communication and coordination process with other staff, other units (e.g., psychiatry, social work, case management) and external providers as indicated in planning for transfer or discharge. **Observation** ☐ Select a patient who is experiencing or did experience an extended wait or delay. This information can be gleaned from department logs, staff and patient interviews. Most commonly, patients in the emergency department or surgical units experience delays in transfer to beds in inpatient care areas. Select patients admitted through the emergency department and begin a tracer there; for example, a medical patient, or a behavioral patient in need of long term placement. Request the ED census from the previous week and choose a patient to trace from the peak period. ☐ Using the experience of this patient, trace the flow of the patient to various units and through the discharge process, where applicable. Note locations, times, and details of delays.
NPG.01.04.01 The hospital has a process for hand-off communication. **NPG.01.04.01, EP 1.** The hospital follows a process to receive or share patient information when the patient is referred to internal providers of care, treatment, and services. **NPG.01.04.01, EP 2.** The hospital's process for hand-off communication provides for the opportunity for discussion between the giver and receiver of patient information. Note: Such information may include the patient's condition, care, treatment, medications, services, and any recent or anticipated changes to any of these.	**Interview** ☐ Ask staff about the patient hand-off process and what information is shared between the giver and receiver. ☐ Ask staff who the hand-off process applies to internally.
NPG.01.05.01 The hospital improves the safety of clinical alarm systems. **NPG.01.05.01, EP 1** Identify the most important alarm signals to manage based on the following:	**Purpose** Make improvements to ensure that alarms on medical equipment are heard and responded to on time.

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

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NPG.01.05.02, EP 1 The hospital develops and implements written criteria describing early warning signs of a change or deterioration in a patient's condition and the appropriate action to take.	**Document Review** Review the written criteria that describes early warning signs of a change or deterioration in patient condition in the form that is available to staff. **Observation** Ask staff to demonstrate how they access the change in patient condition early warning signs criteria and guidance.
NPG.01.05.03 Resuscitative services are available throughout the hospital. **NPG.01.05.03, EP 1** The hospital provides resuscitative services based on national standards of care, guidelines, and the hospital's policies, procedures, or protocols. **NPG.01.05.03, EP 2** Resuscitation equipment is available for use based on the needs of the population served. Note: For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available. **NPG.01.05.03, EP 3** The hospital provides education and training to staff involved in the provision of resuscitative services. The hospital determines which staff complete this education and training based on their job responsibilities and hospital policies and procedures. The education and training are provided at the following intervals: - At orientation - A periodic basis thereafter, as determined by the hospital - When staff responsibilities change Note 1: Topics may cover resuscitation procedures or protocols; use of cardiopulmonary resuscitation techniques, devices, or equipment; and roles and responsibilities during resuscitation events. Note 2: The hospital determines the format and content of education and training (for example, a skills day, a mock code).	**Interview** ☐ Ask staff members about their responsibilities during resuscitation and about the education and training on resuscitation that the hospital has provided. Ask how frequently education and training on resuscitation are provided. ☐ Ask staff if patient population appropriate resuscitation equipment is available and accessible when needed. **Observation** ☐ Verify resuscitation equipment is available, properly maintained, and staff responsible in the use of the equipment are competent **Document Review** **Personnel Files** Review personnel files of staff who per hospital policy should have resuscitative services education and training for evidence of completion at the required intervals.
NPG.01.05.04 The hospital develops and implements processes for post-resuscitation care.	**Interview** ☐ Ask staff if they are aware of any hospital policies, procedures, or protocols for interdisciplinary post-cardiac arrest care.

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

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

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NPG.01.06.02, EP 3 The procedure site is marked by a licensed practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed. In limited circumstances, the licensed practitioner may delegate site marking to an individual who is permitted by the organization to participate in the procedure and has the following qualifications: - An individual in a medical postgraduate education program who is being supervised by the licensed practitioner performing the procedure; who is familiar with the patient; and who will be present when the procedure is performed - A licensed individual who performs duties requiring a collaborative agreement or supervisory agreement with the licensed practitioner performing the procedure (that is, an advanced practice registered nurse [APRN] or physician assistant [PA]); who is familiar with the patient; and who will be present when the procedure is performed. Note: The hospital's leaders define the limited circumstances (if any) in which site marking may be delegated to an individual meeting these qualifications. **NPG.01.06.02, EP 4** The method of marking the site and the type of mark is unambiguous and is used consistently throughout the hospital. Note: The mark is made at or near the procedure site and is sufficiently permanent to be visible after skin preparation and draping. Adhesive markers are not the sole means of marking the site. **NPG.01.06.02, EP 5** A written, alternative process is in place for patients who refuse site marking or when it is technically or anatomically impossible or impractical to mark the site (for example, mucosal surfaces or perineum). Note: Examples of other situations that involve alternative processes include the following: - Minimal access procedures treating a lateralized internal organ, whether percutaneous or through a natural orifice - Teeth - Premature infants, for whom the mark may cause a permanent tattoo	☐ Review patient medical records for those requirements as determined by the organization. **Observation** ☐ Observe patient care in procedural areas to verify hospital processes related to procedural site marking.
NPG.01.06.03 The hospital performs a time-out before the procedure.	**Interview** ☐ In procedural areas, inquire with staff and licensed practitioners about the time out process

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NPG.01.06.03, EP 1 The hospital conducts a time-out immediately before starting the invasive procedure or making the incision. **NPG.01.06.03, EP 2** The time-out has the following characteristics: - It is standardized, as defined by the hospital. - It is initiated by a designated member of the team. - It involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the operating room technician, and other active participants who will be participating in the procedure from the beginning. **NPG.01.06.03, EP 3** When two or more procedures are being performed on the same patient, and the person performing the procedure changes, the hospital performs a time-out before each procedure is initiated. **NPG.01.06.03, EP 4** During the time-out, the team members agree, at a minimum, on the following: - Correct patient identity - The correct site - The procedure to be done **NPG.01.06.03, EP 5** The hospital documents the completion of the time-out. Note: The hospital determines the amount and type of documentation.	○ Who leads the time out? ○ What happens when the process is not followed according to hospital policy and procedure? **Document Review** ☐ Review documents related to procedural services and care of the patient. This may include but is NOT limited to: anesthesia policies, surgical services procedures, medical staff bylaws. ☐ Review patient medical records for those requirements as determined by the organization. **Observation** ☐ Observe patient care in procedural areas to verify hospital processes related to the time out process. **Note:** The purpose of the time-out is to conduct a final assessment that the correct patient, site, and procedure are identified. This requirement focuses on those minimum features of the time-out. Some believe that it is important to conduct the time-out before anesthesia for several reasons, including involvement of the patient. A hospital may conduct the time-out before anesthesia or may add another time-out at that time. During a time-out, activities are suspended to the extent possible so that team members can focus on active confirmation of the patient, site, and procedure. A designated member of the team initiates the time-out and it includes active communication among all relevant members of the procedure team. The procedure is not started until all questions or concerns are resolved. The time-out is most effective when it is conducted consistently across the hospital.
NPG.02.01.01 The mission, vision, and goals guide the hospital's actions. **NPG.02.01.01, EP 1** The governing body, senior managers, and leaders of the organized medical staff work together to create the hospital's mission, vision, and goals, which guide the leaders' actions. The mission, vision, and goals are communicated to staff and the population(s) served.	**Interview** ☐ Ask senior leaders about the creation of the organization's current mission, vision, and goals. Determine who was involved in the creation.

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	☐ Ask leaders and staff at all levels of the organization about how the mission, vision and goals influence day-to-day activity throughout the organization. **Observation** ☐ Look for evidence that the organization's mission, vision, and goals are being communicated throughout the organization.
NPG.02.02.01 The hospital addresses conflicts of interest and ethics. **NPG.02.02.01, EP 1** The governing body, senior managers, and leaders of the organized medical staff work together to define in writing conflicts of interest that could affect safety and quality of care, treatment, and services. **NPG.02.02.01, EP 2** The governing body, senior managers, and leaders of the organized medical staff work together to develop a written policy that defines how conflicts of interest will be addressed. **NPG.02.02.01, EP 3** Conflicts of interest are disclosed as defined by the hospital. **NPG.02.02.01, EP 4** Senior managers and leaders of the organized medical staff work with the governing body to develop and implement an ongoing process for managing conflict among leadership groups that has the potential to adversely affect patient safety or quality of care. **NPG.02.02.01, EP 5** The hospital develops and implements a process that allows staff, patients, and families to address ethical issues or issues prone to conflict.	**Interview** ☐ Ask leaders about the organization's policy and process for managing conflicts of interest among leadership groups. ☐ Ask leaders about the organization's process for staff, patients, and families to raise ethical issues and issues prone to conflict. **Document Review** ☐ Review the organization's written description of conflicts of interest that could affect safety and quality of care, treatment, and services. ☐ Review the organization's written policy on how conflicts of interest will be addressed.
NPG.02.03.01 The hospital's leaders design work processes to focus individuals on safety and quality issues. **NPG.02.03.01, EP 1** The leaders implement a hospitalwide patient safety program as follows: - One or more qualified individuals or an interdisciplinary group manage the safety program. - All departments, programs, and services within the hospital participate in the safety program.	**Interview** ☐ Discuss the Safety Culture in the organization including: • How well the leaders understand the assessment tool, scope of assessment in the organization, response rates, and reported results. • Does the organization have benchmarks? Are these Internal and/or external benchmarks • What quality improvement projects have been undertaken to improve your scores on safety culture?

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- The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as close calls [“near misses”] or good catches) to hazardous conditions and sentinel events. **NPG.02.03.01, EP 2** The leaders encourage external reporting of significant adverse events, including voluntary reporting programs in addition to mandatory programs. Note: Examples of voluntary programs include The Joint Commission Sentinel Event Database and the US Food and Drug Administration (FDA) MedWatch. **NPG.02.03.01, EP 3** As part of the safety program, the leaders create procedures for responding to system or process failures. Note: Responses might include continuing to provide care, treatment, and services to those affected, containing the risk to others, and preserving factual information for subsequent analysis. **NPG.02.03.01, EP 4** The leaders provide and encourage the use of systems for internal reporting of a system or process failure, or the results of a proactive risk assessment, without the risk of retaliation. Note: This EP is intended to minimize staff reluctance to report errors in order to help an organization understand the source and results of system and process failures. The EP does not conflict with holding individuals accountable for errors due to negligence. **NPG.02.03.01, EP 5** The hospital conducts thorough and credible comprehensive systematic analyses (for example, root cause analyses) in response to sentinel events as described in the "Sentinel Event Policy" (SE) chapter of this manual. **NPG.02.03.01, EP 6** The leaders make support systems available for staff who have been involved in an adverse or sentinel event. Note: Support systems recognize that health care workers who are involved in sentinel events may be negatively affected by the event and require support. Support systems provide staff with help and support as well as additional resources through the human resources function or an employee assistance program. Support systems also focus on the process rather than blaming the involved individuals. **NPG.02.03.01, EP 7** At least every 18 months, the hospital selects one high-risk process and conducts a proactive risk assessment. Note: For suggested components, refer to the Proactive Risk Assessment section at the beginning of this chapter.	• Does the Board set expectations for improving safety culture? • Does the organization include safety culture improvement goals in performance expectations for leaders and middle management? □ Discuss the code of conduct that leaders developed and adopted for physicians and staff. • Is it the same for everyone? • Describe your policy and procedures for dealing with intimidating behaviors, especially by physicians. • What has been done to try to eradicate intimidating behavior? • How do staff report intimidating behavior? • How widespread is disrespectful behavior in your organization? ▪ Does the organization measure it? ▪ How do you deal with serial violators? ▪ Do you use the same process for all caregivers? ▪ Are your disciplinary procedures equitable and transparent? • How do you decide if discipline should be used in evaluating errors? ▪ Did the individual depart from agreed and available safe practices or protocols (foresight test)? ▪ Were there mitigating circumstances? • Would another person from the same professional group, with similar training and experience, behave in the same way in similar circumstances (substitution test)? ▪ Were there deficiencies in training, experience or supervision?

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HospitNPG.02.03.01, EP 8 To improve safety and to reduce the risk of medical errors, the hospital analyzes and uses information about system or process failures and the results of proactive risk assessments. **NPG.02.03.01, EP 9** Communication processes are effective in doing the following: - Fostering the safety of the patient and their quality of care - Supporting a culture of safety and quality - Meeting the needs of internal and external users - Informing those who work in the hospital of changes in the environment - Disseminating lessons learned from comprehensive systematic analyses (for example, root cause analyses), system or process failures, and proactive risk assessments to all affected staff. **NPG.02.03.01, EP 10** Leaders evaluate the effectiveness of communication methods. **NPG.02.03.01, EP 11** Leaders regularly evaluate the culture of safety and quality using valid and reliable tools. Possible issues are identified by the culture of safety evaluation. Proposed improvements are prioritized and implemented. **NPG.02.03.01, EP 12** Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety. **NPG.02.03.01, EP 13** Leaders create and implement a process for managing behaviors that undermine a culture of safety.	▪ Were there mitigating circumstances? ☐ In the event an error occurs, and a patient is harmed: • Do you have a process in place to determine whether this was a system error or whether the person responsible should be held accountable? • How do you separate blameless errors (for learning) from blameworthy errors (for discipline, equitably applied to all groups)? • What process do you have in place for reporting a "close call" or an error that occurred but did not reach the patient? ▪ How often is this used? ▪ Can you give me a recent example? • Do you conduct root cause analyses of all "near misses?" **Document Review** ☐ Process/tool used to conduct a safety culture assessment ☐ Current and past results of the safety culture assessment; changes made based on results
NPG.05.03.01 The hospital complies with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines and/or the current World Health Organization (WHO) hand hygiene guidelines. **NPG.05.03.01, EP 1** The hospital implements a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) and/or the current World Health Organization (WHO) hand hygiene guidelines. The program sets goals for improving compliance with hand hygiene based on established goals.	**Interview** ☐ Discuss with staff and providers in all areas of patient care and services the hand hygiene guidelines established in the organization. o Include activities they have identified within the area of survey activities. o Discuss scenarios where safety culture may be identified. For example, hospital staff entering patient rooms- do staff AND patients feel safe to speak up if hand hygiene is not performed?

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	☐ Interview patients and ask if they observe hand hygiene procedures being performed, if so ask when? **Document Review** ☐ Request and review documents related to the hand hygiene program. These may include but are not all inclusive, hand hygiene-- policy, data and PI activities, Infection Control Plan and Risk assessment and goals. **Observation** ☐ Observe care being provided in all areas of the organization, are staff and providers following hand hygiene procedures adopted by the organization?
NPG.06.01.01 Pain assessment and pain management, including safe opioid prescribing, are identified as an organizational priority. **NPG.06.01.01, EP 1** The hospital has a leader or leadership team that is responsible for pain management and safe opioid prescribing, as well as developing and monitoring performance improvement activities. **NPG.06.01.01, EP 2** The hospital provides nonpharmacologic pain treatment modalities. **NPG.06.01.01, EP 3** The hospital provides staff with educational resources and programs to improve pain assessment, pain management, and the safe use of opioid medications based on the identified needs of its patient population. **NPG.06.01.01, EP 4** The hospital provides information to staff on available services for consultation and referral of patients with complex pain management needs. **NPG.06.01.01, EP 5** The hospital identifies opioid treatment programs that can be used for patient referrals. **NPG.06.01.01, EP 6** The hospital facilitates licensed practitioner and pharmacist access to the Prescription Drug Monitoring Program databases. Note: This element of performance is applicable in any state that has a Prescription Drug Monitoring Program database, whether querying is voluntary or is mandated by state regulations for all patients prescribed opioids.	**Interview** ☐ Ask leaders how they have made pain assessment, pain management, and safe opioid prescribing an organizational priority ☐ Ask leaders how they provide staff with educational resources to improve pain assessment, pain management, and the safe use of opioids Ask staff about: ☐ Hospital processes for collecting patient-level data on pain assessment, pain management and safe-opioid prescribing such as: • Hospital process for identifying patients at high risk for adverse outcomes related to opioid treatment. • Hospital process for monitoring patients identified as high risk when receiving opioids. • How they screen, assess, and reassess patients for pain, non-pharmacologic approaches they offer. Ask physicians and other licensed practitioners about:

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NPG.06.01.01, EP 7 Hospital leadership works with its clinical staff to identify and acquire the equipment needed to monitor patients who are at high risk for adverse outcomes from opioid treatment.	☐ Knowledge of pain assessment, pain management, and safe opioid prescribing initiatives by the hospital and any resources that have been made available. • Has the hospital provided access to and criteria that prompts accessing the Patient Drug Monitoring Database? • What non-pharmacologic modalities are available to patients and how were these modalities determined? • What information has leadership provided on available services for consultation and referral of patients with complex pain management needs? • What opioid treatment programs are available for patient referrals? **Document Review** ☐ Review documentation that demonstrates leadership making pain assessment, pain management, and safe opioid prescribing an organizational priority. Examples may include budget items or plans, strategic plans and performance improvement plans
NPG.06.02.01 The hospital assesses and manages the patient's pain and minimizes the risks associated with treatment. **NPG.06.02.01, EP 1** The hospital has defined criteria to screen, assess, and reassess pain that are consistent with the patient's age, condition, and ability to understand. **NPG.06.02.01, EP 2** The hospital screens patients for pain during emergency department visits and at the time of admission. **NPG.06.02.01, EP 3** The hospital treats the patient's pain or refers the patient for treatment. Note: Treatment strategies for pain may include nonpharmacologic, pharmacologic, or a combination of approaches. **NPG.06.02.01, EP 4** The hospital develops a pain treatment plan based on evidence-based practices and the patient's clinical condition, past medical history, and pain management goals.	**Interview** Ask staff about: ☐ Hospital processes for collecting patient-level data on pain assessment, pain management and safe-opioid prescribing such as: • Hospital process for identifying patients at high risk for adverse outcomes related to opioid treatment. • Hospital process for monitoring patients identified as high risk when receiving opioids. • How they screen, assess, and reassess patients for pain, non-pharmacologic approaches they offer. Ask patients and when appropriate, family members about: ☐ How the staff involved them in their pain management, plan of care, what their pain management plan of care includes (non-pharmacologic, pharmacologic or a combination of approaches).

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NPG.06.02.01, EP 5 The hospital involves the patient in the pain management treatment planning process through the following: - Developing realistic expectations and measurable goals that the patient understands for the degree, duration, and reduction of pain - Discussing the objectives used to evaluate treatment progress (for example, relief of pain and improved physical and psychosocial function) - Providing education on pain management, treatment options, and safe use of opioid and nonopioid medications when prescribed **NPG.06.02.01, EP 6** The hospital monitors patients identified as being high risk for adverse outcomes related to opioid treatment. **NPG.06.02.01, EP 7** The hospital reassesses and responds to the patient's pain through the following: - Evaluation and documentation of response(s) to pain intervention(s) - Progress toward pain management goals, including functional ability (for example, ability to take a deep breath, turn in bed, walk with improved pain control) - Side effects of treatment - Risk factors for adverse events caused by the treatment **NPG.06.02.01, EP 8** The hospital educates the patient and family on discharge plans related to pain management, including the following: - Pain management plan of care - Side effects of pain management treatment - Daily living activities, including the home environment, that might exacerbate pain or reduce effectiveness of the pain management plan of care and strategies to address these issues - Safe use, storage, and disposal of opioids when prescribed	☐ Their level of understanding of discharge instructions related to the pain management plan of care including side effects of pain management treatment, activities of daily living in the home environment that may exacerbate pain including strategies to address these issues. **Document Review** ☐ Review patient clinical records for: • Screening, assessments, and reassessments of the patient's pain. • A pain treatment plan and involvement of the patient in the planning process. • Documentation of patient monitoring for pain and their response to pain management interventions, including effectiveness, side effects and risk factors for adverse events caused by the treatment. • Documentation of any patient and family education related to pain management throughout the stay and at the time of discharge.
NPG.06.03.01 The hospital collects data on pain assessment and management.	**Interview** ☐ Discuss with staff, as appropriate, at the unit level: • Data collection processes and responsibilities (for example pain assessment and pain management)

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NPG.06.03.01, EP 1 The hospital analyzes data collected on pain assessment and pain management to identify areas that need change to increase safety and quality for patients.	☐ Ask leaders and staff responsible for the organization's quality assessment and performance improvement activities about the patient safety-related data monitoring that is taking place. Determine if pain assessment, pain management, including non-pharmacologic approaches, and safe opioid use are being monitored.
NPG.07.01.01 The hospital respects the patient's right to receive information in a manner the patient understands. **NPG.07.01.01, EP 1** The hospital respects the patient's right to and need for effective communication. **NPG.07.01.01, EP 2** The hospital provides interpreting and translation services, as necessary. Note: For hospitals that elect The Joint Commission Primary Care Medical Home option: Language interpreting options may include trained bilingual staff, contract interpreting services, or employed language interpreters. These options may be provided in person or via telephone or video. The documents translated, and the languages into which they are translated, are dependent on the primary care medical home's patient population. **NPG.07.01.01, EP 3** The hospital communicates with the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient's needs.	**Interview** ☐ Ask staff about the availability of tools and resources to assist with patient communication, such as: Access to language interpreters, access to translated documents, the potential for involvement of interpreter on care team **Observation** ☐ Look for staff use of available tools and resources to identify and address patient communication needs, such as language identification tools, language interpreter services, communication boards, use of teach back techniques to address health literacy needs, patient access to the nurse call button.
NPG.07.02.01 The hospital honors the patient's right to give or withhold informed consent. **NPG.07.02.01, EP 1** The hospital develops and implements a written policy on informed consent that describes the following: - Specific care, treatment, and services that require informed consent. - Circumstances that would allow for exceptions to obtaining informed consent. - Process used to obtain informed consent. - Physicians or other licensed practitioners permitted to conduct the informed consent discussion in accordance with law and regulation.	**Interview** ☐ Ask staff, including physicians and other practitioners about the process they follow when a patient's care, treatment, and services requires informed consent. • What do they explain and discuss with the patient? • How do they document informed consent in the patient's medical record? • What happens when a patient is unable to provide informed consent? ☐ Ask a patient who is scheduled for a procedure about the process they experienced when they were asked to consent to the procedure. **Document Review**

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- How informed consent is documented in the patient record. Note: Documentation may be recorded in a form, in progress notes, or elsewhere in the record. - When a surrogate decision-maker may give informed consent. **NPG.07.02.01, EP 2** The informed consent process includes a discussion about the following: - Patient's proposed care, treatment, and services. - Potential benefits, risks, and side effects of the patient's proposed care, treatment, and services; the likelihood of the patient achieving their goals; and any potential problems that might occur during recuperation. - Reasonable alternatives to the patient's proposed care, treatment, and services. The discussion encompasses risks, benefits, and side effects related to the alternatives and the risks related to not receiving the proposed care, treatment, and services.	**General** ☐ Confirm that the hospital has a written policy on patient informed consent and that it addresses all the EP requirements. **Patient Clinical Record** ☐ Patient informed consent documented per hospital policy
NPG.07.03.01 The hospital assesses the patient who may be a victim of possible abuse, neglect, and exploitation. **NPG.07.03.01, EP 1** The hospital uses written criteria to identify those patients who may be victims of physical assault, sexual assault, sexual molestation, domestic abuse, elder or child abuse, neglect, and exploitation. Patients are evaluated upon entry into the hospital and on an ongoing basis. Note: Criteria can be based on age, sex, and circumstance. **NPG.07.03.01, EP 2** To assist with referrals of possible victims of abuse, neglect, and exploitation, the hospital maintains a list of private and public community agencies that can provide or arrange for assessment and care. **NPG.07.03.01, EP 3** The hospital educates staff about how to recognize signs of possible abuse, neglect, and exploitation and about their roles in follow-up. **NPG.07.03.01, EP 4** The hospital internally reports cases of possible abuse, neglect, and exploitation. **NPG.07.03.01, EP 5** When the hospital serves a population of patients that need protective services (for example, guardianship or advocacy services, conservatorship, or child or adult protective services), it provides resources to help the family and the courts determine the patient's needs for such services.	**Interview** ☐ Ask staff about the criteria that guides them in identifying potential victims of abuse, neglect, and exploitation. • How do they access these criteria and guidance? • Has the organization offered staff education on how to recognize signs of possible abuse, neglect and exploitation and how to follow-up? • What resources and information does the organization have available for staff to offer possible victims? • What process does staff follow when they suspect a patient may be a victim of abuse, neglect, and exploitation? **Document Review** Review the organization's policy and procedures on patient abuse, neglect and exploitation.

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NPG.07.04.01 The hospital treats the patient in a dignified and respectful manner. **NPG.07.04.01, EP 1** The hospital respects the patient's cultural and personal values, beliefs, and preferences. **NPG.07.04.01, EP 2** The hospital accommodates the patient's right to religious and other spiritual services.	**Interview** ☐ Ask patients or family members how the organization identified and addressed oral and written communication needs with them and, if necessary, how language services were provided ☐ Ask patients or family members if staff inquired about their race and ethnicity and informed them of their rights to religious and other spiritual services. ☐ Ask staff about organization expectations for treatment of patients and observance of patient rights. **Observation** During tracer activity throughout the organization, observe and listen to how staff interact with and care for patients.
NPG.09.01.01 The hospital uses standardized procedures for managing tissues. **NPG.09.01.01, EP 1** The hospital develops and implements standardized written procedures for the acquisition, receipt, storage, and issuance of tissues. **NPG.09.01.01, EP 2** The hospital confirms that tissue suppliers are registered with the US Food and Drug Administration (FDA) as a tissue establishment and maintain a state license when required. Note 1: This element of performance does not apply to autologous tissue- or cellular-based products considered tissue for the purposes of these standards but classified as medical devices by the FDA. Note 2: The supplier's FDA registration status may also be checked annually by using the FDA's online database: https://www.fda.gov/vaccines-blood-biologics/biologics-establishment-registration/findtissueestablishment. **NPG.09.01.01, EP 3** The hospital follows the tissue suppliers' or manufacturers' written directions for transporting, handling, storing, and using tissue. **NPG.09.01.01, EP 4** The hospital maintains daily records to demonstrate that tissues requiring a controlled environment are stored at the required temperatures. Note 1: Types of tissue storage include room temperature, refrigerated, frozen (for example, deep freezing colder than -40°C), and liquid nitrogen storage.	**Interview** ☐ Interview laboratory personnel to discuss: • Process for ensuring that the source facility is licensed (state) and/or registered (federal) (EP 2) • Coordination of tissue ordering, receipt, storage, handling and issuance – validate that these processes are being done according to manufacturer or source facility written directions (EP 3) • Physical Environment (EPs 4-6) ○ Storage – continuous temperature (refrigerator and freezer, not room or ambient storage), functional alarms, emergency backups ○ Documentation of tissue temperatures ○ Acceptance of tissue from source: ▪ Process for ensuring package integrity ▪ Transportation temperature • No thermometer needed but do need to know if shipping containers were validated. **Document Review** ☐ Daily records for tissue storage temperatures ☐ Temperature monitoring logs for tissue storage equipment

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Note 2: Tissues requiring no greater control than "ambient temperature" (defined as the temperature of the immediate environment) for storage would not require temperature monitoring. **NPG.09.01.01, EP 5** The hospital continuously monitors the temperature of refrigerators, freezers, nitrogen tanks, and other storage equipment used to store tissues. Note 1: Continuous temperature recording is not required but may be available with some continuous temperature monitoring systems. Note 2: For tissue stored at room temperature, continuous temperature monitoring is not required. **NPG.09.01.01, EP 6** Refrigerators, freezers, nitrogen tanks, and other storage equipment used to store tissues at a controlled temperature have functional alarms and an emergency backup plan. Note: For tissue stored at room temperature, alarm systems are not required. **NPG.09.01.01, EP 7** In Department of Defense hospitals, Veterans Affairs medical centers, and other federally administered health care agencies, notification to the organ procurement organization of patients who have died or whose death is imminent is done according to procedures approved by the respective agency.	
NPG.09.02.01 The hospital traces all tissues bi-directionally. **NPG.09.02.01, EP 1** The hospital's records allow any tissue to be traced from the donor or tissue supplier to the recipient(s) or other final disposition, including discard, and from the recipient(s) or other final disposition back to the donor or tissue supplier. **NPG.09.02.01, EP 2** The hospital identifies, in writing, the materials and related instructions used to prepare or process tissues.	**Document Review** ☐ Record keeping on tissues • Donor/source facility to final disposition (discarded, returned to source facility or transplanted/implanted to recipient) traceability and vice versa. ○ Source facility information ○ Pre-transplant/implant documentation ○ Post transplant/implant documentation ○ Return information to source facility
NPG.09.03.01 The hospital investigates adverse events related to tissue use or donor infections. **NPG.09.03.01, EP 1** The hospital has a written procedure to investigate tissue adverse events, including disease transmission or other complications that are suspected of being directly related to the use of tissue. The procedure includes the following at a minimum:	**Interview** ☐ Ask laboratory staff responsible for tissue storage and issuance about adverse events investigation and implementation of procedures for: • Tracking and investigation of tissue transplant infections • Reporting of infections to source

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- Investigating disease transmission or other complications that are suspected of being directly related to the use of tissue - Reporting of a post-transplant infection or adverse event related to the use of tissue to the tissue supplier as soon as the hospital becomes aware - Sequestering of tissue whose integrity may have been compromised or that is reported by the tissue supplier as a suspected cause of infection - Identifying and informing tissue recipients of infection risk when donors are subsequently found to have human immunodeficiency virus (HIV), human T-lymphotropic virus-I/II (HTLV-I/II), viral hepatitis, or other infectious agents known to be transmitted through tissue.	• Sequestering other associated tissue, if contamination is suspected • Identification and notification to recipients of suspected infections **Document Review** Confirm that the organization has written procedures to investigate tissue adverse events and that it includes at a minimum those elements identified in the EP.
NPG.10.01.01 Policies and procedures for waived tests are established, current, approved, and readily available. **NPG.10.01.01, EP 1** The person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate, or a qualified designee, establishes written policies and procedures for waived testing that address the following: - Clinical usage and limitations of the test methodology - Need for confirmatory testing (for example, recommendations made by the manufacturer for rapid tests) and result follow-up recommendations (for example, a recommendation to repeat the test when results are higher or lower than the reportable range of the test) - Specimen type, collection, and identification, and required labeling - Specimen preservation, if applicable - Instrument maintenance and function checks, such as calibration - Storage conditions for test components - Reagent use, including not using a reagent after its expiration date - Quality control (including frequency and type) and corrective action when quality control is unacceptable - Test performance	**Interview** ☐ Interview the waived testing director or supervisor whose name appears on the CLIA certificate, or a qualified designee about • Policies and procedures for waived testing ○ Do they reflect manufacturers' instructions for use and include specific operational policies? • How these policies and procedures are made available to testing personnel. **Document Review** Confirm that waived testing policies and procedures address all the required items from the EP.

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- Result reporting, including not reporting individual patient results unless quality control is acceptable - Equipment performance evaluation Note 1: Policies and procedures for waived testing are made available to testing personnel. Note 2: The designee should be knowledgeable by virtue of training, experience, and competence about the waived testing performed. **NPG.10.01.01, EP 2** Policies or procedures for each waived test are consistent with manufacturers' instructions for use and include specific operational policies (that is, detailed quality control protocols and any other institution-specific procedures regarding the test or instrument).	
NPG.10.02.01 Staff performing waived tests are competent. **NPG.10.02.01, EP 1** Staff who perform waived testing have been trained for each test that they are authorized to perform. The training for each waived test is documented. Note: This includes training on the use and maintenance of instruments. **NPG.10.02.01, EP 2** Competence for waived testing is assessed according to hospital policy at defined intervals, but at least at the time of orientation and annually thereafter. Competency is assessed using at least two of the following methods per person per test: - Performance of a test on a blind specimen - Periodic observation of routine work by the supervisor or qualified designee - Monitoring of each user's quality control performance - Use of a written test specific to the test assessed This competency is documented. Note 1: When a licensed practitioner performs waived testing that does not involve an instrument and the test falls within their specialty, the hospital may use the medical staff credentialing and privileging process to document evidence of training and competency in lieu of annual competency assessment. In this circumstance, individual privileges include the specific waived tests appropriate to the scope of practice that they are authorized to perform. At the discretion of the person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate or	**Interview** ☐ Ask staff who are performing waived testing about their orientation and training as well as their competency assessment for performing the specific test(s). • How often is their competency in performing waived testing assessed? **Document Review** **Personnel Files** ☐ Confirm through documentation that staff who perform waived testing have been trained for each test they perform. ☐ Confirm through documentation that staff competence for waived testing has been assessed according to hospital policy at defined intervals, but at least at orientation and annually thereafter. • Does documentation reflect that staff competency was assessed using at least two of the methods presented in the EP?

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according to hospital policy, more stringent competency requirements may be implemented. Note 2: Provider-performed microscopy (PPM) procedures are not waived tests.	
NPG.11.01.01 The hospital manages security risks. **NPG.11.01.01, EP 1** The hospital controls access to and from areas it identifies as security sensitive. **NPG.11.01.01, EP 2** The hospital develops and implements written policies and procedures to follow in the event of a security incident, including an infant or pediatric abduction. **NPG.11.01.01, EP** 3 The hospital develops and implements a process(es) for continually monitoring, internally reporting, and investigating the following: - Injuries to patients or others within the hospital's facilities and grounds - Occupational illnesses and staff injuries - Incidents of damage to its property or the property of others - Safety and security incidents involving patients, staff, or others within its facilities, including those related to workplace violence - Hazardous materials and waste spills and exposures - Fire safety management problems, deficiencies, and failures - Medical or laboratory equipment management problems, failures, and use errors - Utility systems management problems, failures, or use errors Note 1: All the incidents and issues listed above may be reported to staff in quality assessment, improvement, or other functions. A summary of such incidents may also be shared with the person designated to coordinate safety management activities. Note 2: Review of incident reports often requires that legal processes be followed to preserve confidentiality. Opportunities to improve care, treatment, and services, or to prevent similar incidents, are not lost as a result of following the legal process. **NPG.11.01.01, EP** 4 The hospital coordinates administrative and clinical decisions for patients under legal or correctional restrictions on the following:	**Interview** ☐ Ask organization staff about the areas that are considered security sensitive and require controlled access. ☐ Ask about the methods of controlled access that are being used throughout the organization and the effectiveness. ☐ Ask about the organization's internal safety and security reporting process. • How accessible (ease of locating and use) is the reporting process to staff? • Is staff encouraged to report both actual and potential for safety and security issues? ☐ Ask leaders and staff to describe: • How they monitor safety and security throughout the organization (e.g., unit-, department-, building/site-level) and with what frequency. • The process that is followed to investigate and address safety and security incident reports. ☐ Ask leaders and staff about the processes that are followed when the organization is providing care to patients under legal or correctional restrictions. How does the organization coordinate administrative and clinical decisions for these patients? **Document Review** Review organization written policies and procedures related to security incidents, including infant or pediatric patient abduction. **Observation** During individual tracer and other building tour activity, visit areas that are subject to controlled access to observe the security measures that are in place.

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- Use of seclusion and restraint for nonclinical purposes - Imposition of disciplinary restrictions - Restriction of rights - Plan for discharge and continuing care, treatment, and services - Length of stay.	
NPG.11.02.01 The hospital assesses and manages the patient's risks for falls. **NPG.11.02.01, EP 1** The hospital implements fall risk reduction interventions based on the patient population, setting, and individual patient's assessed risks.	**Interview** ☐ Ask staff about the assessment process for determining if a patient is at risk for falls. • Describe the types of interventions the organization has available for staff to use with patients that are at risk for falls. ☐ If possible, interview a patient or patients that have been identified as at risk for falls. Ask if they are aware of this assessment and how staff are working with them to reduce their risk for a fall. **Document Review** **Patient Clinical Record** Review the clinical records of patients who were identified as fall risks to see if documentation reflects the interventions that are being used to mitigate the risk of falls and avoid injuries due to a fall. **Observation** Try to observe a patient or patients who have been assessed as being at risk for falls to see what risk reduction interventions are in place and how staff are working with these patients.
NPG.11.03.01 The hospital manages utility systems. **NPG.11.03.01, EP 1** The hospital develops and implements written procedures for responding to utility system disruptions. The procedures include but are not limited to shutting off a malfunctioning system and notifying staff in the affected areas. **NPG.11.03.01, EP 2** The hospital develops and implements a policy to provide emergency backup for essential medication dispensing equipment identified by the hospital, such as automatic dispensing cabinets, medication carousels, and central medication robots. Note: Examples of emergency backup can include	**Interview** ☐ Facilities staff about utility systems and the procedures that are followed if there be a disruption in operations. ☐ Ask facilities staff about the emergency back-up systems that are in place in case of a malfunctioning utility system. **Document Review** ☐ Confirm that there are written procedures for responding to utility system disruptions.

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emergency power, battery-based indoor generators, or other actions describing how dispensing and administration of medications will continue when emergency backup is needed. **NPG.11.03.01, EP 3** The hospital develops and implements a policy to provide emergency backup for essential refrigeration for medications identified by the hospital, such as designated refrigerators and freezers. Note: Examples of emergency backup can include emergency power, battery-based indoor generators, or other actions describing how refrigeration of medications will continue when emergency backup is needed.	☐ Confirm that the organization has policies for providing utility system emergency backup to essential medication dispensing equipment and essential medication refrigeration and freezer units.
NPG.12.04.01 The hospital verifies that staff complete all requirements for employment and practice within their scope of practice. **NPG.12.04.01, EP 1:** The hospital obtains a criminal background check on the applicant as required by law and regulation or hospital policy. Criminal background checks are documented. **NPG.12.04.01, EP 2:** Staff comply with applicable health screening as required by law and regulation or hospital policy. Health screening compliance is documented. **NPG.12.04.01, EP 3:** Staff who provide patient care, treatment, and services practice within the scope of their license, certification, or registration, in accordance with law and regulation.	**Interview** Ask clinical leaders how they monitor staff to determine that they are providing patient care, treatment and services within their scope of practice. **Document Review** **Personnel Files** ☐ Verify criminal background checks are obtained on applicants per law and regulation or hospital policy. ☐ Verify through review of a sample of employee health files any documentation that staff has undergone required health screenings. **Observation** Observe clinical staff throughout the organization providing care, treatment and services to patients.
NPG.12.05.01 The hospital provides education and training and evaluates staff competence. **NPG.12.05.01, EP 1:** The hospital orients staff on the following: - Relevant hospitalwide and unit-specific policies and procedures - Their specific job duties, including those related to infection prevention and control and assessing and managing pain - Sensitivity to cultural diversity based on their job duties and responsibilities - Patient rights, including ethical aspects of care, treatment, or services and the process used to address ethical issues based on their job duties and responsibilities. Completion of this orientation is documented.	**Interview** ☐ Ask staff responsible for the human resources functions in the organization to describe the orientation process for new staff to the organization, job responsibilities, and/or clinical responsibilities. Ask about the topics that are included in the curriculum for all staff and all clinical staff. ☐ Ask human resources staff what they know about department and job-level orientation processes and content. ☐ Ask human resources staff about the conduct of staff performance evaluations. Is there a common process used

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NPG.12.05.01, EP 2: The hospital evaluates staff performance once every three years, or more frequently as required by hospital policy or in accordance with law and regulation. Staff are evaluated based on performance expectations that reflect their job responsibilities. This evaluation is documented.	throughout the organization? Anything unique to clinical staff? What is the frequency of such evaluations? **Document Review** **General** ☐ Review staff orientation curriculum to determine what hospital policies and procedures are covered; make a note to validate with staff encountered during individual patient tracers. **Personnel Files** ☐ Review personnel files for documentation of staff member orientation completion and any performance evaluations. Check that each are based on job responsibilities.
NPG.12.06.01 The hospital evaluates staffing during performance improvement activities. **NPG.12.06.01, EP 1:** When the hospital identifies undesirable patterns, trends, or variations in its performance related to the safety or quality of care (for example, as identified in the analysis of data or a single undesirable event), it includes the adequacy of staffing, including nurse staffing, in its analysis of possible causes. Note 1: Adequacy of staffing includes the number, skill mix, and competency of all staff. In their analysis, hospitals may also wish to examine issues such as processes related to workflow; competency assessment; credentialing; supervision of staff; and orientation, training, and education. Note 2: Hospitals may find value in using the staffing effectiveness indicators (which include National Quality Forum Nursing Sensitive Measures) to help identify potential staffing issues. **NPG.12.06.01, EP 2:** When analysis reveals a problem with the adequacy of staffing, the leaders responsible for the hospitalwide patient safety program (as addressed at NPG.02.03.01, EP 1) are informed, in a manner determined by the safety program, of the results of this analysis and actions taken to resolve the identified problem(s). **NPG.12.06.01, EP 3:** At least once a year, the leaders responsible for the hospitalwide patient safety program review a written report on the results of any	**Interview** ☐ Ask leaders and staff responsible for organization quality and performance improvement: • When staffing adequacy is considered or evaluated in association with a quality or safety issue that is in need of correction or improvement. • How are organization leaders responsible for the organization-wide patient safety program informed of analyses that reveal staffing adequacy problems and actions taken to resolve the problems. • How frequently are the leaders of the organizationwide safety program presented with the results of staffing adequacy analyses and actions taken to resolve problems. • If any information is shared with governance about staffing adequacy analyses? **Document Review** Review any written reports related to staffing adequacy analyses that are provided to safety program leaders and governance.

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

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Board of Radiology, or in diagnostic imaging physics by the American Board of Medical Physics, or in diagnostic radiological physics by the Canadian College of Physicists in Medicine, or meet all of the following requirements: - A graduate degree in physics, medical physics, biophysics, radiologic physics, medical health physics, or a closely related science or engineering discipline from an accredited college or university - College coursework in the biological sciences with at least one course in biology or radiation biology and one course in anatomy, physiology, or a similar topic related to the practice of medical physics - Documented experience in a clinical CT environment conducting at least 10 CT performance evaluations under the direct supervision of a board-certified medical physicist Note: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. **NPG.13.01.01, EP 3:** The hospital verifies and documents that individuals who perform diagnostic computed tomography (CT) examinations participate in ongoing education that includes annual training on the following: - Radiation dose optimization techniques and tools for pediatric and adult patients addressed in the Image Gently® and Image Wisely® campaigns - Safe procedures for operation of the types of CT equipment they will use Note 1: Information on the Image Gently and Image Wisely initiatives can be found online at https://www.imagegently.org and https://www.imagewisely.org, respectively. Note 2: This element of performance does not apply to CT systems used for therapeutic radiation treatment planning or delivery or for calculating attenuation coefficients for nuclear medicine studies. Note 3: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. **NPG.13.01.01, EP 4:** The hospital verifies and documents that technologists who perform magnetic resonance imaging (MRI) examinations participate in	

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ongoing education, including annual training on safe MRI practices in the MRI environment that addresses the following: - Patient screening criteria that address ferromagnetic items, electrically conductive items, medical implants and devices, and risk for nephrogenic systemic fibrosis (NSF) - Proper patient and equipment positioning activities to avoid thermal injuries - Equipment and supplies that have been determined to be acceptable for use in the MRI environment (MR safe or MR conditional) - MRI safety response procedures for patients who require urgent or emergent medical care - MRI system emergency shutdown procedures, such as MRI system quench and cryogen safety procedures - Patient hearing protection - Management of patients with claustrophobia, anxiety, or emotional distress Note: Terminology for defining the safety of items in the magnetic resonance environment is provided in ASTM F2503 Standard Practice for Marking Medical Devices and Other Items for Safety in the Magnetic Resonance Environment (http://www.astm.org).	
NPG.13.02.01 The hospital's imaging services have a designated leader and follow current safe imaging practices. **NPG.13.02.01, EP 1:** The hospital designates an individual to serve as the radiation safety officer who is responsible for making certain that radiologic services are provided in accordance with law, regulation, and hospital policy. This individual has the necessary authority and leadership support to do the following: - Monitor and verify compliance with established radiation safety practices (including oversight of dosimetry monitoring) - Provide recommendations for improved radiation safety - Intervene as needed to stop unsafe practices - Implement corrective action **NPG.13.02.01, EP 2:** The hospital provides radiology services that meet safety standards approved by nationally recognized professional organizations. At a minimum, diagnostic radiology services are maintained and available at all times the hospital provides services, including emergency services.	**Interview** ☐ Identify who the organization has identified to serve as the radiation safety officer. Ask this individual about their responsibilities and the authority and leadership support they receive to make certain radiologic services are provided in accordance with law, regulation, and hospital policy. ☐ Ask about the availability of diagnostic radiology services and the availability of therapeutic radiology services if provided by the organization. ☐ Ask radiology services leaders and staff about imaging services protocols and what these are based on, as well as who is involved in the review and update. **Document Review** Confirm the organization is following diagnostic CT imaging protocols and that they are current with standards of practice.

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Note: If the hospital also provides other radiology services, such as therapeutic radiology, the requirements of this element of performance also apply to those services. **NPG.13.02.01, EP 3:** The hospital establishes or adopts diagnostic computed tomography (CT) imaging protocols based on current standards of practice, which address key criteria including the following: - Clinical indication - Contrast administration - Age (to indicate whether the patient is pediatric or an adult) - Patient size and body habitus - Expected radiation dose index range Note: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. **NPG.13.02.01, EP 4:** Diagnostic computed tomography (CT) imaging protocols are reviewed and kept current with input from an interpreting physician, medical physicist, and lead imaging technologist to make certain that they adhere to current standards of practice and account for changes in CT imaging equipment. These reviews are conducted at time frames identified by the hospital. (For rehabilitation and psychiatric distinct part units in hospitals, refer to MS.17.01.03, EP 5 for supervision of radiologic services) Note: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.	
NPG.13.03.01 The hospital manages imaging safety risks. **NPG.13.03.01, EP 1:** The hospital manages magnetic resonance imaging (MRI) safety risks associated with the following: - Patients who may experience claustrophobia, anxiety, or emotional distress - Patients who may require urgent or emergent medical care - Patients with medical implants, devices, or imbedded metallic foreign objects (such as shrapnel) - Ferromagnetic objects entering the MRI environment - Acoustic noise **NPG.13.03.01, EP 2:** The hospital manages magnetic resonance imaging (MRI) safety risks by doing the following:	**Interview** ☐ Ask radiology leaders and staff about the safety program they have in place related to imaging services. ☐ Ask for details related to managing MRI safety risks ☐ If provided, ask about dosimetry monitoring for staff who are performing these services and who is providing this monitoring. ☐ When diagnostic CT services are provided ask if the organization is engaging a diagnostic medical physicist to perform the services that are noted in EPs 3-5. **Observation**

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- Restricting access of everyone not trained in MRI safety or screened by staff trained in MRI safety from the scanner room and the area that immediately precedes the entrance to the MRI scanner room. - Making sure that these restricted areas are controlled by and under the direct supervision of staff trained in MRI safety. - Posting signage at the entrance to the MRI scanner room that conveys that potentially dangerous magnetic fields are present in the room. Signage should also indicate that the magnet is always on except in cases where the MRI system, by its design, can have its magnetic field routinely turned on and off by the operator. **NPG.13.03.01, EP 3:** For diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist does the following: - Measures the radiation dose (in the form of volume computed tomography dose index [CTDIvol]) produced by each diagnostic CT imaging system for the following four CT protocols: adult brain, adult abdomen, pediatric brain, and pediatric abdomen. If one or more of these protocols is not used by the hospital, other commonly used CT protocols may be substituted. - Verifies that the radiation dose (in the form of CTDIvol) produced and measured for each protocol tested is within 20 percent of the CTDIvol displayed on the CT console. The dates, results, and verifications of these measurements are documented. Note 1: This element of performance is only applicable for systems capable of calculating and displaying radiation doses. Note 2: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. Note 3: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. (For more information, refer to HR.11.01.03, EP 1; HR.11.02.01, EP 2; NPG.12.04.01, EP 3) **NPG.13.03.01, EP 4:** For diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist conducts a performance evaluation of all CT imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes the use of phantoms to assess the following imaging metrics:	☐ Visit radiology services as part of tracer activity to look for evidence that imaging safety risks are being managed. ☐ Review reports and records that demonstrate the organization is engaging the services of a diagnostic medical physicist or MRI scientist to perform the services noted in EPs 3-5.

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

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determined by the medical physicist or MRI scientist. (For more information, refer to HR.11.01.03, EP 1; HR.11.02.01, EP 2; NPG.12.04.01, EP 3)	
NPG.13.04.01 The hospital monitors quality improvement projects related to imaging safety. **NPG.13.04.01, EP 1:** The hospital collects data on the following: - Patient thermal injuries that occur during magnetic resonance imaging (MRI) exams - Incidents where ferromagnetic object unintentionally entered the MRI scanner room - Injuries resulting from the presence of ferromagnetic objects in the MRI scanner room **NPG.13.04.01, EP 2:** The hospital reviews and analyzes incidents where the radiation dose index (computed tomography dose index [CTDIvol], dose length product [DLP], or size-specific dose estimate [SSDE]) from diagnostic CT examinations exceeded expected dose index ranges identified in imaging protocols. These incidents are then compared to external benchmarks. Note 1: While the CTDIvol, DLP, and SSDE are useful indicators for monitoring radiation dose indices from the CT machine, they do not represent the patient's radiation dose. Note 2: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.	**Interview** ☐ Ask imaging services leaders and staff about the data being collected to monitor safety of imaging services. ☐ Ask about the frequency of analysis and reporting of the imaging safety data. ☐ Who is monitoring these data and determining if there is any action needed to correct or improve performance. ☐ Who is responsible for reviewing and analyzing incidents related to CT and MRI incidents.
NPG.14.01.01 The hospital safely manages pharmaceutical services. **NPG.14.01.01, EP 1** When an on-site pharmacy is not open 24 hours a day, 7 days a week, the following occurs: - A health care professional, who the hospital determines is qualified, reviews the medication order in the pharmacist's absence	**Interview** ☐ Ask organization leaders and staff who reviews medication orders in the pharmacist's absence. ☐ Ask the pharmacist about their process for reviewing orders that are received while the pharmacy is closed.

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- A pharmacist conducts a retrospective review of all medication orders during this period as soon as a pharmacist is available or the pharmacy opens **NPG.14.01.01, EP 2** When automatic dispensing cabinets (ADCs) are used, the hospital develops and implements a policy that describes the types of medication overrides that will be reviewed for appropriateness and the frequency of the reviews. A 100% review of overrides is not required.	☐ Ask the pharmacist and other clinical leaders about the policy and procedures for automatic dispensing cabinet medication overrides.
NPG.14.02.01 The hospital selects and procures medications. **NPG.14.02.01, EP 1** The hospital standardizes and limits the number of drug concentrations available to meet patient care needs. **NPG.14.02.01, EP 2** The hospital follows a process to communicate medication shortages and outages to staff who participate in medication management. **NPG.14.02.01, EP 3** The hospital follows written medication substitution protocols to be used in the event of a medication shortage or outage and communicates the medication substitution protocols for shortages or outages to all affected staff.	**Interview** ☐ Discuss with leaders and staff: • The safeguards the organization has in place to reduce the risk of errors and minimize patient or staff harm related to high alert or hazardous medication(s) and look alike and sound alike medications. • Interventions/solutions the organization/unit has in place to prevent medication errors (standardizing processes). • Process to communicate medication shortages and outages to staff who participate in medication management, and the substitution protocols that will be followed • Medication substitution protocols that are followed in the event of a medication shortage or outage. **Document Review** ☐ Review organization lists and processes for managing high alert and hazardous medication(s) and look alike and sound alike medications ☐ For hazardous drugs, review organization requirements for drug precaution labeling and appropriate personal protective equipment and observe handling by nursing staff if possible.
NPG.14.03.01 The hospital labels all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings. Note: Medication containers include syringes, medicine cups, and basins. **NPG.14.03.01, EP 1** In perioperative and other procedural settings both on and off the sterile field, the hospital labels medications and solutions that are not immediately administered. This applies even if there is only one medication	**Interview** ☐ Discuss with staff in procedural areas what procedures are followed for medication safety specific to labeling of medications and containers. **Document Review**

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being used. Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process. **NPG.14.03.01, EP 2** In perioperative and other procedural settings both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to another container. **NPG.14.03.01, EP 3** In perioperative and other procedural settings both on and off the sterile field, medication or solution labels include the following: - Medication or solution name - Strength - Amount of medication or solution containing medication (if not apparent from the container) - Diluent name and volume (if not apparent from the container) - Expiration date and time Note: The date and time are not necessary for short procedures, as defined by the hospital. **NPG.14.03.01, EP 4** The hospital verifies all medication or solution labels both verbally and visually. Verification is done by two individuals qualified to participate in the procedure whenever the person preparing the medication or solution is not the person who will be administering it. **NPG.14.03.01, EP 5** The hospital labels each medication or solution as soon as it is prepared, unless it is immediately administered. Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.	Review any policy or procedures, data collection, PI activities for hospital performance and evaluation. Data collection may also be found with hospital internal reporting systems. **Observation** In perioperative and other procedural settings observe actions of staff for medication preparation both on and off the sterile field.
NPG.14.04.01 The hospital reduces the likelihood of patient harm associated with the use of anticoagulant therapy. Note: This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for preventing venous thromboembolism (for example, related to procedures or hospitalization).	**Interview** Interview staff about monitoring patients on anticoagulant therapy. **Document Review** Review hospital approved protocols and evidence based practice guidelines for reversal of anticoagulation management and bleeding events.

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NPG.14.04.01, EP 1 The hospital uses approved protocols and evidence-based practice guidelines for reversal of anticoagulation and management of bleeding events related to each anticoagulant medication. **NPG.14.04.01, EP 2** The hospital uses approved protocols and evidence-based practice guidelines for perioperative management of all patients on oral anticoagulants. Note: Perioperative management may address the use of bridging medications, timing for stopping an anticoagulant, and timing and dosing for restarting an anticoagulant. **NPG.14.04.01, EP 3** The hospital uses only oral unit-dose products, prefilled syringes, or premixed infusion bags when these types of products are available. Note: For pediatric patients, prefilled syringe products should be used only if specifically designed for children.	☐ Review performance improvement data and discuss any ongoing activities for anticoagulation therapy. ☐ Review medical records of patients on anticoagulant therapy, including those in perioperative areas and management of the pediatric patient.
NPG.14.05.01 The hospital maintains and communicates accurate patient medication information. **NPG.14.05.01, EP 1** The hospital obtains information on the medications the patient is currently taking when they are admitted to the hospital or are seen in an outpatient setting. This information is documented in a list or other format that is useful to those who manage medications. Note 1: Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications. Note 2: It is often difficult to obtain complete information on current medications from a patient. A good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the EP. **NPG.14.05.01, EP 2** Define the types of medication information (for example, name, dose, route, frequency, purpose) to be collected in non-24-hour settings. Note: Examples of non-24-hour settings include the emergency department, primary care, outpatient radiology, ambulatory surgery, and diagnostic settings. **NPG.14.05.01, EP 3** Compare the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve discrepancies. Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the hospital, does the comparison.	**Interview** ☐ Interview the staff who compares the medication information the patient brought to the hospital with the medications ordered: o How are discrepancies, omissions, duplication, unclear information resolved? o Is this person qualified to do this comparison? Review staff/credential file as appropriate. ☐ Interview patient and family about discharge medications. Determine from review of hospital policy if the patient was provided with any required information upon discharge. **Document Review** ☐ Review patient medical records for o medication reconciliation in both inpatient and outpatient settings and determine if the documentation is congruent in accordance with defined policy and procedures. o Be sure to determine if the documentation follows the hospital defined types of medication information. For example, name, dose, route, frequency etc. **Observation**

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NPG.14.05.01 EP 4 Provide the patient (or family, caregiver, or support person as needed) with written information on the medications the patient should be taking when they are discharged from the hospital or at the end of an outpatient encounter (for example, name, dose, route, frequency, purpose). **NPG.14.05.01, EP 5** Explain the importance of managing medication information to the patient when they are discharged from the hospital or at the end of an outpatient encounter. Note: Examples include instructing the patient to give a list to their primary care provider; to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added; and to carry medication information at all times in the event of emergency situations. (For information on patient education on medications, refer to Standards MM.16.01.01, PC.12.02.01, and PC.14.01.01.)	□ Observe staff discharge process on patient care units. This may also be observed in outpatient areas. Ensure compliance through review of hospital policy and procedures.

OPTIONAL Primary Care Medical Home (PCMH) Certification Evaluation Guide (Hospital and Critical Access Hospital)

Program Information:
Primary care medical home certification is optional and can be obtained initially through an extension survey (focused only on PCMH-specific requirements) or as part of your triennial accreditation survey. Once certification is obtained, re-certification will always occur at the time of the triennial survey.

If an extension survey is chosen as the route for initially obtaining PCMH certification, then only the unique PCMH accreditation requirements are evaluated during the certification survey.

When PCMH certification is obtained as part of the accreditation survey, all hospital standards as well as the unique PCMH accreditation requirements are evaluated. Surveyors will integrate the evaluation of PCMH requirements into the hospital survey as appropriate to your organization.

Organization Participants
Staff involved in patient care, support staff, and clinic management staff at each PCMH location seeking certification.

Logistical Needs
Hospitals can choose which sites they want to be PCMH certified. During the surveyor planning session, your hospital will need to provide the surveyor with information related to the services provided at those ambulatory care clinics that have been selected for primary care medical home certification, the locations or distance of the clinic from the hospital site, and the individuals who are serving in the role of the primary care clinician at each site. This information will help the surveyor determine which sites will be visited.

Documents for Surveyor Review
- Performance improvement data related to:
    - Disease management outcomes
    - Patient access to care
    - Patient experience and satisfaction related to access to care, treatment, or services, and communication
    - Patient perception of the comprehensiveness, coordination, and continuity of care, treatment, or services
    - Patient perception of the continuity of care

- PCMH Self-assessment tool (completion of this tool is optional). A copy of the tool can be downloaded from The Joint Commission's website at https://www.jointcommission.org/accreditation-and-certification/certification/certifications-by-setting/hospital-certifications/primary-care-medical-home-certification/

Scope of PCMH Survey
The survey will focus on evaluating the organization's provision of patient-centered care, comprehensive care, coordinated care, and superb access to care. Additionally, the survey will include an evaluation of the organization's system-based approach to quality, that is, the commitment to quality and quality improvement through ongoing engagement in activities such as:

- Using evidence-based medicine and clinical decision support tools,
- Guiding shared decision making with patients and families,
- Engaging in performance measurement and improvement,
- Measuring and responding to patient experiences and patient satisfaction, and
- Practicing population health management.

The site visit to PCMH locations will include evaluation of hospital accreditation standards as well as unique PCMH standards.

Individual tracer activity for unique PCMH requirements will focus on areas such as:

Optional Primary Care Medical Home Evaluation Guide

- Information provided to patients related to access to care, treatment and services, as well as primary care clinician information (for example, information related to selection of primary care clinician, how to access clinic staff, make appointments, and obtain specialty care)
- Tracking and follow-up on referrals and test results
- Interdisciplinary team collaboration and communication
- Involvement of patients in establishing treatment goals
- How patients are assessed for health literacy, where this is information documented in the medical record and how do they ensure it is available to all care team members
- The development of self-management goals, when are they developed, and where are they documented in the medical record?
- 24/7 access to prescription renewal requests, test results, clinical advice for urgent health care needs, and appointment availability
- Competence of primary care clinicians and staff
- PI activities related to PCMH