The Joint Commission

Hospital Crosswalk – Current State Compared to Future State

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§482.1	§482.1 Basis and scope.		
§482.1(a)	(a) Statutory basis.		
§482.1(a)(1)	(1) Section 1861(e) of the [Social Security] Act provides that—		
§482.1(a)(1)(i)	(i) Hospitals participating in Medicare must meet certain specified requirements; and	**LD.04.01.01, EP 2** The hospital provides care, treatment, and services in accordance with licensure requirements, laws, and 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). (See Appendix A [AXA] for the language of this CMS requirement.)	**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)
§482.1(a)(1)(ii)	(ii) The Secretary may impose additional requirements if they are found necessary in the interest of the health and safety of the individuals who are furnished services in hospitals.	**LD.04.01.01, EP 2** The hospital provides care, treatment, and services in accordance with licensure requirements, laws, and 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). (See Appendix A [AXA] for the language of this CMS requirement.)	**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)
§482.1(b)	(b) Scope. Except as provided in subpart A of part 488 of this chapter, the provisions of this part serve as the basis of survey activities for the purpose of determining whether a hospital qualifies for a provider agreement under Medicare and Medicaid.	**LD.04.01.01, EP 2** The hospital provides care, treatment, and services in accordance with licensure requirements, laws, and rules and regulations. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital	**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

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		meets the Centers for Medicare & Medicaid Services' (CMS) definition of a hospital in accordance with 42 CFR 482.1(a)(1) and (b). (See Appendix A [AXA] for the language of this CMS requirement.)	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)
§482.11	§482.11 Condition of Participation: Compliance with Federal, State and Local Laws		
§482.11(a)	(a) The hospital must be in compliance with applicable Federal laws related to the health and safety of patients.	**LD.04.01.01, EP 2** The hospital provides care, treatment, and services in accordance with licensure requirements, laws, and 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). (See Appendix A [AXA] for the language of this CMS requirement.)	**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)
§482.11(b)	(b) The hospital must be--		
§482.11(b)(1)	(1) Licensed; or	**LD.04.01.01, EP 1** The hospital is licensed, is certified, or has a permit, in accordance with law and regulation, to provide the care, treatment, or services for which the hospital is seeking accreditation from The Joint Commission. Note 1: Each service location that performs laboratory testing (waived or nonwaived) must have a Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate as specified by the federal CLIA regulations (42 CFR 493.55 and 493.3) and applicable state law. Laboratory services meet the applicable requirements at 42 CFR 482.27. Note 2: For more information on how to obtain a CLIA certificate, see http://www.cms.gov/Regulations-and-	**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.

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		Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_Certificate_International_Laboratories.html.	
§482.11(b)(2)	(2) Approved as meeting standards for licensing established by the agency of the State or locality responsible for licensing hospitals.	**LD.04.01.01, EP 1** The hospital is licensed, is certified, or has a permit, in accordance with law and regulation, to provide the care, treatment, or services for which the hospital is seeking accreditation from The Joint Commission. Note 1: Each service location that performs laboratory testing (waived or nonwaived) must have a Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate as specified by the federal CLIA regulations (42 CFR 493.55 and 493.3) and applicable state law. Laboratory services meet the applicable requirements at 42 CFR 482.27. Note 2: For more information on how to obtain a CLIA certificate, see http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_Certificate_International_Laboratories.html.	**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.
§482.11(c)	(c) The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws.	**HR.01.01.01, EP 2** The hospital verifies and documents the following: - Credentials of staff using the primary source when licensure, certification, or registration is required by law and regulation to practice their profession. 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.	**HR.11.01.03, EP 1** All staff who provide patient care, treatment, and services are qualified and possess a current license, certification, or registration, in accordance with law and regulation. **MS.17.01.03, EP 3** The credentialing process requires that the 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

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		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. **HR.01.01.01, EP 3** The hospital verifies and documents that the applicant has the education and experience required by the job responsibilities. **MS.06.01.03, EP 6** 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: - The applicant's current licensure at the time of initial granting, renewal, and revision of privileges, and at the time of license expiration - The applicant's relevant training - The applicant's current competence **MS.06.01.05, EP 1** 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. **MS.06.01.05, EP 2** The hospital, based on recommendations by the	**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.

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		organized medical staff and approval by the governing body, establishes criteria that determine a physician's or other licensed practitioner's ability to provide patient care, treatment, and services within the scope of the privilege(s) requested. Evaluation of all of the following are included in the criteria: - Current licensure and/or certification, as appropriate, verified with the primary source - The applicant's specific relevant training, verified with the primary source - Evidence of physical ability to perform the requested privilege - Data from professional practice review by an organization(s) that currently privileges the applicant (if available) - Peer and/or faculty recommendation - When renewing privileges, review of the physician's or other licensed practitioner's performance within the hospital **MS.06.01.05, EP 8** Peer recommendation includes written information regarding the physician's or other licensed practitioner's current: - Medical/clinical knowledge - Technical and clinical skills - Clinical judgment - Interpersonal skills - Communication skills - Professionalism Note: Peer recommendation may be in the form of written documentation reflecting informed opinions on each applicant's scope and level of performance, or a	

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		written peer evaluation of physician- or other licensed practitioner-specific data collected from various sources for the purpose of validating current competence.	
§482.12	§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.	**LD.01.01.01, EP 1** The hospital identifies those responsible for governance. **LD.01.01.01, EP 2** The governing body identifies those responsible for planning, management, and operational activities. **LD.01.03.01, EP 1** The governing body defines in writing its responsibilities. **LD.01.03.01, EP 2** The governing body provides for organization management and planning. **LD.01.03.01, EP 5** The governing body provides for the resources needed to maintain safe, quality care, treatment, and services. **LD.01.03.01, EP 12** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a governing body that assumes full legal responsibility for the operation of the hospital. **LD.03.01.01, EP 5** Leaders create and implement a process for managing behaviors that undermine a culture of safety.	**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.

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		LD.03.06.01, EP 2 Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.04.01.01, EP 3** Leaders act on or comply with reports or recommendations from external authorized agencies, such as accreditation, certification, or regulatory bodies. **LD.04.01.05, EP 4** Staff are held accountable for their responsibilities. **LD.04.01.07, EP 1** Leaders review, approve, and manage the implementation of policies and procedures that guide and support patient care, treatment, and services.	
§482.12(a)	§482.12(a) Standard: Medical Staff. The governing body must:		
§482.12(a)(1)	(1) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff;	**MS.01.01.01, EP 2** The organized medical staff adopts and amends medical staff bylaws. Adoption or amendment of medical staff bylaws cannot be delegated. After adoption or amendment by the organized medical staff, the proposed bylaws are submitted to the governing body for action. Bylaws become effective only upon governing body approval. (See the "Leadership" [LD] chapter for requirements regarding the governing body's authority and conflict management processes. See Element of Performance 17 for information on which medical staff	**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

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		members are eligible to vote.) **MS.01.01.01, EP 7** The governing body upholds the medical staff bylaws, rules and regulations, and policies that have been approved by the governing body. **MS.01.01.01, EP 12** The medical staff bylaws include the following requirements: The structure of the medical staff. **MS.01.01.01, EP 13** The medical staff bylaws include the following requirements: Qualifications for appointment to the medical staff. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: 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 other licensed practitioners who are determined to be eligible for appointment by the governing body. **MS.01.01.01, EP 27** The medical staff bylaws include the following requirements: The process for appointment and re-appointment to membership on 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
§482.12(a)(2)	(2) Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff;	**MS.02.01.01, EP 8** The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on, at least, all of	**LD.11.01.01, EP 2** The governing body does the following: - Approves and is responsible for the effective operation of the grievance process

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		the following: Medical staff membership. **MS.06.01.07, EP 8** The governing body or delegated governing body committee has final authority for granting, renewing, or denying privileges. **MS.07.01.01, EP 5** Membership is recommended by the medical staff and granted by the governing body.	- 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
§482.12(a)(3)	(3) Assure that the medical staff has bylaws;	**MS.01.01.01, EP 1** The organized medical staff develops medical staff bylaws, rules and regulations, and policies. **MS.01.01.01, EP 2** The organized medical staff adopts and amends medical staff bylaws. Adoption or amendment of medical staff bylaws cannot be delegated. After adoption or	**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

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		amendment by the organized medical staff, the proposed bylaws are submitted to the governing body for action. Bylaws become effective only upon governing body approval. (See the "Leadership" [LD] chapter for requirements regarding the governing body's authority and conflict management processes. See Element of Performance 17 for information on which medical staff members are eligible to vote.) **MS.01.01.01, EP 7** The governing body upholds the medical staff bylaws, rules and regulations, and policies that have been approved by the governing body.	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
§482.12(a)(4)	(4) Approve medical staff bylaws and other medical staff rules and regulations;	**MS.01.01.01, EP 2** The organized medical staff adopts and amends medical staff bylaws. Adoption or amendment of medical staff bylaws cannot be delegated. After adoption or amendment by the organized medical staff, the proposed bylaws are submitted to the governing body for action. Bylaws become effective only upon governing body approval. (See the "Leadership" [LD] chapter for requirements regarding the governing body's authority and conflict management processes. See Element of Performance 17 for information on which medical staff members are eligible to vote.)	**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

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		MS.01.01.01, EP 7 The governing body upholds the medical staff bylaws, rules and regulations, and policies that have been approved by the governing body.	- 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
§482.12(a)(5)	(5) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients;	**LD.01.05.01, EP 6** The organized medical staff is accountable to the governing body for the quality of care provided to patients.	**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

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			- 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
§482.12(a)(6)	(6) Ensure the criteria for selection are individual character, competence, training, experience, and judgment; and	**MS.06.01.03, EP 6** 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: - The applicant's current licensure at the time of initial granting, renewal, and revision of privileges, and at the time of license expiration - The applicant's relevant training - The applicant's current competence **MS.06.01.05, EP 2** The hospital, based on recommendations by the organized medical staff and approval by the governing body, establishes criteria that determine a physician's or other licensed practitioner's ability to provide patient care, treatment, and services within the scope of the privilege(s) requested. Evaluation of all of the following are included in the criteria: - Current licensure and/or certification, as appropriate,	**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

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		verified with the primary source - The applicant's specific relevant training, verified with the primary source - Evidence of physical ability to perform the requested privilege - Data from professional practice review by an organization(s) that currently privileges the applicant (if available) - Peer and/or faculty recommendation - When renewing privileges, review of the physician's or other licensed practitioner's performance within the hospital **MS.06.01.05, EP 7** The hospital queries the National Practitioner Data Bank (NPDB) in accordance with applicable law and regulation. **MS.06.01.05, EP 8** Peer recommendation includes written information regarding the physician's or other licensed practitioner's current: - Medical/clinical knowledge - Technical and clinical skills - Clinical judgment - Interpersonal skills - Communication skills - Professionalism Note: Peer recommendation may be in the form of written documentation reflecting informed opinions on each applicant's scope and level of performance, or a written peer evaluation of physician- or other licensed practitioner-specific data collected from various	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

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		sources for the purpose of validating current competence. **MS.06.01.05, EP 9** Before recommending privileges, the organized medical staff also evaluates the following: - Challenges to any licensure or registration - Voluntary and involuntary relinquishment of any license or registration - Voluntary and involuntary termination of medical staff membership - Voluntary and involuntary limitation, reduction, or loss of clinical privileges - Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant - Documentation as to the applicant's health status - Relevant physician- or other licensed practitioner-specific data as compared to aggregate data, when available - Morbidity and mortality data, when available	
§482.12(a)(7)	(7) 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.	**MS.06.01.07, EP 2** The hospital, based on recommendations by the organized medical staff and approval by the governing body, develops criteria that will be considered in the decision to grant, limit, or deny a requested privilege. Note: Medical staff membership and professional privileges are not dependent solely upon certification, fellowship, or membership in a specialty body or society. **MS.07.01.01, EP 1** The organized medical staff develops criteria for	**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

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		medical staff membership. Note: Medical staff membership and professional privileges are not dependent solely upon certification, fellowship, or membership in a specialty body or society.	- 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
§482.12(a)(8)	(8) 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	**LD.04.03.09, EP 2** The hospital describes, in writing, the nature and scope of services provided through contractual agreements. **LD.04.03.09, EP 4** Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: In most cases, each physician and other licensed practitioner providing services through a contractual agreement must be credentialed and privileged by the hospital using their services following the process described in the “Medical Staff” (MS) chapter. Note 2: For hospitals that do not use Joint Commission accreditation for deemed status purposes: When the	**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

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	recommendations that rely on information provided by the distant-site hospital.	hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following: - Verify that all physicians and other licensed practitioners who will be providing patient care, treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges. - Specify in the written agreement that the contracted organization will ensure that all contracted services provided by physicians and other licensed practitioners will be within the scope of their privileges. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders who monitor the contracted services are the governing body. **LD.04.03.09, EP 23** 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).	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) through (a)(7) and 482.22(a)(1) through (a)(2).

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		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.06.01.01 through MS.06.01.13). - The governing body of the originating site grants privileges to a distant site physician or other licensed practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site. **MS.02.01.01, EP 11** The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on, at least, all of the following: The delineation of privileges for each physician and other licensed practitioner privileged through the medical staff process. **MS.06.01.07, EP 8** The governing body or delegated governing body committee has final authority for granting, renewing, or denying privileges.	
§482.12(a)(9)	(9) Ensure that when telemedicine services are furnished to the hospital's patients through an agreement with a distant-site telemedicine entity, the written agreement	**LD.04.03.09, EP 2** The hospital describes, in writing, the nature and scope of services provided through contractual agreements.	**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

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	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.	**LD.04.03.09, EP 3** Designated leaders approve contractual agreements. **LD.04.03.09, EP 4** Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: In most cases, each physician and other licensed practitioner providing services through a contractual agreement must be credentialed and privileged by the hospital using their services following the process described in the “Medical Staff” (MS) chapter. Note 2: For hospitals that do not use Joint Commission accreditation for deemed status purposes: When the hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following: - Verify that all physicians and other licensed practitioners who will be providing patient care, treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges. - Specify in the written agreement that the contracted organization will ensure that all contracted services provided by physicians and other licensed practitioners will be within the scope of their privileges. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders who monitor the contracted services are the governing body. **LD.04.03.09, EP 5** Leaders monitor contracted services by communicating	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 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.

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		the expectations in writing to the provider of the contracted services. Note: A written description of the expectations can be provided either as part of the written agreement or in addition to it. **LD.04.03.09, EP 6** Leaders monitor contracted services by evaluating these services in relation to the hospital's expectations. **LD.04.03.09, EP 23** 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:	

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		- 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.06.01.01 through MS.06.01.13). - The governing body of the originating site grants privileges to a distant site physician or other licensed practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site. **MS.02.01.01, EP 11** The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on, at least, all of the following: The delineation of privileges for each physician and other licensed practitioner privileged through the medical staff process. **MS.06.01.07, EP 8** The governing body or delegated governing body committee has final authority for granting, renewing, or denying privileges.	
§482.12(a)(10)	(10) 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	**LD.01.03.01, EP 13** 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 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 patients of the hospital. For a multi-	**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

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	governing body, the single multihospital 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).	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.	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(b)	§482.12(b) Standard: Chief Executive Officer The governing body must appoint a chief executive officer who is responsible for managing the hospital.	**LD.01.03.01, EP 4** The governing body selects the chief executive responsible for managing the hospital.	**LD.11.01.01, EP 6** The governing body appoints the chief executive officer responsible for managing the hospital.
§482.12(c)	§482.12(c) Standard: Care of Patients In accordance with hospital policy, the governing body must ensure that the following requirements are met:		
§482.12(c)(1)	(1) Every Medicare patient is under the care of:		
§482.12(c)(1)(i)	(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.);	**MS.03.01.03, EP 1** Physicians and clinical psychologists with appropriate privileges manage and coordinate the patient's care, treatment, and services. Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). **MS.03.01.03, EP 3** A patient's general medical condition is managed and coordinated by a doctor of medicine or osteopathy. For hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy manages and coordinates the care of any Medicare or Medicaid patient's psychiatric problem that is not specifically within the scope of practice of a	**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

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		doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor, as limited under 42 CFR 482.12(c)(1)(v); or a clinical psychologist.	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 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
§482.12(c)(1)(ii)	(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;	**MS.03.01.03, EP 1** Physicians and clinical psychologists with appropriate privileges manage and coordinate the patient's care, treatment, and services. Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). **MS.03.01.03, EP 3** A patient's general medical condition is managed and coordinated by a doctor of medicine or osteopathy. For hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy manages and coordinates the care of any Medicare or Medicaid patient's psychiatric problem that is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor, as limited under 42 CFR 482.12(c)(1)(v); or a clinical psychologist.	**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

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			- A clinical psychologist as defined in 42 CFR 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
§482.12(c)(1)(iii)	(iii) A doctor of podiatric medicine, but only with respect to functions which he or she is legally authorized by the State to perform;	**MS.03.01.03, EP 1** Physicians and clinical psychologists with appropriate privileges manage and coordinate the patient's care, treatment, and services. Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). **MS.03.01.03, EP 3** A patient's general medical condition is managed and coordinated by a doctor of medicine or osteopathy. For hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy manages and coordinates the care of any Medicare or Medicaid patient's psychiatric problem that is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor, as limited under 42 CFR 482.12(c)(1)(v); or a clinical psychologist.	**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 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
§482.12(c)(1)(iv)	(iv) A doctor of optometry who is legally authorized to practice optometry by the State in which he or she practices;	**MS.03.01.03, EP 1** Physicians and clinical psychologists with appropriate privileges manage and coordinate the patient's care, treatment, and services.	**LD.11.01.01, EP 7** The governing body makes certain that patients are under the care of the appropriate licensed practitioners.

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		Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). **MS.03.01.03, EP 3** A patient’s general medical condition is managed and coordinated by a doctor of medicine or osteopathy. For hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy manages and coordinates the care of any Medicare or Medicaid patient’s psychiatric problem that is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor, as limited under 42 CFR 482.12(c)(1)(v); or a clinical psychologist.	**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 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
§482.12(c)(1)(v)	(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	**MS.03.01.03, EP 1** Physicians and clinical psychologists with appropriate privileges manage and coordinate the patient’s care, treatment, and services. Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). **MS.03.01.03, EP 3** A patient’s general medical condition is managed and coordinated by a doctor of medicine or osteopathy. For	**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

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		hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy manages and coordinates the care of any Medicare or Medicaid patient's psychiatric problem that is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor, as limited under 42 CFR 482.12(c)(1)(v); or a clinical psychologist.	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 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
§482.12(c)(1)(vi)	(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.	**MS.03.01.03, EP 1** Physicians and clinical psychologists with appropriate privileges manage and coordinate the patient's care, treatment, and services. Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). **MS.03.01.03, EP 3** A patient's general medical condition is managed and coordinated by a doctor of medicine or osteopathy. For hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy manages and coordinates the care of any Medicare or Medicaid patient's psychiatric problem that is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric	**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

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		medicine, or optometry; a chiropractor, as limited under 42 CFR 482.12(c)(1)(v); or a clinical psychologist.	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 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
§482.12(c)(2)	(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.	**MS.03.01.01, EP 2** Physicians and other licensed practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff. **MS.03.01.03, EP 1** Physicians and clinical psychologists with appropriate privileges manage and coordinate the patient's care, treatment, and services. Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). **MS.03.01.03, EP 3** A patient's general medical condition is managed and coordinated by a doctor of medicine or osteopathy. For hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy manages and coordinates the care of any Medicare or Medicaid patient's psychiatric problem that is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor, as limited under 42 CFR 482.12(c)(1)(v); or a clinical psychologist.	**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 5, that patient is under the care of a doctor of medicine or osteopathy.

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		MS.03.01.03, EP 13 For hospitals that use Joint Commission accreditation for deemed status purposes: Patients are admitted to the hospital only on the decision of a licensed practitioner permitted by the state to admit patients to a hospital.	
§482.12(c)(2) continued	Element Deleted	**MS.03.01.03, EP 1** Physicians and clinical psychologists with appropriate privileges manage and coordinate the patient's care, treatment, and services. Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). **MS.03.01.03, EP 3** A patient's general medical condition is managed and coordinated by a doctor of medicine or osteopathy. For hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy manages and coordinates the care of any Medicare or Medicaid patient's psychiatric problem that is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor, as limited under 42 CFR 482.12(c)(1)(v); or a clinical psychologist.	
§482.12(c)(3)	(3) A doctor of medicine or osteopathy is on duty or on call at all times.	**MS.03.01.03, EP 12** For hospitals that use Joint Commission accreditation for deemed status purposes: A 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 2** A doctor of medicine or osteopathy is on duty or on call at all times.

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§482.12(c)(4)	(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--	**MS.03.01.03, EP 1** Physicians and clinical psychologists with appropriate privileges manage and coordinate the patient's care, treatment, and services. Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). **MS.03.01.03, EP 3** A patient's general medical condition is managed and coordinated by a doctor of medicine or osteopathy. For hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy manages and coordinates the care of any Medicare or Medicaid patient's psychiatric problem that is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor, as limited under 42 CFR 482.12(c)(1)(v); or a clinical psychologist.	**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)(i)	(i) Is present on admission or develops during hospitalization; and	**MS.03.01.03, EP 1** Physicians and clinical psychologists with appropriate privileges manage and coordinate the patient's care, treatment, and services. Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). **MS.03.01.03, EP 3** A patient's general medical condition is managed and coordinated by a doctor of medicine or osteopathy. For hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy manages and coordinates the care of any	**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.

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		Medicare or Medicaid patient's psychiatric problem that is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor, as limited under 42 CFR 482.12(c)(1)(v); or a clinical psychologist.	
§482.12(c)(4)(ii)	(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--	**MS.03.01.03, EP 1** Physicians and clinical psychologists with appropriate privileges manage and coordinate the patient's care, treatment, and services. Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). **MS.03.01.03, EP 3** A patient's general medical condition is managed and coordinated by a doctor of medicine or osteopathy. For hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy manages and coordinates the care of any Medicare or Medicaid patient's psychiatric problem that is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor, as limited under 42 CFR 482.12(c)(1)(v); or a clinical psychologist.	**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)(ii)(A)	(A) Defined by the medical staff;	**MS.03.01.01, EP 2** Physicians and other licensed practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff. **MS.03.01.03, EP 1** Physicians and clinical psychologists with appropriate privileges manage and coordinate the patient's care,	**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,

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		treatment, and services. Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). **MS.03.01.03, EP 3** A patient’s general medical condition is managed and coordinated by a doctor of medicine or osteopathy. For hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy manages and coordinates the care of any Medicare or Medicaid patient’s psychiatric problem that is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor, as limited under 42 CFR 482.12(c)(1)(v); or a clinical psychologist.	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)(ii)(B)	(B) Permitted by State law; and	**MS.03.01.03, EP 1** Physicians and clinical psychologists with appropriate privileges manage and coordinate the patient’s care, treatment, and services. Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). **MS.03.01.03, EP 3** A patient’s general medical condition is managed and coordinated by a doctor of medicine or osteopathy. For hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy manages and coordinates the care of any Medicare or Medicaid patient’s psychiatric problem that is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric	**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.

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		medicine, or optometry; a chiropractor, as limited under 42 CFR 482.12(c)(1)(v); or a clinical psychologist.	
§482.12(c)(4)(ii)(C)	(C) Limited, under paragraph (c)(1)(v) of this section, with respect to chiropractors.	**MS.03.01.03, EP 1** Physicians and clinical psychologists with appropriate privileges manage and coordinate the patient's care, treatment, and services. Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). **MS.03.01.03, EP 3** A patient's general medical condition is managed and coordinated by a doctor of medicine or osteopathy. For hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy manages and coordinates the care of any Medicare or Medicaid patient's psychiatric problem that is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor, as limited under 42 CFR 482.12(c)(1)(v); or a clinical psychologist.	**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(d)	§482.12(d) Standard: Institutional Plan and Budget The institution must have an overall institutional plan that meets the following conditions:		
§482.12(d)(1)	(1) The plan must include an annual operating budget that is prepared according to generally accepted accounting principles.	**LD.04.01.03, EP 4** The governing body approves an annual operating budget and, when needed, a long-term capital expenditure plan.	**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

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			each anticipated income or expense. - The plan provides for capital expenditures for at least a 3-year period, including the year in which the operating budget is applicable.
§482.12(d)(2)	(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.	**LD.04.01.03, EP 3** The operating budget reflects the hospital's goals and objectives. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the Centers for Medicare & Medicaid Services' (CMS) Institutional Plan and Budget requirements in accordance with 42 CFR 482.12(d). (See Appendix A [AXA] for the language of this CMS requirement.) **LD.04.01.03, EP 4** The governing body approves an annual operating budget and, when needed, a long-term capital expenditure plan.	**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 provides for capital expenditures for at least a 3-year period, including the year in which the operating budget is applicable.
§482.12(d)(3)	(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.	**LD.04.01.03, EP 3** The operating budget reflects the hospital's goals and objectives. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the Centers for Medicare & Medicaid Services' (CMS) Institutional Plan and Budget requirements in accordance with 42 CFR 482.12(d). (See Appendix A [AXA] for the language of this CMS requirement.) **LD.04.01.03, EP 4** The governing body approves an annual operating	**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 provides for capital expenditures for at least a 3-year period, including the year in which the operating budget is applicable.

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		budget and, when needed, a long-term capital expenditure plan.	
§482.12(d)(4)	(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:	**LD.04.01.03, EP 3** The operating budget reflects the hospital's goals and objectives. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the Centers for Medicare & Medicaid Services' (CMS) Institutional Plan and Budget requirements in accordance with 42 CFR 482.12(d). (See Appendix A [AXA] for the language of this CMS requirement.) **LD.04.01.03, EP 4** The governing body approves an annual operating budget and, when needed, a long-term capital expenditure plan.	**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 - Replacement, modernization, and expansion of buildings and equipment
§482.12(d)(4)(i)	(i) Acquisition of land;	**LD.04.01.03, EP 3** The operating budget reflects the hospital's goals and objectives. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the Centers for Medicare & Medicaid Services' (CMS) Institutional Plan and Budget requirements in accordance with 42 CFR 482.12(d). (See Appendix A [AXA] for the language of this CMS requirement.) **LD.04.01.03, EP 4** The governing body approves an annual operating budget and, when needed, a long-term capital expenditure plan.	**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 - Replacement, modernization, and expansion of buildings and equipment

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§482.12(d)(4)(ii)	(ii) Improvement of land, buildings, and equipment; or	**LD.04.01.03, EP 3** The operating budget reflects the hospital's goals and objectives. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the Centers for Medicare & Medicaid Services' (CMS) Institutional Plan and Budget requirements in accordance with 42 CFR 482.12(d). (See Appendix A [AXA] for the language of this CMS requirement.) **LD.04.01.03, EP 4** The governing body approves an annual operating budget and, when needed, a long-term capital expenditure plan.	**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 - Replacement, modernization, and expansion of buildings and equipment
§482.12(d)(4)(iii)	(iii) The replacement, modernization, and expansion of buildings and equipment.	**LD.04.01.03, EP 3** The operating budget reflects the hospital's goals and objectives. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the Centers for Medicare & Medicaid Services' (CMS) Institutional Plan and Budget requirements in accordance with 42 CFR 482.12(d). (See Appendix A [AXA] for the language of this CMS requirement.) **LD.04.01.03, EP 4** The governing body approves an annual operating budget and, when needed, a long-term capital expenditure plan.	**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 - Replacement, modernization, and expansion of buildings and equipment
§482.12(d)(5)	(5) The plan must be submitted for review to the planning agency designated in accordance with section 1122(b) of the Act,	**LD.04.01.01, EP 2** The hospital provides care, treatment, and services in accordance with licensure requirements, laws, and	**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

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	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 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--	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). (See Appendix A [AXA] for the language of this CMS requirement.)	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 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.
§482.12(d)(5) continued	Element Deleted	**LD.04.01.01, EP 2** The hospital provides care, treatment, and services in accordance with licensure requirements, laws, and 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). (See Appendix A [AXA]	

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		for the language of this CMS requirement.) **LD.04.01.03, EP 3** The operating budget reflects the hospital's goals and objectives. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the Centers for Medicare & Medicaid Services' (CMS) Institutional Plan and Budget requirements in accordance with 42 CFR 482.12(d). (See Appendix A [AXA] for the language of this CMS requirement.)	
§482.12(d)(5)(i)	(i) The facilities do not provide common services at the same site;	**LD.04.01.01, EP 2** The hospital provides care, treatment, and services in accordance with licensure requirements, laws, and 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). (See Appendix A [AXA] for the language of this CMS requirement.) **LD.04.01.03, EP 3** The operating budget reflects the hospital's goals and objectives. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the Centers for Medicare & Medicaid Services' (CMS) Institutional Plan and Budget requirements in accordance with 42 CFR 482.12(d). (See Appendix A [AXA] for the language of this CMS requirement.)	**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 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.

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			- 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.
§482.12(d)(5)(ii)	(ii) The facilities are not available under a contract of reasonable duration;	**LD.04.01.01, EP 2** The hospital provides care, treatment, and services in accordance with licensure requirements, laws, and 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). (See Appendix A [AXA] for the language of this CMS requirement.) **LD.04.01.03, EP 3** The operating budget reflects the hospital's goals and objectives. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the Centers for Medicare & Medicaid Services' (CMS) Institutional Plan and Budget requirements in accordance with 42 CFR 482.12(d). (See Appendix A [AXA] for the language of this CMS requirement.)	**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 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.

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§482.12(d)(5)(iii)	(iii) Full and equal medical staff privileges in the facilities are not available;	**LD.04.01.01, EP 2** The hospital provides care, treatment, and services in accordance with licensure requirements, laws, and 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). (See Appendix A [AXA] for the language of this CMS requirement.) **LD.04.01.03, EP 3** The operating budget reflects the hospital's goals and objectives. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the Centers for Medicare & Medicaid Services' (CMS) Institutional Plan and Budget requirements in accordance with 42 CFR 482.12(d). (See Appendix A [AXA] for the language of this CMS requirement.)	**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 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.
§482.12(d)(5)(iv)	(iv) Arrangements with these facilities are not administratively feasible; or	**LD.04.01.01, EP 2** The hospital provides care, treatment, and services in accordance with licensure requirements, laws, and rules and regulations. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital	**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

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		meets the Centers for Medicare & Medicaid Services' (CMS) definition of a hospital in accordance with 42 CFR 482.1(a)(1) and (b). (See Appendix A [AXA] for the language of this CMS requirement.) **LD.04.01.03, EP 3** The operating budget reflects the hospital's goals and objectives. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the Centers for Medicare & Medicaid Services' (CMS) Institutional Plan and Budget requirements in accordance with 42 CFR 482.12(d). (See Appendix A [AXA] for the language of this CMS requirement.)	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 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.
§482.12(d)(5)(v)	(v) The purchase of these services is more costly than if the HMO or CMP provided the services directly.	**LD.04.01.01, EP 2** The hospital provides care, treatment, and services in accordance with licensure requirements, laws, and 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). (See Appendix A [AXA] for the language of this CMS requirement.) **LD.04.01.03, EP 3**	**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 maintenance organization (HMO) or competitive medical plan (CMP) that meets the requirements of section 1876(b) of the Social Security Act (42

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		The operating budget reflects the hospital's goals and objectives. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the Centers for Medicare & Medicaid Services' (CMS) Institutional Plan and Budget requirements in accordance with 42 CFR 482.12(d). (See Appendix A [AXA] for the language of this CMS requirement.)	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.
§482.12(d)(6)	(6) The plan must be reviewed and updated annually	**LD.04.01.03, EP 4** The governing body approves an annual operating budget and, when needed, a long-term capital expenditure plan.	**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)(7)	(7) The plan must be prepared--		
§482.12(d)(7)(i)	(i) Under the direction of the governing body; and	**LD.01.03.01, EP 2** The governing body provides for organization management and planning.	**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)(7)(ii)	(ii) By a committee consisting of representatives of the governing body, the	**LD.01.01.01, EP 2** The governing body identifies those responsible for planning, management, and operational activities.	**LD.13.01.05, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes: The institutional plan is prepared by

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	administrative staff, and the medical staff of the institution.	**LD.01.03.01, EP 8** The governing body provides the organized medical staff with the opportunity to participate in governance. **LD.04.01.03, EP 1** Leaders solicit comments from those who work in the hospital when developing the operational and capital budgets.	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(e)	§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.	**LD.04.03.09, EP 2** The hospital describes, in writing, the nature and scope of services provided through contractual agreements. **LD.04.03.09, EP 3** Designated leaders approve contractual agreements. **LD.04.03.09, EP 4** Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: In most cases, each physician and other licensed practitioner providing services through a contractual agreement must be credentialed and privileged by the hospital using their services following the process described in the "Medical Staff" (MS) chapter. Note 2: For hospitals that do not use Joint Commission accreditation for deemed status purposes: When the hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following: - Verify that all physicians and other licensed practitioners who will be providing patient care,	**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 comply with applicable Centers for Medicare & Medicaid Services (CMS) Conditions of Participation and standards for contract services.

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		treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges. - Specify in the written agreement that the contracted organization will ensure that all contracted services provided by physicians and other licensed practitioners will be within the scope of their privileges. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders who monitor the contracted services are the governing body. **LD.04.03.09, EP 5** Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services. Note: A written description of the expectations can be provided either as part of the written agreement or in addition to it. **LD.04.03.09, EP 6** Leaders monitor contracted services by evaluating these services in relation to the hospital's expectations.	
§482.12(e)(1)	(1) The governing body must ensure that the services performed under a contract are provided in a safe and effective manner.	**LD.01.03.01, EP 5** The governing body provides for the resources needed to maintain safe, quality care, treatment, and services. **LD.04.03.09, EP 6** Leaders monitor contracted services by evaluating these services in relation to the hospital's expectations. **LD.04.03.09, EP 7** Leaders take steps to improve contracted services that do not meet expectations.	**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 comply with

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		Note: Examples of improvement efforts to consider include the following: - Increase monitoring of the contracted services - Provide consultation or training to the contractor - Renegotiate the contract terms - Apply defined penalties - Terminate the contract	applicable Centers for Medicare & Medicaid Services (CMS) Conditions of Participation and standards for contract services.
§482.12(e)(2)	(2) The hospital must maintain a list of all contracted services, including the scope and nature of the services provided.	**LD.04.03.09, EP 2** The hospital describes, in writing, the nature and scope of services provided through contractual agreements.	**LD.13.03.03, EP 1** The hospital maintains a list of all contracted services, including the scope and nature of the services provided.
§482.12(f)	§482.12(f) Standard: Emergency Services		
§482.12(f)(1)	(1) If emergency services are provided at the hospital, the hospital must comply with the requirements of §482.55.	**LD.01.03.01, EP 3** The governing body approves the hospital's written scope of services. **LD.04.01.01, EP 2** The hospital provides care, treatment, and services in accordance with licensure requirements, laws, and 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). (See Appendix A [AXA] for the language of this CMS requirement.) **LD.04.03.01, EP 2** The hospital provides essential services, including the following: - Diagnostic radiology - Dietary - Emergency - Medical records	**LD.13.03.01, EP 8** For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55.

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		- Nuclear medicine - Nursing care - Pathology and clinical laboratory - Pharmaceutical - Physical rehabilitation - Respiratory care - Social work Note 1: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to "Appendix A: Medicare Requirements for Hospitals" (AXA). Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The diagnostic radiology services provided by the hospital, as well as staff qualifications, meet professionally approved standards.	
§482.12(f)(2)	(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.	**MS.03.01.01, EP 14** For hospitals that use Joint Commission accreditation for deemed status purposes: When emergency services are not provided at the hospital, the medical staff has written policies and procedures for appraisal of emergencies, initial treatment of patients, and referral of patients when needed.	**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

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			- Makes certain that the medical staff has bylaws - Approves medical staff bylaws and other medical staff rules and regulations - Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients - Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment - Makes certain that under no circumstances is the accordance of staff membership or professional privileges in the 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
§482.12(f)(3)	(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.	**MS.03.01.01, EP 13** For hospitals that use Joint Commission accreditation for deemed status purposes: When emergency services are provided at the hospital but not at one or more off-campus locations, the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the 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

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			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
§482.13	§482.13 Condition of Participation: Patient's Rights A hospital must protect and promote each patient's rights.	**RI.01.01.01, EP 1** The hospital has written policies on patient rights. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's written policies address procedures regarding patient visitation rights, including any clinically necessary or reasonable restrictions or limitations. **RI.01.01.01, EP 2** The hospital informs the patient of the patient's rights. Note 1: 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. 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. Also included is the right to withdraw or deny such consent at	**RI.11.01.01, EP 1** The hospital develops and implements written policies to protect and promote patient rights.

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		any time. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital informs each patient (or support person, where appropriate) of the patient's rights in advance of furnishing or discontinuing patient care whenever possible. **RI.01.01.01, EP 4** The hospital treats the patient in a dignified and respectful manner that supports the patient's dignity.	
§482.13(a)	§482.13(a) Standard: Notice of Rights		
§482.13(a)(1)	(1) A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.	**RI.01.01.01, EP 1** The hospital has written policies on patient rights. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's written policies address procedures regarding patient visitation rights, including any clinically necessary or reasonable restrictions or limitations. **RI.01.01.01, EP 2** The hospital informs the patient of the patient's rights. Note 1: 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. 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. Also included is the right to withdraw or deny such consent at any time. Note 2: For hospitals that use Joint Commission	**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.

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		accreditation for deemed status purposes: The hospital informs each patient (or support person, where appropriate) of the patient's rights in advance of furnishing or discontinuing patient care whenever possible. **RI.01.02.01, EP 2** When a patient is unable to make decisions about their care, treatment, and services, the hospital involves a surrogate decision-maker in making these decisions. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The selection of the surrogate decision-maker is in accordance with state law. **RI.01.02.01, EP 3** The hospital provides the patient or surrogate decision-maker with written information about the right to refuse care, treatment, and services. **RI.01.02.01, EP 8** The hospital involves the patient's family in care, treatment, and services decisions to the extent permitted by the patient or surrogate decision-maker, in accordance with law and regulation.	
§482.13(a)(2)	Element Deleted	**RI.01.07.01, EP 1** The hospital establishes a complaint resolution process for the prompt resolution of patient complaints that includes a clearly explained procedure for the submission of a patient's written or verbal complaint and informs the patient and the patient's family about it. Note: The governing body is responsible for the effective operation of the complaint resolution process unless it	

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		delegates this responsibility in writing to a complaint resolution committee.	
§482.13(a)(2) continued	(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:	**RI.01.07.01, EP 20** For hospitals that use Joint Commission accreditation for deemed status purposes: The process for resolving complaints 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.	**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 are provided at the hospital but not at one or more off-campus locations **RI.14.01.01, EP 1**

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			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.
§482.13(a)(2) continued	Element Deleted	**RI.01.07.01, EP 1** The hospital establishes a complaint resolution process for the prompt resolution of patient complaints that includes a clearly explained procedure for the submission of a patient's written or verbal complaint and informs the patient and the patient's family about it. Note: The governing body is responsible for the effective operation of the complaint resolution process unless it delegates this responsibility in writing to a complaint resolution committee.	
§482.13(a)(2)(i)	(i) The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital.	**RI.01.01.03, EP 1** The hospital provides information in a manner tailored to the patient's age, language, and ability to understand. **RI.01.07.01, EP 1** The hospital establishes a complaint resolution process for the prompt resolution of patient complaints that includes a clearly explained procedure for the submission of a patient's written or verbal complaint and informs the patient and the patient's family about it. Note: The governing body is responsible for the effective	**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.

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		operation of the complaint resolution process unless it delegates this responsibility in writing to a complaint resolution committee.	
§482.13(a)(2)(ii)	(ii) The grievance process must specify time frames for review of the grievance and the provision of a response.	**RI.01.07.01, EP 19** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital determines time frames for complaint review and response.	**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)(iii)	(iii) In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.	**RI.01.07.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: In its resolution of complaints, the hospital provides the individual with a written notice of its decision, which contains the following: - The name of the hospital contact person - The steps taken on behalf of the individual to investigate the complaint - The results of the process - The date of completion of the complaint process	**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(b)	§482.13(b) Standard: Exercise of Rights		
§482.13(b)(1)	(1) The patient has the right to participate in the development and implementation of his or her plan of care.	**RI.01.02.01, EP 1** The hospital involves the patient in making decisions about their care, treatment, and services, including the right to have the patient's family and physician or other licensed practitioner promptly notified of their admission to or discharge or transfer from the hospital. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient is informed, prior to the notification occurring, of any process to automatically notify the patient's established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well	**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.

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		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. Note 2: 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. **RI.01.02.01, EP 2** When a patient is unable to make decisions about their care, treatment, and services, the hospital involves a surrogate decision-maker in making these decisions. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The selection of the surrogate decision-maker is in accordance with state law. **RI.01.02.01, EP 8** The hospital involves the patient's family in care, treatment, and services decisions to the extent permitted by the patient or surrogate decision-maker, in accordance with law and regulation.	
§482.13(b)(2)	(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	**RI.01.01.03, EP 3** The hospital provides information to the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient's needs. **RI.01.02.01, EP 1**	**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

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	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.	The hospital involves the patient in making decisions about their care, treatment, and services, including the right to have the patient's family and physician or other licensed practitioner promptly notified of their admission to or discharge or transfer from the hospital. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient is informed, prior to the notification occurring, of any process to automatically notify the patient's established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well as all applicable post–acute care services providers and suppliers. The 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. Note 2: 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. **RI.01.02.01, EP 2** When a patient is unable to make decisions about their care, treatment, and services, the hospital involves a surrogate decision-maker in making these decisions. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The selection of the surrogate decision-maker is in accordance with state law.	has the right to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

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		RI.01.02.01, EP 3 The hospital provides the patient or surrogate decision-maker with written information about the right to refuse care, treatment, and services. **RI.01.02.01, EP 4** The hospital respects the right of the patient or surrogate decision-maker to refuse care, treatment, and services in accordance with law and regulation. **RI.01.02.01, EP 8** The hospital involves the patient's family in care, treatment, and services decisions to the extent permitted by the patient or surrogate decision-maker, in accordance with law and regulation. **RI.01.02.01, EP 20** The hospital provides the patient or surrogate decision-maker with the information about the following: - Outcomes of care, treatment, and services that the patient needs in order to participate in current and future health care decisions. - Unanticipated outcomes of the patient's care, treatment, and services that are sentinel events as defined by The Joint Commission. This information is provided by the physician or other licensed practitioner responsible for managing the patient's care, treatment, and services. (Refer to the Glossary for a definition of sentinel event.) **RI.01.03.01, EP 1** The hospital follows a written policy on informed consent that describes the following:	

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		- The specific care, treatment, and services that require informed consent - Circumstances that would allow for exceptions to obtaining informed consent - The process used to obtain informed consent - The physician or other licensed practitioner permitted to conduct the informed consent discussion in accordance with law and regulation - How informed consent is documented in the patient record Note: Documentation may be recorded in a form, in progress notes, or elsewhere in the record. - When a surrogate decision-maker may give informed consent **RI.01.03.01, EP 2** The informed consent process includes a discussion about the following: - The 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. **RI.01.05.01, EP 1** The hospital follows written policies on advance directives, forgoing or withdrawing life-sustaining	

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		treatment, and withholding resuscitative services that address the following: - Providing patients with written information about advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services. - Providing the patient upon admission with information on the extent to which the hospital is able, unable, or unwilling to honor advance directives. - For outpatient hospital settings: Communicating its policy on advance directives upon request or when warranted by the care, treatment, and services provided. - Whether the hospital will honor advance directives in its outpatient settings. - That the hospital will honor the patient's right to formulate or review and revise the patient's advance directives. - Informing staff who are involved in the patient's care, treatment, and services whether or not the patient has an advance directive. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient's right to formulate advance directives and have staff and licensed practitioners comply with these directives is in accordance with 42 CFR 489.100, 489.102, and 489.104.	
§482.13(b)(3)	(3) The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with §489.100 of this part (Definition), §489.102 of this part	**LD.04.01.01, EP 2** The hospital provides care, treatment, and services in accordance with licensure requirements, laws, and rules and regulations. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: 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 comply with these directives, in accordance with law and regulation. Note: For hospitals that use Joint Commission accreditation for

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	(Requirements for providers), and §489.104 of this part (Effective dates).	meets the Centers for Medicare & Medicaid Services' (CMS) definition of a hospital in accordance with 42 CFR 482.1(a)(1) and (b). (See Appendix A [AXA] for the language of this CMS requirement.) **RI.01.05.01, EP 1** The hospital follows written policies on advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services that address the following: - Providing patients with written information about advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services. - Providing the patient upon admission with information on the extent to which the hospital is able, unable, or unwilling to honor advance directives. - For outpatient hospital settings: Communicating its policy on advance directives upon request or when warranted by the care, treatment, and services provided. - Whether the hospital will honor advance directives in its outpatient settings. - That the hospital will honor the patient's right to formulate or review and revise the patient's advance directives. - Informing staff who are involved in the patient's care, treatment, and services whether or not the patient has an advance directive. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient's right to formulate advance directives and have staff and licensed practitioners comply with these directives is in	deemed status purposes: Law and regulation includes, at a minimum, 42 CFR 489.100, 489.102, and 489.104.

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		accordance with 42 CFR 489.100, 489.102, and 489.104. **RI.01.05.01, EP 9** The hospital documents whether or not the patient has an advance directive. **RI.01.05.01, EP 10** Upon request, the hospital refers the patient to resources for assistance in formulating advance directives. **RI.01.05.01, EP 17** The existence or lack of an advance directive does not determine the patient's right to access care, treatment, and services.	
§482.13(b)(4)	(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.	**RI.01.01.01, EP 5** The hospital respects the patient's right to and need for effective communication. **RI.01.02.01, EP 1** The hospital involves the patient in making decisions about their care, treatment, and services, including the right to have the patient's family and physician or other licensed practitioner promptly notified of their admission to or discharge or transfer from the hospital. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient is informed, prior to the notification occurring, of any process to automatically notify the patient's established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well as all applicable post–acute care services providers and	**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 automatically notify the patient's established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well as all applicable post–acute care service providers and suppliers. The 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.

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		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. Note 2: 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. **RI.01.02.01, EP 8** The hospital involves the patient's family in care, treatment, and services decisions to the extent permitted by the patient or surrogate decision-maker, in accordance with law and regulation.	
§482.13(c)	§482.13(c) Standard: Privacy and Safety		
§482.13(c)(1)	(1) The patient has the right to personal privacy.	**RI.01.01.01, EP 7** The hospital respects the patient's right to privacy. Note 1: This element of performance (EP) addresses a patient's personal privacy. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident's right to privacy includes privacy and confidentiality of their personal records and written communications, including the right to send and receive mail promptly.	**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 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.
§482.13(c)(2)	(2) The patient has the right to receive care in a safe setting.	**EC.01.01.01, EP 5** The hospital has a written plan for managing the following: The security of everyone who enters the hospital's facilities.	**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

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		EC.02.01.01, EP 1 The hospital implements its process to identify safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital's facilities. Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts. **EC.02.01.01, EP 3** The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment. **EC.02.01.01, EP 7** The hospital identifies individuals entering its facilities. Note: The hospital determines which of those individuals require identification and how to do so. **EC.02.01.01, EP 8** The hospital controls access to and from areas it identifies as security sensitive. **EC.02.01.01, EP 9** The hospital has written procedures to follow in the event of a security incident, including an infant or pediatric abduction. **EC.02.01.01, EP 10** When a security incident occurs, the hospital follows its	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). **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

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		identified procedures. **EC.02.06.01, EP 1** Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided. **EC.04.01.01, EP 1** 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 - 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.	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 - 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.

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		Opportunities to improve care, treatment, and services, or to prevent similar incidents, are not lost as a result of following the legal process. **EC.04.01.01, EP 3** Based on its process(es), the hospital reports and investigates the following: Injuries to patients or others in the hospital's facilities. **EC.04.01.01, EP 6** Based on its process(es), the hospital reports and investigates the following: Safety and security incidents involving patients, staff, or others within its facilities, including those related to workplace violence. **NPSG.15.01.01, 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 general 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.	

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		Note: Nonpsychiatric units in general 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). **NPSG.15.01.01, EP 2** Screen 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. **NPSG.15.01.01, EP 3** Use 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. **NPSG.15.01.01, EP 4** Document patients' overall level of risk for suicide and	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		the plan to mitigate the risk for suicide. **NPSG.15.01.01, EP 5** Follow 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 - Monitoring patients who are at high risk for suicide **NPSG.15.01.01, EP 7** Monitor implementation and effectiveness of policies and procedures for screening, assessment, and management of patients at risk for suicide and take action as needed to improve compliance. **RI.01.01.01, EP 4** The hospital treats the patient in a dignified and respectful manner that supports the patient's dignity. **RI.01.06.03, EP 1** The hospital protects the patient from harassment, neglect, exploitation, and abuse that could occur while the patient is receiving care, treatment, and services. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital also determines how it will protect residents from corporal punishment and involuntary seclusion.	
§482.13(c)(3)	(3) The patient has the right to be free from all forms of abuse or harassment.	**RI.01.06.03, EP 1** The hospital protects the patient from harassment, neglect, exploitation, and abuse that could occur while	**RI.13.01.01, EP 1** The hospital protects the patient from harassment, neglect, exploitation, corporal punishment, involuntary seclusion, and

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		the patient is receiving care, treatment, and services. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital also determines how it will protect residents from corporal punishment and involuntary seclusion. **RI.01.06.03, EP 2** The hospital evaluates all allegations, observations, and suspected cases of neglect, exploitation, and abuse that occur within the hospital. **RI.01.06.03, EP 3** The hospital reports allegations, observations, and suspected cases of neglect, exploitation, and abuse to appropriate authorities based on its evaluation of the suspected events, or as required by law. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to the administrator of the facility and to other officials (including the state survey agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law and established procedures. The alleged violations are reported in the following time frames: - No later than 2 hours after the allegation is made if the allegation involves abuse or serious bodily injury - No later than 24 hours after the allegation is made if	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.

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		the allegation does not involve abuse or serious bodily injury	
§482.13(d)	§482.13(d) Standard: Confidentiality of Patient Records		
§482.13(d)(1)	(1) The patient has the right to the confidentiality of his or her clinical records.	**IM.02.01.01, EP 1** The hospital follows a written policy addressing the privacy and confidentiality of health information. **IM.02.01.01, EP 3** The hospital uses health information only for purposes permitted by law and regulation or as further limited by its policy on privacy. **IM.02.01.01, EP 4** The hospital discloses health information only as authorized by the patient or as otherwise consistent with law and regulation. **IM.02.01.03, EP 1** The hospital follows a written policy that addresses the security of health information, including access, use, and disclosure. **IM.02.01.03, EP 2** The hospital implements a written policy addressing the following: - The integrity of health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction - The intentional destruction of health information - When and by whom the removal of health information is permitted	**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.

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		Note: Removal refers to those actions that place health information outside the hospital's control.	
§482.13(d)(2)	(2) The patient has the right to access their medical records, including current medical records, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such medical records are maintained electronically); or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, and within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits.	**RI.01.01.01, EP 10** The hospital allows the patient, through oral or written request, to access, request amendment to, and obtain information on disclosures of the patient's health information, in accordance with law and regulation. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Access to medical records, including past and current records, is in the form and format requested by the patient (including in electronic form or format when available). If electronic is unavailable, the medical record is in hard copy form or another form agreed to by the organization and patient. 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 electronic or hard-copy requests within a reasonable time frame (that is, as quickly as its recordkeeping system permits).	**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 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(e)	§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.	**PC.03.05.01, EP 1** The hospital uses restraint or seclusion only to protect the immediate physical safety of the patient, staff, or others. **PC.03.05.01, EP 2** The hospital does not use restraint or seclusion as a means of corporal punishment, coercion, discipline, convenience, or staff retaliation. **PC.03.05.01, EP 5** The hospital discontinues restraint or seclusion at the earliest possible time, regardless of the scheduled	**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 restrictive interventions have been ineffective and is discontinued at the earliest possible time, regardless of the length of time specified in the order. **RI.13.01.01, EP 1** The hospital protects the patient from harassment, neglect, exploitation, corporal punishment, involuntary seclusion, and verbal, mental, sexual, or physical abuse that could occur while

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		expiration of the order. **RI.01.06.03, EP 1** The hospital protects the patient from harassment, neglect, exploitation, and abuse that could occur while the patient is receiving care, treatment, and services. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital also determines how it will protect residents from corporal punishment and involuntary seclusion. **RI.01.06.03, EP 2** The hospital evaluates all allegations, observations, and suspected cases of neglect, exploitation, and abuse that occur within the hospital. **RI.01.06.03, EP 3** The hospital reports allegations, observations, and suspected cases of neglect, exploitation, and abuse to appropriate authorities based on its evaluation of the suspected events, or as required by law. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to the administrator of the facility and to other officials (including the state survey agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law and established procedures. The alleged violations are reported in the following time	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.

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		frames: - No later than 2 hours after the allegation is made if the allegation involves abuse or serious bodily injury - No later than 24 hours after the allegation is made if the allegation does not involve abuse or serious bodily injury	
§482.13(e)(1)	(1) Definitions.		
§482.13(e)(1)(i)	(i) A restraint is—		
§482.13(e)(1)(i)(A)	(A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or	**PC.03.05.09, EP 1** The hospital's policies and procedures regarding restraint or seclusion include the following: - Physician and other licensed practitioner training requirements - Staff training requirements - The determination of who has authority to order restraint and seclusion - The determination of who has authority to discontinue the use of restraint or seclusion - The determination of who can initiate the use of restraint or seclusion - The circumstances under which restraint or seclusion is discontinued - The requirement that restraint or seclusion is discontinued as soon as is safely possible - A determination of who can assess and monitor patients in restraint or seclusion - Time frames for assessing and monitoring patients in restraint or seclusion - A definition of restraint - A definition of seclusion - A definition or description of what constitutes the use of medications as a restraint Note 1: For hospitals that use Joint Commission	**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 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).

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		accreditation for deemed status purposes: The hospital's definition of restraint or the use of medications as a restraint is in accordance with 42 CFR 482.13(e)(1)(i)(A–C): 42 CFR 482.13(e)(1) Definitions. (i) A restraint is— (A) 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 42 CFR 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. 42 CFR 482.13(e)(1)(i)(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort). Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's definition of seclusion is in accordance with 42 CFR 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 be used only for the management of violent or self-destructive behavior.	
§482.13(e)(1)(i)(B)	(B) A drug or medication when it is used as a restriction to manage the patient's behavior	**PC.03.05.09, EP 1** The hospital's policies and procedures regarding	**PC.13.02.01, EP 4** The hospital restraint policies are followed when any manual

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	or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.	restraint or seclusion include the following: - Physician and other licensed practitioner training requirements - Staff training requirements - The determination of who has authority to order restraint and seclusion - The determination of who has authority to discontinue the use of restraint or seclusion - The determination of who can initiate the use of restraint or seclusion - The circumstances under which restraint or seclusion is discontinued - The requirement that restraint or seclusion is discontinued as soon as is safely possible - A determination of who can assess and monitor patients in restraint or seclusion - Time frames for assessing and monitoring patients in restraint or seclusion - A definition of restraint - A definition of seclusion - A definition or description of what constitutes the use of medications as a restraint Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's definition of restraint or the use of medications as a restraint is in accordance with 42 CFR 482.13(e)(1)(i)(A–C): 42 CFR 482.13(e)(1) Definitions. (i) A restraint is— (A) 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 42 CFR 482.13(e)(1)(i)(B) (A restraint is—) A drug or medication when it is used as a restriction to	method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or when a drug or medication is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. Note: A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

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		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. 42 CFR 482.13(e)(1)(i)(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort). Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's definition of seclusion is in accordance with 42 CFR 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 be used only for the management of violent or self-destructive behavior.	
§482.13(e)(1)(i)(C)	(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).	**PC.03.05.09, EP 1** The hospital's policies and procedures regarding restraint or seclusion include the following: - Physician and other licensed practitioner training requirements - Staff training requirements - The determination of who has authority to order restraint and seclusion - The determination of who has authority to discontinue the use of restraint or seclusion - The determination of who can initiate the use of restraint or seclusion	**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 physical holding of a patient for the purpose of conducting routine physical

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		- The circumstances under which restraint or seclusion is discontinued - The requirement that restraint or seclusion is discontinued as soon as is safely possible - A determination of who can assess and monitor patients in restraint or seclusion - Time frames for assessing and monitoring patients in restraint or seclusion - A definition of restraint - A definition of seclusion - A definition or description of what constitutes the use of medications as a restraint Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's definition of restraint or the use of medications as a restraint is in accordance with 42 CFR 482.13(e)(1)(i)(A–C): 42 CFR 482.13(e)(1) Definitions. (i) A restraint is— (A) 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 42 CFR 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. 42 CFR 482.13(e)(1)(i)(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate	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).

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		in activities without the risk of physical harm (this does not include a physical escort). Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's definition of seclusion is in accordance with 42 CFR 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 be used only for the management of violent or self-destructive behavior.	
§482.13(e)(1)(ii)	(ii) Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.	**PC.03.05.09, EP 1** The hospital's policies and procedures regarding restraint or seclusion include the following: - Physician and other licensed practitioner training requirements - Staff training requirements - The determination of who has authority to order restraint and seclusion - The determination of who has authority to discontinue the use of restraint or seclusion - The determination of who can initiate the use of restraint or seclusion - The circumstances under which restraint or seclusion is discontinued - The requirement that restraint or seclusion is discontinued as soon as is safely possible - A determination of who can assess and monitor patients in restraint or seclusion - Time frames for assessing and monitoring patients in restraint or seclusion - A definition of restraint - A definition of seclusion	**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.

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		- A definition or description of what constitutes the use of medications as a restraint Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's definition of restraint or the use of medications as a restraint is in accordance with 42 CFR 482.13(e)(1)(i)(A–C): 42 CFR 482.13(e)(1) Definitions. (i) A restraint is— (A) 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 42 CFR 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. 42 CFR 482.13(e)(1)(i)(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort). Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's definition of seclusion is in accordance with 42 CFR 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 be	

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		used only for the management of violent or self-destructive behavior.	
§482.13(e)(2)	(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.	**PC.03.05.01, EP 3** The hospital uses restraint or seclusion only when less restrictive interventions are ineffective. **PC.03.05.01, EP 4** The hospital uses the least restrictive form of restraint or seclusion that protects the physical safety of the patient, staff, or others.	**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 restrictive interventions have been ineffective and is discontinued at the earliest possible time, regardless of the length of time specified in the order.
§482.13(e)(3)	(3) The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.	**PC.03.05.01, EP 4** The hospital uses the least restrictive form of restraint or seclusion that protects the physical safety of the patient, staff, or others.	**PC.13.02.01, EP 2** The hospital uses the least restrictive form of restraint or seclusion that will be effective to protect the patient, a staff member, or others from harm.
§482.13(e)(4)	(4) The use of restraint or seclusion must be --		
§482.13(e)(4)(i)	(i) in accordance with a written modification to the patient's plan of care.	**PC.03.05.03, EP 2** The use of restraint and seclusion is in accordance with a written modification to the patient's plan of care.	**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)(ii)	(ii) implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law.	**PC.03.05.03, EP 1** The hospital implements restraint or seclusion using safe techniques identified by the hospital's policies and procedures in accordance with law and regulation.	**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

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§482.13(e)(5)	(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.	**PC.03.05.05, EP 1** A physician or other authorized licensed practitioner responsible for the patient's care orders the use of restraint or seclusion in accordance with hospital policy and law and regulation.	**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)(6)	(6) Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).	**PC.03.05.05, EP 2** The hospital does not use standing orders or PRN (also known as "as needed") orders for 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)(7)	(7) The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion.	**PC.03.05.05, EP 3** The attending physician or clinical psychologist 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).	**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)(8)	(8) Unless superseded by State law that is more restrictive --		
§482.13(e)(8)(i)	(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 with the following limits for up to a total of 24 hours:	**PC.03.05.05, 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, 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.	**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, staff, or others may be renewed within the following time 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.

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§482.13(e)(8)(i)(A)	(A) 4 hours for adults 18 years of age or older;	**PC.03.05.05, 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, 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.	**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, staff, or others may be renewed within the following time 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.
§482.13(e)(8)(i)(B)	(B) 2 hours for children and adolescents 9 to 17 years of age; or	**PC.03.05.05, 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, 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.	**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, staff, or others may be renewed within the following time 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.
§482.13(e)(8)(i)(C)	(C) 1 hour for children under 9 years of age; and	**PC.03.05.05, 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, 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	**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, staff, or others may be renewed within the following time 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

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		- 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.	Orders may be renewed according to the time limits for a maximum of 24 consecutive hours.
§482.13(e)(8)(ii)	(ii) 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 seclusion by hospital policy in accordance with State law must see and assess the patient.	**PC.03.05.05, 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 in accordance with hospital policy and law and regulation.	**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, in accordance with hospital policy and law and regulation.
§482.13(e)(8)(iii)	(iii) 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.	**PC.03.05.05, EP 6** Orders for restraint used to protect the physical safety of the nonviolent or non-self-destructive patient are renewed in accordance with hospital policy.	**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)(9)	(9) Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.	**PC.03.05.01, EP 5** The hospital discontinues restraint or seclusion at the earliest possible time, regardless of the scheduled expiration of the order.	**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 restrictive interventions have been ineffective and is discontinued at the earliest possible time, regardless of the length of time specified in the order.
§482.13(e)(10)	(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.	**PC.03.05.07, 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.	**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)(11)	(11) Physician and other licensed practitioner training requirements must be	**PC.03.05.09, EP 1** The hospital's policies and procedures regarding	**PC.13.02.09, EP 1** The hospital's policies and procedures regarding the use of

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	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.	restraint or seclusion include the following: - Physician and other licensed practitioner training requirements - Staff training requirements - The determination of who has authority to order restraint and seclusion - The determination of who has authority to discontinue the use of restraint or seclusion - The determination of who can initiate the use of restraint or seclusion - The circumstances under which restraint or seclusion is discontinued - The requirement that restraint or seclusion is discontinued as soon as is safely possible - A determination of who can assess and monitor patients in restraint or seclusion - Time frames for assessing and monitoring patients in restraint or seclusion - A definition of restraint - A definition of seclusion - A definition or description of what constitutes the use of medications as a restraint Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's definition of restraint or the use of medications as a restraint is in accordance with 42 CFR 482.13(e)(1)(i)(A–C): 42 CFR 482.13(e)(1) Definitions. (i) A restraint is— (A) 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 42 CFR 482.13(e)(1)(i)(B) (A restraint is—) A drug or medication when it is used as a restriction to	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 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.

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		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. 42 CFR 482.13(e)(1)(i)(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort). Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's definition of seclusion is in accordance with 42 CFR 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 be used only for the management of violent or self-destructive behavior. **PC.03.05.09, 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 and seclusion.	
§482.13(e)(12)	(12) 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		

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	seen face-to-face within 1 hour after the initiation of the intervention --		
§482.13(e)(12)(i)	(i) By a --		
§482.13(e)(12)(i)(A)	(A) Physician or other licensed practitioner; or	**PC.03.05.11, EP 1** A physician or other licensed practitioner responsible for the care of the patient 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; this individual is trained in accordance with the requirements in PC.03.05.17, EP 3. Note: States may have statute or regulation requirements that are more restrictive than the requirements in this element of performance.	**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)(12)(i)(B)	(B) Registered nurse who has been trained in accordance with the requirements specified in paragraph (f) of this section.	**PC.03.05.11, EP 1** A physician or other licensed practitioner responsible for the care of the patient 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; this individual is trained in accordance with the requirements in PC.03.05.17, EP 3. Note: States may have statute or regulation requirements that are more restrictive than the requirements in this element of performance.	**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)(12)(ii)	(ii)To evaluate –		

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§482.13(e)(12)(ii)(A)	(A) the patient's immediate situation;	**PC.03.05.11, EP 2** 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. **PC.03.05.11, EP 3** The in-person evaluation, 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, 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	**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)(B)	(B) The patient's reaction to the intervention;	**PC.03.05.11, EP 2** 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. **PC.03.05.11, EP 3** The in-person evaluation, conducted within one hour of the initiation of restraint or seclusion for the management of violent or self-destructive behavior that	**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

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		jeopardizes the physical safety of the patient, staff, or others, 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)(C)	(C) The patient's medical and behavioral condition; and	**PC.03.05.11, EP 2** 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. **PC.03.05.11, EP 3** The in-person evaluation, 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, 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	**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)(D)	(D)The need to continue or terminate the restraint or seclusion.	**PC.03.05.11, EP 2** 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	**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

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		possible after the evaluation, as determined by hospital policy. **PC.03.05.11, EP 3** The in-person evaluation, 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, 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	- 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)(13)	(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.	**PC.03.05.11, EP 1** A physician or other licensed practitioner responsible for the care of the patient 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; this individual is trained in accordance with the requirements in PC.03.05.17, EP 3. Note: States may have statute or regulation requirements that are more restrictive than the requirements in this element of performance.	**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)(14)	(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	**PC.03.05.11, EP 1** A physician or other licensed practitioner responsible for the care of the patient evaluates the patient in-person within one hour of the initiation of restraint or seclusion used for the management of violent or self-	**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

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	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.	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; this individual is trained in accordance with the requirements in PC.03.05.17, EP 3. Note: States may have statute or regulation requirements that are more restrictive than the requirements in this element of performance. **PC.03.05.11, EP 2** 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.	practitioner responsible for the care of the patient as soon as possible after the evaluation, as determined by hospital policy.
§482.13(e)(15)	(15) All requirements specified under this paragraph are applicable to the simultaneous use of restraint and seclusion. Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored –		
§482.13(e)(15)(i)	(i) Face-to-face by an assigned, trained staff member; or	**PC.03.05.13, EP 1** The patient who is simultaneously restrained and secluded is 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.	**PC.13.02.13, EP 1** The patient who is simultaneously restrained and secluded is 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.

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§482.13(e)(15)(ii)	(ii) By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.	**PC.03.05.13, EP 1** The patient who is simultaneously restrained and secluded is 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.	**PC.13.02.13, EP 1** The patient who is simultaneously restrained and secluded is 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.
§482.13(e)(16)	(16) When restraint or seclusion is used, there must be documentation in the patient's medical record of the following:		
§482.13(e)(16)(i)	(i) The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior;	**PC.03.05.15, EP 1** Documentation of restraint and seclusion in the medical record includes the following: - Any in-person medical and behavioral evaluation for restraint or seclusion used to manage violent or self-destructive behavior - A description of the patient's behavior and the intervention used - Any alternatives or other less restrictive interventions attempted - The patient's condition or symptom(s) that warranted the use of the restraint or seclusion - The patient's response to the intervention(s) used, including the rationale for continued use of the intervention - Individual patient assessments and reassessments - The intervals for monitoring - Revisions to the plan of care - The patient's behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint or seclusion - Injuries to the patient - Death associated with the use of restraint or seclusion	**PC.13.02.15, EP 1** Documentation of restraint or seclusion in the medical record includes the following: - 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

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		- The identity of the physician, clinical psychologist, or other licensed practitioner who ordered the restraint or seclusion - Orders for restraint or seclusion - Notification of the use of restraint or seclusion to the attending physician - Consultations 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)(16)(ii)	(ii) A description of the patient's behavior and the intervention used.	**PC.03.05.15, EP 1** Documentation of restraint and seclusion in the medical record includes the following: - Any in-person medical and behavioral evaluation for restraint or seclusion used to manage violent or self-destructive behavior - A description of the patient’s behavior and the intervention used - Any alternatives or other less restrictive interventions attempted - The patient’s condition or symptom(s) that warranted the use of the restraint or seclusion - The patient’s response to the intervention(s) used, including the rationale for continued use of the intervention - Individual patient assessments and reassessments - The intervals for monitoring - Revisions to the plan of care - The patient’s behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint or seclusion - Injuries to the patient - Death associated with the use of restraint or seclusion	**PC.13.02.15, EP 1** Documentation of restraint or seclusion in the medical record includes the following: - 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

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		- The identity of the physician, clinical psychologist, or other licensed practitioner who ordered the restraint or seclusion - Orders for restraint or seclusion - Notification of the use of restraint or seclusion to the attending physician - Consultations 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)(16)(iii)	(iii) Alternatives or other less restrictive interventions attempted (as applicable).	**PC.03.05.15, EP 1** Documentation of restraint and seclusion in the medical record includes the following: - Any in-person medical and behavioral evaluation for restraint or seclusion used to manage violent or self-destructive behavior - A description of the patient’s behavior and the intervention used - Any alternatives or other less restrictive interventions attempted - The patient’s condition or symptom(s) that warranted the use of the restraint or seclusion - The patient’s response to the intervention(s) used, including the rationale for continued use of the intervention - Individual patient assessments and reassessments - The intervals for monitoring - Revisions to the plan of care - The patient’s behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint or seclusion - Injuries to the patient - Death associated with the use of restraint or seclusion	**PC.13.02.15, EP 1** Documentation of restraint or seclusion in the medical record includes the following: - 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

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		- The identity of the physician, clinical psychologist, or other licensed practitioner who ordered the restraint or seclusion - Orders for restraint or seclusion - Notification of the use of restraint or seclusion to the attending physician - Consultations 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)(16)(iv)	(iv) The patient's condition or symptom(s) that warranted the use of the restraint or seclusion.	**PC.03.05.15, EP 1** Documentation of restraint and seclusion in the medical record includes the following: - Any in-person medical and behavioral evaluation for restraint or seclusion used to manage violent or self-destructive behavior - A description of the patient’s behavior and the intervention used - Any alternatives or other less restrictive interventions attempted - The patient’s condition or symptom(s) that warranted the use of the restraint or seclusion - The patient’s response to the intervention(s) used, including the rationale for continued use of the intervention - Individual patient assessments and reassessments - The intervals for monitoring - Revisions to the plan of care - The patient’s behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint or seclusion - Injuries to the patient - Death associated with the use of restraint or seclusion	**PC.13.02.15, EP 1** Documentation of restraint or seclusion in the medical record includes the following: - 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

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		- The identity of the physician, clinical psychologist, or other licensed practitioner who ordered the restraint or seclusion - Orders for restraint or seclusion - Notification of the use of restraint or seclusion to the attending physician - Consultations 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)(16)(v)	(v) The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.	**PC.03.05.15, EP 1** Documentation of restraint and seclusion in the medical record includes the following: - Any in-person medical and behavioral evaluation for restraint or seclusion used to manage violent or self-destructive behavior - A description of the patient’s behavior and the intervention used - Any alternatives or other less restrictive interventions attempted - The patient’s condition or symptom(s) that warranted the use of the restraint or seclusion - The patient’s response to the intervention(s) used, including the rationale for continued use of the intervention - Individual patient assessments and reassessments - The intervals for monitoring - Revisions to the plan of care - The patient’s behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint or seclusion - Injuries to the patient - Death associated with the use of restraint or seclusion	**PC.13.02.15, EP 1** Documentation of restraint or seclusion in the medical record includes the following: - 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

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		- The identity of the physician, clinical psychologist, or other licensed practitioner who ordered the restraint or seclusion - Orders for restraint or seclusion - Notification of the use of restraint or seclusion to the attending physician - Consultations 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(f)	§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.	**PC.03.05.03, EP 1** The hospital implements restraint or seclusion using safe techniques identified by the hospital’s policies and procedures in accordance with law and regulation. **PC.03.05.17, EP 3** Based on the population served, staff education, training, and demonstrated knowledge focus on the following: - Strategies 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	**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

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		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 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, including required periodic recertification	
§482.13(f)(1)	(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 –	**PC.03.05.17, EP 3** Based on the population served, staff education, training, and demonstrated knowledge focus on the following: - Strategies 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	

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		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 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, including required periodic recertification	
§482.13(f)(1)(i)	(i) Before performing any of the actions specified in this paragraph;	**PC.03.05.17, EP 2** 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 and seclusion - On a periodic basis thereafter	**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)(ii)	(ii) As part of orientation; and	**PC.03.05.17, EP 2** 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 and seclusion - On a periodic basis thereafter	**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)(iii)	(iii) Subsequently on a periodic basis consistent with hospital policy.	**PC.03.05.17, EP 2** 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 and seclusion - On a periodic basis thereafter	**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

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§482.13(f)(2)	(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:		
§482.13(f)(2)(i)	(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.	**PC.03.05.17, EP 3** Based on the population served, staff education, training, and demonstrated knowledge focus on the following: - Strategies 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 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	**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 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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		of cardiopulmonary resuscitation, including required periodic recertification	
§482.13(f)(2)(ii)	(ii) The use of nonphysical intervention skills.	**PC.03.05.17, EP 3** Based on the population served, staff education, training, and demonstrated knowledge focus on the following: - Strategies 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 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, including required periodic recertification	**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 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

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§482.13(f)(2)(iii)	(iii) Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.	**PC.03.05.17, EP 3** Based on the population served, staff education, training, and demonstrated knowledge focus on the following: - Strategies 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 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, including required periodic recertification	**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 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
§482.13(f)(2)(iv)	(iv) The safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and	**PC.03.05.17, EP 3** Based on the population served, staff education, training, and demonstrated knowledge focus on the	**PC.13.02.17, EP 3** Based on the population served, staff education, training, and demonstrated knowledge focus on the following:

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	respond to signs of physical and psychological distress (for example, positional asphyxia).	following: - Strategies 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 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, including required periodic recertification	- 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 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
§482.13(f)(2)(v)	(v) Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.	**PC.03.05.17, EP 3** Based on the population served, staff education, training, and demonstrated knowledge focus on the following: - Strategies to identify staff and patient behaviors, events, and environmental factors that may trigger	**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

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		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 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, including required periodic recertification	- 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 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
§482.13(f)(2)(vi)	(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.	**PC.03.05.17, EP 3** Based on the population served, staff education, training, and demonstrated knowledge focus on the following: - Strategies 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	**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

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		- 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 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, including required periodic recertification	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 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
§482.13(f)(2)(vii)	(vii) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.	**PC.03.05.17, EP 3** Based on the population served, staff education, training, and demonstrated knowledge focus on the following: - Strategies 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	**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

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		- 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 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, including required periodic recertification	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 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
§482.13(f)(3)	(3) Trainer Requirements. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors.	**PC.03.05.17, EP 4** Individuals providing staff training in restraint or seclusion have education, training, and experience in the techniques used to address patient behaviors that necessitate the use of restraint or seclusion.	**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)(4)	(4) Training Documentation. The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.	**PC.03.05.17, EP 5** The hospital documents in staff records that restraint and seclusion training and demonstration of competence were completed.	**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(g)	§482.13(g) Standard: Death Reporting Requirements: Hospitals must report deaths associated with the use of seclusion or restraint.	**PC.03.05.19, 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 (CMS) regarding deaths related to	**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:

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		restraint or seclusion (this requirement does not apply to deaths related to the use of soft wrist restraints; for more information, refer to EP 3 in this standard): - 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. The types of restraints included in this reporting requirement are all restraints except soft wrist restraints. Note: In this element of performance "reasonable to assume" includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time or deaths related to chest compression, restriction of breathing, or asphyxiation.	- Each death that 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.
§482.13(g)(1)	(1) With the exception of deaths described under paragraph (g)(2) of this section, the hospital must report the following information to CMS by telephone, facsimile, or electronically, as determined by CMS, no later than the close of business on the next business day following knowledge of the patient's death:	**PC.03.05.19, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The deaths addressed in PC.03.05.19, EP 1, are reported to the Centers for Medicare & Medicaid Services (CMS) by telephone, by facsimile, or electronically no later than the close of the next business day following knowledge of the patient's death. The date and time that the patient's death was reported is documented in the patient's medical record.	**PC.13.02.19, EP 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)(i)	(i) Each death that occurs while a patient is in restraint or seclusion.	**PC.03.05.19, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital reports the following information to the Centers for Medicare &	**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

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		Medicaid Services (CMS) regarding deaths related to restraint or seclusion (this requirement does not apply to deaths related to the use of soft wrist restraints; for more information, refer to EP 3 in this standard): - 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. The types of restraints included in this reporting requirement are all restraints except soft wrist restraints. Note: 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.	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.
§482.13(g)(1)(ii)	(ii) Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.	**PC.03.05.19, 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 (CMS) regarding deaths related to restraint or seclusion (this requirement does not apply to deaths related to the use of soft wrist restraints; for more information, refer to EP 3 in this standard): - 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	**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 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

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		one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death. The types of restraints included in this reporting requirement are all restraints except soft wrist restraints. Note: 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.	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.
§482.13(g)(1)(iii)	(iii) Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death, regardless of the type(s) of restraint used on the patient during this time. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing, or asphyxiation.	**PC.03.05.19, 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 (CMS) regarding deaths related to restraint or seclusion (this requirement does not apply to deaths related to the use of soft wrist restraints; for more information, refer to EP 3 in this standard): - 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. The types of restraints included in this reporting requirement are all restraints except soft wrist restraints. Note: 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	**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 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.

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		or deaths related to chest compression, restriction of breathing, or asphyxiation.	
§482.13(g)(2)	(2) When no seclusion has been used and when the only restraints used on the patient are those applied exclusively to the patient's wrist(s), and which are composed solely of soft, non-rigid, cloth-like materials, the hospital staff must record in an internal log or other system, the following information:		
§482.13(g)(2)(i)	(i) Any death that occurs while a patient is in such restraints.	**PC.03.05.19, 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, non-rigid, 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 CMS, either electronically or in writing, immediately upon request	**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 patient's care, medical record number, and primary diagnosis(es) - Makes the information in the log or other system available to the Centers for Medicare and Medicaid Services, either electronically or in writing, immediately upon request

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§482.13(g)(2)(ii)	(ii) Any death that occurs within 24 hours after a patient has been removed from such restraints.	**PC.03.05.19, 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, non-rigid, 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 CMS, either electronically or in writing, immediately upon request	**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 patient's care, medical record number, and primary diagnosis(es) - Makes the information in the log or other system available to the Centers for Medicare and Medicaid Services, either electronically or in writing, immediately upon request
§482.13(g)(3)	(3) The staff must document in the patient's medical record the date and time the death was:		
§482.13(g)(3)(i)	(i) Reported to CMS for deaths described in paragraph (g)(1) of this section; or	**PC.03.05.19, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The deaths addressed in PC.03.05.19, EP 1, are reported to the Centers for Medicare & Medicaid Services (CMS) by telephone, by facsimile, or electronically no later than the close of	**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.

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		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.	The date and time that the patient's death was reported is documented in the patient's medical record.
§482.13(g)(3)(ii)	(ii) Recorded in the internal log or other system for deaths described in paragraph (g)(2) of this section.	**PC.03.05.19, 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, non-rigid, 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 CMS, either electronically or in writing, immediately upon request	**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 patient's care, medical record number, and primary diagnosis(es) - Makes the information in the log or other system available to the Centers for Medicare and Medicaid Services, either electronically or in writing, immediately upon request
§482.13(g)(4)	(4) For deaths described in paragraph (g)(2) of this section, entries into the internal log or other system must be documented as follows:		

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§482.13(g)(4)(i)	(i) Each entry must be made not later than seven days after the date of death of the patient.	**PC.03.05.19, 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, non-rigid, 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 CMS, either electronically or in writing, immediately upon request	**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 patient's care, medical record number, and primary diagnosis(es) - Makes the information in the log or other system available to the Centers for Medicare and Medicaid Services, either electronically or in writing, immediately upon request
§482.13(g)(4)(ii)	(ii) Each entry must document the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner who is responsible for the care of the patient, medical record number, and primary diagnosis(es).	**PC.03.05.19, 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, non-rigid, 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	**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.

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		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 CMS, either electronically or in writing, immediately upon request	- Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. - Documents in the patient record the date and time that the death was recorded in the log or other system - Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the patient's care, medical record number, and primary diagnosis(es) - Makes the information in the log or other system available to the Centers for Medicare and Medicaid Services, either electronically or in writing, immediately upon request
§482.13(g)(4)(iii)	(iii) The information must be made available in either written or electronic form to CMS immediately upon request.	**PC.03.05.19, 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, non-rigid, 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	**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 patient's care, medical record

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		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 CMS, either electronically or in writing, immediately upon request	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(h)	§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:	**RI.01.01.01, EP 1** The hospital has written policies on patient rights. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's written policies address procedures regarding patient visitation rights, including any clinically necessary or reasonable restrictions or limitations.	**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 visitors designated by the patient, including but not limited to a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. The patient also has the right to withdraw or deny consent for visitors at any time. Note 1: 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)(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.	**RI.01.01.01, EP 2** The hospital informs the patient of the patient's rights. Note 1: 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. 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. Also included is the right to withdraw or deny such consent at	**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 visitors designated by the patient, including but not limited to a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. The patient also has the right to withdraw or deny consent for visitors at any time. Note 1: 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

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		any time. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital informs each patient (or support person, where appropriate) of the patient's rights in advance of furnishing or discontinuing patient care whenever possible.	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)(2)	(2) Inform each patient (or support person, where appropriate) of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.	**RI.01.01.01, EP 2** The hospital informs the patient of the patient's rights. Note 1: 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. 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. Also included is the right to withdraw or deny such consent at any time. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital informs each patient (or support person, where appropriate) of the patient's rights in advance of furnishing or discontinuing patient care whenever possible. **RI.01.01.01, EP 28** The hospital allows a family member, friend, or other individual to be present with the patient for emotional support during the course of stay. Note: The hospital allows for the presence of a support individual of the patient's choice, unless the individual's presence infringes on others' rights, safety, or is	**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 visitors designated by the patient, including but not limited to a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. The patient also has the right to withdraw or deny consent for visitors at any time. Note 1: 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.

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		medically or therapeutically contraindicated. The individual may or may not be the patient's surrogate decision-maker or legally authorized representative. (For more information on surrogate or family involvement in patient care, treatment, and services, refer to RI.01.02.01, EP 8.)	
§482.13(h)(3)	(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.	**RI.01.01.01, EP 29** 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.	**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)(4)	(4) Ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences.	**RI.01.01.01, EP 28** The hospital allows a family member, friend, or other individual to be present with the patient for emotional support during the course of stay. Note: The hospital allows for the presence of a support individual of the patient's choice, unless the individual's presence infringes on others' rights, safety, or is medically or therapeutically contraindicated. The individual may or may not be the patient's surrogate decision-maker or legally authorized representative. (For more information on surrogate or family involvement in patient care, treatment, and services, refer to RI.01.02.01, EP 8.)	**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.
§482.15	§482.15 Condition of Participation: Emergency Preparedness The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop	**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:	**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

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	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:	- 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.	- 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(a)	(a) Emergency plan. The hospital must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:	**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	**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

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

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		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)	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)
§482.15(a)(2)	(2) Include strategies for addressing emergency events identified by the risk assessment.	**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.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.
§482.15(a)(3)	(3) Address patient population, including, but not limited to, persons at-risk; the type of services the hospital has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.	**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	**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

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		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. **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,	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. **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

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		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.	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.
§482.15(a)(4)	(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.	**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 officials' efforts to leverage support and resources and to provide an integrated response during an emergency or disaster incident.	**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 officials' efforts to leverage support and resources and to provide an integrated response during an emergency or disaster incident.
§482.15(b)	(b) Policies and procedures. The hospital must develop and implement emergency preparedness policies and procedures,	**EM.12.01.01, EP 1** The hospital has a written all-hazards emergency operations plan (EOP) with supporting policies and	**EM.12.01.01, EP 1** The hospital has a written all-hazards emergency operations plan (EOP) with supporting policies and procedures that provides

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	based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:	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: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program	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: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program
§482.15(b)(1)	(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:		

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§482.15(b)(1)(i)	(i) Food, water, medical, and pharmaceutical supplies.	**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.12.01.01, 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
§482.15(b)(1)(ii)	(ii) Alternate sources of energy to maintain the following:		
§482.15(b)(1)(ii)(A)	(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.	**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 levels cannot be maintained, the hospital considers partial or full evacuation or closure.	**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 levels cannot be maintained, the hospital considers partial or full evacuation or closure.
§482.15(b)(1)(ii)(B)	(B) Emergency lighting.	**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	**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

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		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 levels cannot be maintained, the hospital considers partial or full evacuation or closure.	- 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 levels cannot be maintained, the hospital considers partial or full evacuation or closure.
§482.15(b)(1)(ii)(C)	(C) Fire detection, extinguishing, and alarm systems.	**EC.02.03.01, EP 9** The written fire response plan describes the specific roles of staff at and away from a fire's point of origin, including when and how to sound and report fire alarms, how to contain smoke and fire, how to use a fire extinguisher, how to assist and relocate patients, how to evacuate to areas of refuge, and how staff will cooperate with firefighting authorities. Staff are periodically instructed on and kept informed of their duties under the plan, including cooperation with firefighting authorities. A copy of the plan is readily available with the telephone operator or security. Note: For full text, refer to NFPA 101-2012: 18/19.7.1; 7.2. **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	**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 levels cannot be maintained, the hospital considers partial or full evacuation or closure.

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		- 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 levels cannot be maintained, the hospital considers partial or full evacuation or closure.	
§482.15(b)(1)(ii)(D)	(D) Sewage and waste disposal.	**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 levels cannot be maintained, the hospital considers partial or full evacuation or closure.	**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 levels cannot be maintained, the hospital considers partial or full evacuation or closure.
§482.15(b)(2)	(2) 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.	**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	**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.

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		include the use of established technology or tracking systems or taking head counts at defined intervals.	
§482.15(b)(3)	(3) Safe evacuation from the hospital, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.	**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, and service needs of evacuees, staff responsibilities, and transportation. **EM.12.02.01, EP 6** 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.	**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, 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.

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§482.15(b)(4)	(4) A means to shelter in place for patients, staff, and volunteers who remain in the facility.	**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, and service needs of evacuees, staff responsibilities, and transportation.	**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, and service needs of evacuees, staff responsibilities, and transportation.
§482.15(b)(5)	(5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.	**IM.01.01.03, EP 1** The hospital follows a written plan for managing interruptions to its information processes (paper-based, electronic, or a mix of paper-based and electronic). **IM.01.01.03, EP 2** The hospital's plan for managing interruptions to information processes addresses the following: - Scheduled and unscheduled interruptions of electronic information systems - Training for staff on alternative procedures to follow when electronic information systems are unavailable - Backup of electronic information systems **IM.02.01.01, EP 1** The hospital follows a written policy addressing the privacy and confidentiality of health information. **IM.02.01.01, EP 4** The hospital discloses health information only as authorized by the patient or as otherwise consistent with law and regulation.	**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.

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		IM.02.01.03, EP 1 The hospital follows a written policy that addresses the security of health information, including access, use, and disclosure. **IM.02.01.03, EP 5** The hospital protects against unauthorized access, use, and disclosure of health information.	
§482.15(b)(6)	(6) The use of volunteers in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.	**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 functions - Integration of staffing agencies, volunteer staffing, or deployed medical assistance teams into assigned roles and responsibilities	**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 functions - Integration of staffing agencies, volunteer staffing, or deployed medical assistance teams into assigned roles and responsibilities
§482.15(b)(7)	(7) The development of arrangements with other hospitals and other providers to	**EM.12.02.05, EP 1** The hospital’s plan for providing patient care and clinical	**EM.12.02.05, EP 1** The hospital’s plan for providing patient care and clinical support

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	receive patients in the event of limitations or cessation of operations to maintain the continuity of services to hospital patients.	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.	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)(8)	(8) The role of the hospital 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.	**EM.12.01.01, EP 9** 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/what-we-do/emergency-response/how-can-we-help/waivers-flexibilities and https://www.cms.gov/about-cms/agency-information/emergency/downloads/consolidated_medicare_ffs_emergency_qsas.pdf.	**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/what-we-do/emergency-response/how-can-we-help/waivers-flexibilities and https://www.cms.gov/about-cms/agency-information/emergency/downloads/consolidated_medicare_ffs_emergency_qsas.pdf.
§482.15(c)	(c) Communication plan. The hospital must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:	**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	**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:

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		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: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program	- 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: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program
§482.15(c)(1)	(1) Names and contact information for the following:		
§482.15(c)(1)(i)	(i) Staff.	**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:	**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:

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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.	- 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)(ii)	(ii) Entities providing services under arrangement.	**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)	**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

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		Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident.	organizations/individuals need to be contacted to assist with the emergency or disaster incident.
§482.15(c)(1)(iii)	(iii) Patients' physicians.	**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.	**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)(iv)	(iv) Other hospitals and CAHs	**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,	**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

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		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.	- 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)(v)	(v) Volunteers.	**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.	**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)(2)	(2) Contact information for the following:		
§482.15(c)(2)(i)	(i) Federal, State, tribal, regional, and local emergency preparedness staff.	**EM.12.02.01, EP 1** The hospital maintains a contact list of individuals and	**EM.12.02.01, EP 1** The hospital maintains a contact list of individuals and entities that

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		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.	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)(2)(ii)	(ii) Other sources of assistance.	**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)	**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)

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		- Other sources of assistance (such as health care coalitions) Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident.	Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident.
§482.15(c)(3)	(3) Primary and alternate means for communicating with the following:		
§482.15(c)(3)(i)	(i) Hospital's staff.	**EM.12.02.01, EP 6** 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.	**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.
§482.15(c)(3)(ii)	(ii) Federal, State, tribal, regional, and local emergency management agencies.	**EM.12.02.01, EP 6** 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	**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

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		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.	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.
§482.15(c)(4)	(4) A method for sharing information and medical documentation for patients under the hospital's care, as necessary, with other health care providers to maintain the continuity of care.	**EM.12.02.01, EP 5** 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 information is consistent with 45 CFR 164.510(b)(1)(ii) and (b)(4). **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 information is consistent with 45 CFR 164.510(b)(1)(ii) and (b)(4). **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.

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§482.15(c)(5)	(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii).	**EM.12.02.01, EP 5** 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 information is consistent with 45 CFR 164.510(b)(1)(ii) and (b)(4).	**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 information is consistent with 45 CFR 164.510(b)(1)(ii) and (b)(4).
§482.15(c)(6)	(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).	**EM.12.02.01, EP 5** 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 information is consistent with 45 CFR 164.510(b)(1)(ii) and (b)(4).	**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 information is consistent with 45 CFR 164.510(b)(1)(ii) and (b)(4).
§482.15(c)(7)	(7) A means of providing information about the hospital's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.	**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,	**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

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		evacuation or transfer of patients, and temporary loss of part or all organization function.	protective equipment, staffing shortages, evacuation or transfer of patients, and temporary loss of part or all organization function.
§482.15(d)	(d) Training and testing. The hospital 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.	**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 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	**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 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.

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		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.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
§482.15(d)(1)	(1) Training program. The hospital must do all of the following:		
§482.15(d)(1)(i)	(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.	**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 are consistent with their roles and responsibilities in an emergency. The initial education and training include the following: - Activation and deactivation of the emergency operations plan - Communications plan - Emergency response policies and procedures - Evacuation, shelter-in-place, lockdown, and surge procedures - Where and how to obtain resources and supplies for emergencies (such as procedure manuals or equipment) Documentation is required.	**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 are consistent with their roles and responsibilities in an emergency. The initial education and training include the following: - Activation and deactivation of the emergency operations plan - Communications plan - Emergency response policies and procedures - Evacuation, shelter-in-place, lockdown, and surge procedures - Where and how to obtain resources and supplies for emergencies (such as procedure manuals or equipment) Documentation is required.

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§482.15(d)(1)(ii)	(ii) Provide emergency preparedness training at least every 2 years.	**EM.15.01.01, EP 3** The hospital provides ongoing education and training to all staff, individuals providing services under arrangement, and volunteers that are consistent with their roles and responsibilities in an emergency. The education and training occur at the following times: - At least every two years - When roles or responsibilities change - When there are significant revisions to the emergency operations plan, policies, and/or procedures - When procedural changes are made during an emergency or disaster incident requiring just-in-time education and training Documentation is required. Note 1: Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization. Note 2: 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.15.01.01, EP 3** The hospital provides ongoing education and training to all staff, individuals providing services under arrangement, and volunteers that are consistent with their roles and responsibilities in an emergency. The education and training occur at the following times: - At least every two years - When roles or responsibilities change - When there are significant revisions to the emergency operations plan, policies, and/or procedures - When procedural changes are made during an emergency or disaster incident requiring just-in-time education and training Documentation is required. Note 1: Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization. Note 2: 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.
§482.15(d)(1)(iii)	(iii) Maintain documentation of the training.	**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 are consistent with their roles and responsibilities in an emergency. The initial education and training include the following: - Activation and deactivation of the emergency	**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 are consistent with their roles and responsibilities in an emergency. The initial education and training include the following: - Activation and deactivation of the emergency operations plan - Communications plan

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		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 are consistent with their roles and responsibilities in an emergency. The education and training occur at the following times: - At least every two years - When roles or responsibilities change - When there are significant revisions to the emergency operations plan, policies, and/or procedures - When procedural changes are made during an emergency or disaster incident requiring just-in-time education and training Documentation is required. Note 1: Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization. Note 2: 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	- 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 are consistent with their roles and responsibilities in an emergency. The education and training occur at the following times: - At least every two years - When roles or responsibilities change - When there are significant revisions to the emergency operations plan, policies, and/or procedures - When procedural changes are made during an emergency or disaster incident requiring just-in-time education and training Documentation is required. Note 1: Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization. Note 2: 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.

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		revised elements of the emergency management program.	
§482.15(d)(1)(iv)	(iv) Demonstrate staff knowledge of emergency procedures.	**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 are consistent with their roles and responsibilities in an emergency. The initial education and training include the following: - Activation and deactivation of the emergency operations plan - Communications plan - Emergency response policies and procedures - Evacuation, shelter-in-place, lockdown, and surge procedures - Where and how to obtain resources and supplies for emergencies (such as procedure manuals or equipment) Documentation is required. **EM.15.01.01, EP 3** The hospital provides ongoing education and training to all staff, individuals providing services under arrangement, and volunteers that are consistent with their roles and responsibilities in an emergency. The education and training occur at the following times: - At least every two years - When roles or responsibilities change - When there are significant revisions to the emergency operations plan, policies, and/or procedures - When procedural changes are made during an emergency or disaster incident requiring just-in-time education and training	**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 are consistent with their roles and responsibilities in an emergency. The initial education and training include the following: - Activation and deactivation of the emergency operations plan - Communications plan - Emergency response policies and procedures - Evacuation, shelter-in-place, lockdown, and surge procedures - Where and how to obtain resources and supplies for emergencies (such as procedure manuals or equipment) Documentation is required. **EM.15.01.01, EP 3** The hospital provides ongoing education and training to all staff, individuals providing services under arrangement, and volunteers that are consistent with their roles and responsibilities in an emergency. The education and training occur at the following times: - At least every two years - When roles or responsibilities change - When there are significant revisions to the emergency operations plan, policies, and/or procedures - When procedural changes are made during an emergency or disaster incident requiring just-in-time education and training Documentation is required. Note 1: Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined

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		Documentation is required. Note 1: Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization. Note 2: 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.	and 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.
§482.15(d)(1)(v)	(v) If the emergency preparedness policies and procedures are significantly updated, the hospital must conduct training on the updated policies and procedures.	**EM.15.01.01, EP 3** The hospital provides ongoing education and training to all staff, individuals providing services under arrangement, and volunteers that are consistent with their roles and responsibilities in an emergency. The education and training occur at the following times: - At least every two years - When roles or responsibilities change - When there are significant revisions to the emergency operations plan, policies, and/or procedures - When procedural changes are made during an emergency or disaster incident requiring just-in-time education and training Documentation is required. Note 1: Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization. Note 2: Hospitals are not required to retrain staff on the	**EM.15.01.01, EP 3** The hospital provides ongoing education and training to all staff, individuals providing services under arrangement, and volunteers that are consistent with their roles and responsibilities in an emergency. The education and training occur at the following times: - At least every two years - When roles or responsibilities change - When there are significant revisions to the emergency operations plan, policies, and/or procedures - When procedural changes are made during an emergency or disaster incident requiring just-in-time education and training Documentation is required. Note 1: Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization. Note 2: Hospitals are not required to retrain staff on the entire emergency operations plan but can choose to provide education

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		entire emergency operations plan but can choose to provide education and training specific to the new or revised elements of the emergency management program.	and training specific to the new or revised elements of the emergency management program.
§482.15(d)(2)	(2) Testing. The hospital must conduct exercises to test the emergency plan at least twice per year. The hospital must do all of the following:	**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 hospital provides documentation that it activated its emergency operations plan.	**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 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.

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		Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises.	
§482.15(d)(2)(i)	(i) Participate in an annual full-scale exercise that is community-based; or	**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 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.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 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.

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§482.15(d)(2)(i)(A)	(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.	**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 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.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 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.
§482.15(d)(2)(i)(B)	(B) If the hospital experiences an actual natural or man-made emergency that	**EM.16.01.01, EP 2** The hospital is required to conduct two exercises per	**EM.16.01.01, EP 2** The hospital is required to conduct two exercises per year to test

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	requires activation of the emergency plan, the hospital is exempt from engaging in its next required fullscale community-based exercise or individual, facility-based functional exercise following the onset of the emergency event.	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 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.	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 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.
§482.15(d)(2)(ii)	(ii) Conduct an additional exercise that may include, but is not limited to the following:		

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§482.15(d)(2)(ii)(A)	(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or	**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 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.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 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.
§482.15(d)(2)(ii)(B)	(B) A mock disaster drill; or	**EM.16.01.01, EP 2** The hospital is required to conduct two exercises per	**EM.16.01.01, EP 2** The hospital is required to conduct two exercises per year to test

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		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 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.	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 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.
§482.15(d)(2)(ii)(C)	(C) A tabletop exercise or workshop that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of	**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	**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

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	problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	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 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.	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 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.
§482.15(d)(2)(iii)	(iii) Analyze the hospital's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the hospital's emergency plan, as needed.	**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	**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

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		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 an actual emergency or disaster incident. The report summarizes what took place during the event, analyzes the actions taken by participants, and provides areas needing improvement. **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	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 an actual emergency or disaster incident. The report summarizes what took place during the event, analyzes the actions taken by participants, and provides areas needing improvement. **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
§482.15(e)	(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	**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	**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

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	procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.	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. **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.	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. **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.
§482.15(e)(1)	(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.	**EC.01.01.01, EP 12** The hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. **EC.02.05.07, EP 11** The hospital meets all other emergency power system 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. **LS.01.01.01, EP 8**	**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

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		The hospital complies with the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	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.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 requirements found in NFPA 99-2012 Health Care Facilities Code,

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			NFPA 110-2010 Standard for Emergency and Standby Power Systems, and NFPA 101-2012 Life Safety Code requirements.
§482.15(e)(2)	(2) Emergency generator inspection and testing. The hospital must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.	**EC.02.05.07, EP 3** The hospital performs a functional test of Level 1 stored emergency power supply systems (SEPSS) on a monthly basis and performs a test of Level 2 SEPSS on a quarterly basis. Test duration is for five minutes or as specified for its class (whichever is less). The hospital performs an annual test at full load for 60% of the full duration of its class. The test results and completion dates are documented. Note 1: Non–SEPSS battery backup emergency power systems that the hospital has determined to be critical for operations during a power failure (for example, laboratory equipment or electronic health records) should be properly tested and maintained in accordance with manufacturers' recommendations. Note 2: Level 1 SEPSS are intended to automatically supply illumination or power to critical areas and equipment essential for safety to human life. Included are systems that supply emergency power for such functions as illumination for safe exiting, ventilation where it is essential to maintain life, fire detection and alarm systems, public safety communications systems, and processes where the current interruption would produce serious life safety or health hazards to patients, the public, or staff. Note 3: Class defines the minimum time for which the SEPSS is designed to operate at its rated load without being recharged. Note 4: For additional guidance on operational inspection and testing, see NFPA 111-2010: 8.4.	**PE.04.01.03, EP 3** The hospital meets the emergency power system and generator requirements found in NFPA 99-2012 Health Care Facilities Code, NFPA 110-2010 Standard for Emergency and Standby Power Systems, and NFPA 101-2012 Life Safety Code requirements.

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		EC.02.05.07, EP 4 Every week, the hospital inspects the emergency power supply system (EPSS), including all associated components and batteries. The results and completion dates of the inspections are documented. (For full text, refer to NFPA 110-2010: 8.3.1; 8.3.3; 8.3.4; 8.3.7; 8.4.1) **EC.02.05.07, EP 5** At least monthly, the hospital tests each emergency generator beginning with a cold start under load for at least 30 continuous minutes. The cooldown period is not part of the 30 continuous minutes. The test results and completion dates are documented. (For full text, refer to NFPA 99-2012: 6.4.4.1) **EC.02.05.07, EP 6** The monthly tests for diesel-powered emergency generators are conducted with a dynamic load that is at least 30% of the nameplate rating of the generator or meets the manufacturer's recommended prime movers' exhaust gas temperature. If the hospital does not meet either the 30% of nameplate rating or the recommended exhaust gas temperature during any test in EC.02.05.07, EP 5, then it must test the emergency generator once every 12 months using supplemental (dynamic or static) loads of 50% of nameplate rating for 30 minutes, followed by 75% of nameplate rating for 60 minutes, for a total of 1½ continuous hours. (For full text, refer to NFPA 99-2012: 6.4.4.1) Note: Tests for non-diesel-powered generators need only be conducted with available load. **EC.02.05.07, EP 7**	

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		At least monthly, the hospital tests all automatic and manual transfer switches on the inventory. The test results and completion dates are documented. (For full text, refer to NFPA 99-2012: 6.4.4.1) **EC.02.05.07, EP 8** At least annually, the hospital tests the fuel quality to ASTM standards. The test results and completion dates are documented. Note: For additional guidance, see NFPA 110-2010: 8.3.8. **EC.02.05.07, EP 9** At least once every 36 months, hospitals with a generator providing emergency power test each emergency generator for a minimum of 4 continuous hours. The test results and completion dates are documented. Note: For additional guidance, see NFPA 110-2010, Chapter 8. **EC.02.05.07, EP 10** The 36-month diesel-powered emergency generator test uses a dynamic or static load that is at least 30% of the nameplate rating of the generator or meets the manufacturer's recommended prime movers' exhaust gas temperature. Note 1: Tests for non-diesel-powered generators need only be conducted with available load. Note 2: For additional guidance, see NFPA 110-2010, Chapter 8. **EC.02.05.07, EP 11**	

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		The hospital meets all other emergency power system 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.	
§482.15(e)(3)	(3) Emergency generator fuel. Hospitals that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.	**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 following: - If part of a health care system, coordinating within the	**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 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

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		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 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. **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.	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 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. **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.
§482.15(f)	(f) Integrated healthcare systems. If a hospital 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 hospital may choose to participate in the healthcare		

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	system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must--		
§482.15(f)(1)	(1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.	**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	**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)(2)	(2) Be developed and maintained in a manner that takes into account each separately certified facility's unique	**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	**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

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	circumstances, patient populations, and services offered.	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	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)(3)	(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.	**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	**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

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		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	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)(4)	(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following:	**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	**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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- 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 **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	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 **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

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		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 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.	cooperating and collaborating with other health care facilities; health care coalitions; and local, tribal, regional, state, and federal emergency preparedness officials' efforts to leverage support and resources and to provide an integrated response during an emergency or disaster incident. **EM.13.01.01, EP 1** The 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 providing essential services include use of off-site locations, space maintained by another organization, existing facilities or space, telework (remote work), or telehealth.

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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.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.
§482.15(f)(4)(i)	(i) A documented community-based risk assessment, utilizing an all-hazards approach.	**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	**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

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		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	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)(4)(ii)	(ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.	**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	**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

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		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	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)(5)	(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.	**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	**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

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		- 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 **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	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 **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.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,

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		- Securing information and records **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 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	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 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

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		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	- Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program
§482.15(g)	(g) Transplant hospitals. If a hospital has one or more transplant programs (as defined in § 482.70)--		
§482.15(g)(1)	(1) A representative from each transplant program must be included in the development and maintenance of the hospital's emergency preparedness program; and	**EM.09.01.01, EP 4** For hospitals that use Joint Commission accreditation for deemed status purposes: If a hospital has one or more transplant programs the following must occur: - A representative from each transplant program must be included in the development and maintenance of the hospital's emergency preparedness program - The hospital must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the hospital, each transplant program, and the organ procurement organization (OPO) for the donation service area where the hospital is situated, unless the hospital has been granted a waiver to work with another OPO, during an emergency	**EM.09.01.01, EP 4** For hospitals that use Joint Commission accreditation for deemed status purposes: If a hospital has one or more transplant programs (as defined in 42 CFR 482.70) the following must occur: - A representative from each transplant program must be included in the development and maintenance of the hospital's emergency preparedness program - The hospital must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the hospital, each transplant program, and the organ procurement organization (OPO) for the donation service area where the hospital is situated, unless the hospital has been granted a waiver to work with another OPO, during an emergency
§482.15(g)(2)	(2) The hospital must develop and maintain mutually agreed upon protocols that address	**EM.09.01.01, EP 4** For hospitals that use Joint Commission accreditation	**EM.09.01.01, EP 4** For hospitals that use Joint Commission accreditation for deemed

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	the duties and responsibilities of the hospital, each transplant program, and the OPO for the DSA where the hospital is situated, unless the hospital has been granted a waiver to work with another OPO, during an emergency.	for deemed status purposes: If a hospital has one or more transplant programs the following must occur: - A representative from each transplant program must be included in the development and maintenance of the hospital's emergency preparedness program - The hospital must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the hospital, each transplant program, and the organ procurement organization (OPO) for the donation service area where the hospital is situated, unless the hospital has been granted a waiver to work with another OPO, during an emergency	status purposes: If a hospital has one or more transplant programs (as defined in 42 CFR 482.70) the following must occur: - A representative from each transplant program must be included in the development and maintenance of the hospital's emergency preparedness program - The hospital must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the hospital, each transplant program, and the organ procurement organization (OPO) for the donation service area where the hospital is situated, unless the hospital has been granted a waiver to work with another OPO, during an emergency
§482.15(h)	(h) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.		

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§482.15(h)(1)	(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.		
§482.15(h)(1)(i)	(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.	**EC.01.01.01, EP 12** The hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	**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.
§482.15(h)(1)(ii)	(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.	**EC.01.01.01, EP 12** The hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	**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

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			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.
§482.15(h)(1)(iii)	(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.	**EC.01.01.01, EP 12** The hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	**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.
§482.15(h)(1)(iv)	(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.	**EC.01.01.01, EP 12** The hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	**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.

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			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.
§482.15(h)(1)(v)	(v) TIA 12-5 to NFPA 99, issued August 1, 2013.	**EC.01.01.01, EP 12** The hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	**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.
§482.15(h)(1)(vi)	(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.	**EC.01.01.01, EP 12** The hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	**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

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			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.
§482.15(h)(1)(vii)	(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.	**LS.01.01.01, EP 8** The hospital complies with the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	**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 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.
§482.15(h)(1)(viii)	(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.	**LS.01.01.01, EP 8** The hospital complies with the Life Safety Code (NFPA	**PE.03.01.01, EP 3** The hospital meets the applicable provisions of the Life Safety

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		101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	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 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.
§482.15(h)(1)(ix)	(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.	**LS.01.01.01, EP 8** The hospital complies with the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	**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 &

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			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.
§482.15(h)(1)(x)	(x) TIA 12-3 to NFPA 101, issued October 22, 2013.	**LS.01.01.01, EP 8** The hospital complies with the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	**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

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			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.
§482.15(h)(1)(xi)	(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.	**LS.01.01.01, EP 8** The hospital complies with the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	**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 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.

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§482.15(h)(1)(xii)	(xii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.	**EC.02.05.07, EP 11** The hospital meets all other emergency power system 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.	**PE.04.01.03, EP 3** The hospital meets the emergency power system and generator requirements found in NFPA 99-2012 Health Care Facilities Code, NFPA 110-2010 Standard for Emergency and Standby Power Systems, and NFPA 101-2012 Life Safety Code requirements.
§482.15(h)(2)	(2) [Reserved]		
§482.21	§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. 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.	**LD.01.03.01, EP 21** For hospitals that use Joint Commission accreditation for deemed status purposes: 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, and include services provided under contract. (For more information on contracted services, see Standard LD.04.03.09) Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital is not required to participate in a quality improvement organization (QIO) cooperative project, but its own projects are required to be of comparable effort. **LD.03.02.01, EP 1** Leaders set expectations for using data and information for the following: - Improving the safety and quality of care, treatment, or services - Decision making that supports the safety and quality of care, treatment, and services - Identifying and responding to internal and external changes in the environment **LD.03.05.01, EP 1**	**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.14.03.03) 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. **PI.14.01.01, EP 1** The hospital acts on improvement priorities.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		The hospital has a systematic approach to change and performance improvement. **LD.03.05.01, EP 2** Structures for managing change and performance improvement do the following: - Foster the safety of the patient and the quality of care, treatment, and services - Support both safety and quality throughout the hospital - Adapt to changes in the environment **LD.03.05.01, EP 3** Leaders evaluate the effectiveness of processes for the management of change and performance improvement. **LD.03.07.01, EP 1** Performance improvement occurs hospitalwide. **LD.03.07.01, EP 2** As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities and patient health outcomes - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities - Identify the frequency of data collection for performance improvement activities - Reprioritize performance improvement activities in response to changes in the internal or external environment **LD.03.09.01, EP 1**	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		The leaders implement a hospitalwide patient safety program as follows: - One or more qualified individuals or an interdisciplinary group manage the safety program. - All departments, programs, and services within the hospital participate in the safety program. - The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as close calls [“near misses”] or good catches) to hazardous conditions and sentinel events. **LD.04.03.09, EP 2** The hospital describes, in writing, the nature and scope of services provided through contractual agreements. **LD.04.03.09, EP 4** Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: In most cases, each physician and other licensed practitioner providing services through a contractual agreement must be credentialed and privileged by the hospital using their services following the process described in the “Medical Staff” (MS) chapter. Note 2: For hospitals that do not use Joint Commission accreditation for deemed status purposes: When the hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following: - Verify that all physicians and other licensed practitioners who will be providing patient care,	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges. - Specify in the written agreement that the contracted organization will ensure that all contracted services provided by physicians and other licensed practitioners will be within the scope of their privileges. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders who monitor the contracted services are the governing body. **LD.04.03.09, EP 5** Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services. Note: A written description of the expectations can be provided either as part of the written agreement or in addition to it. **LD.04.03.09, EP 6** Leaders monitor contracted services by evaluating these services in relation to the hospital's expectations. **LD.04.03.09, EP 7** Leaders take steps to improve contracted services that do not meet expectations. Note: Examples of improvement efforts to consider include the following: - Increase monitoring of the contracted services - Provide consultation or training to the contractor - Renegotiate the contract terms - Apply defined penalties - Terminate the contract	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		PI.03.01.01, EP 3 The hospital uses statistical tools and techniques to analyze and display data. **PI.03.01.01, EP 4** The hospital analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations. **PI.03.01.01, EP 8** The hospital uses the results of data analysis to identify improvement opportunities. **PI.04.01.01, EP 2** The hospital acts on improvement priorities. **PI.04.01.01, EP 5** The hospital acts when it does not achieve or sustain planned improvements.	
§482.21(a)	§482.21(a) Standard: Program Scope		
§482.21(a)(1)	(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 and identify and reduce medical errors.	**LD.03.02.01, EP 1** Leaders set expectations for using data and information for the following: - Improving the safety and quality of care, treatment, or services - Decision making that supports the safety and quality of care, treatment, and services - Identifying and responding to internal and external changes in the environment **LD.03.05.01, EP 1** The hospital has a systematic approach to change and	**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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		performance improvement. **LD.03.05.01, EP 2** Structures for managing change and performance improvement do the following: - Foster the safety of the patient and the quality of care, treatment, and services - Support both safety and quality throughout the hospital - Adapt to changes in the environment **LD.03.05.01, EP 3** Leaders evaluate the effectiveness of processes for the management of change and performance improvement. **LD.03.07.01, EP 1** Performance improvement occurs hospitalwide. **LD.03.07.01, EP 2** As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities and patient health outcomes - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities - Identify the frequency of data collection for performance improvement activities - Reprioritize performance improvement activities in response to changes in the internal or external environment **LD.03.09.01, EP 1** The leaders implement a hospitalwide patient safety	performance programs including but not limited to data related to hospital readmissions and hospital-acquired conditions.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		program as follows: - One or more qualified individuals or an interdisciplinary group manage the safety program. - All departments, programs, and services within the hospital participate in the safety program. - The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as close calls [“near misses”] or good catches) to hazardous conditions and sentinel events. **LD.03.09.01, 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.	
§482.21(a)(2)	(2) The hospital must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital service and operations.	**LD.03.07.01, EP 2** As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities and patient health outcomes - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities - Identify the frequency of data collection for performance improvement activities - Reprioritize performance improvement activities in response to changes in the internal or external environment **LD.03.09.01, EP 5** The hospital conducts thorough and credible comprehensive systematic analyses (for example, root	**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.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		cause analyses) in response to sentinel events as described in the "Sentinel Event Policy" (SE) chapter of this manual. **PI.01.01.01, EP 2** The hospital collects data on the following: Performance improvement priorities identified by leaders. **PI.01.01.01, EP 3** The hospital collects data on the following: Operative or other procedures that place patients at risk of disability or death. **PI.01.01.01, EP 4** The hospital collects data on the following: Surgeries in which the postoperative diagnosis (clinical or pathological) was unexpected and could indicate that a clinically significant diagnostic error occurred. Note: The hospital's medical staff determine which unexpected postoperative diagnoses are clinically significant. Examples may include but are not limited to the following: - A preoperative pathology or cytology report was interpreted as a malignancy, but no malignancy was found in the surgical specimen. - A patient underwent surgery for acute appendicitis, but the appendix was normal on the postsurgical pathology exam. - An operation was performed because of a presumed malignancy based on a radiology report, but no malignancy was found. **PI.01.01.01, EP 5**	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		The hospital collects data on the following: Adverse events related to using moderate or deep sedation or anesthesia. **PI.01.01.01, EP 6** The hospital collects data on the following: The use of blood and blood components. **PI.01.01.01, EP 7** The hospital collects data on the following: All reported and confirmed transfusion reactions. **PI.01.01.01, EP 10** The hospital collects data on the following: - The number and location of cardiac arrests (for example, ambulatory area, telemetry unit, critical care unit) - The outcomes of resuscitation (for example, return of spontaneous circulation [ROSC], survival to discharge) Note: ROSC is defined as return of spontaneous and sustained circulation for at least 20 consecutive minutes following resuscitation efforts. - Transfer to a higher level of care **PI.01.01.01, EP 12** The hospital collects data on the following: Significant medication errors. **PI.01.01.01, EP 13** The hospital collects data on the following: Significant adverse drug reactions. **PI.01.01.01, EP 14**	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		The hospital collects data on the following: Patient perception of the safety and quality of care, treatment, or services. **PI.03.01.01, EP 3** The hospital uses statistical tools and techniques to analyze and display data. **PI.03.01.01, EP 4** The hospital analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations. **PI.03.01.01, EP 8** The hospital uses the results of data analysis to identify improvement opportunities.	
§482.21(b)	§482.21(b) Standard: Program Data		
§482.21(b)(1)	(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 quality reporting and quality performance programs, including but not limited to data related to hospital readmissions and hospital-acquired conditions.	**LD.03.02.01, EP 4** For hospitals that use Joint Commission accreditation for deemed status purposes: The quality assessment and performance improvement program incorporates quality indicator data, including patient care data and other relevant data such as that submitted to or received from Medicare quality reporting and quality performance programs (for example, data related to hospital readmissions and hospital-acquired conditions).	**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.
§482.21(b)(2)	(2) The hospital must use the data collected to--		

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§482.21(b)(2)(i)	(i) Monitor the effectiveness and safety of services and quality of care; and	**LD.03.02.01, EP 1** Leaders set expectations for using data and information for the following: - Improving the safety and quality of care, treatment, or services - Decision making that supports the safety and quality of care, treatment, and services - Identifying and responding to internal and external changes in the environment **LD.03.09.01, 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. **PI.03.01.01, EP 4** The hospital analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.	**PI.13.01.01, EP 1** The hospital analyzes and compares internal data over time and uses the results of data analysis to do the following: - Monitor the effectiveness and safety of services - Monitor the quality of care - Identify opportunities for improvement and changes that will lead to improvement
§482.21(b)(2)(ii)	(ii) Identify opportunities for improvement and changes that will lead to improvement.	**LD.03.01.01, EP 2** Leaders prioritize and implement changes identified by the evaluation. **PI.03.01.01, EP 8** The hospital uses the results of data analysis to identify improvement opportunities.	**PI.13.01.01, EP 1** The hospital analyzes and compares internal data over time and uses the results of data analysis to do the following: - Monitor the effectiveness and safety of services - Monitor the quality of care - Identify opportunities for improvement and changes that will lead to improvement
§482.21(b)(3)	(3) The frequency and detail of data collection must be specified by the hospital's governing body.	**LD.03.07.01, EP 2** As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities and patient health outcomes - Give priority to high-volume, high-risk, or problem-	**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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		prone processes for performance improvement activities - Identify the frequency of data collection for performance improvement activities - Reprioritize performance improvement activities in response to changes in the internal or external environment	- 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
§482.21(c)	§482.21(c) Standard: Program Activities		
§482.21(c)(1)	(1) The hospital must set priorities for its performance improvement activities that--		
§482.21(c)(1)(i)	(i) Focus on high-risk, high-volume, or problem-prone areas;	**LD.03.07.01, EP 2** As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities and patient health outcomes - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities - Identify the frequency of data collection for performance improvement activities - Reprioritize performance improvement activities in response to changes in the internal or external environment	**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
§482.21(c)(1)(ii)	(ii) Consider the incidence, prevalence, and severity of problems in those areas; and	**LD.03.07.01, EP 2** As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities and patient health outcomes - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities - Identify the frequency of data collection for performance improvement activities	**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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Reprioritize performance improvement activities in response to changes in the internal or external environment	- Identify the frequency and detail of data collection for performance improvement activities
§482.21(c)(1)(iii)	(iii) Affect health outcomes, patient safety, and quality of care.	**LD.03.07.01, EP 2** As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities and patient health outcomes - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities - Identify the frequency of data collection for performance improvement activities - Reprioritize performance improvement activities in response to changes in the internal or external environment	**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
§482.21(c)(2)	(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.	**LD.03.08.01, EP 1** The hospital's design of new or modified services or processes incorporates the following: - The needs of patients, staff, and others - The results of performance improvement activities - Information about potential risks to patients - Evidence-based information in the decision-making process - Information about sentinel events Note 1: A proactive risk assessment is one of several ways to assess potential risks to patients. For suggested components, refer to the "Proactive Risk Assessment" section at the beginning of this chapter. Note 2: Evidence-based information could include practice guidelines, successful practices, information from current literature, and clinical standards.	**PI.12.01.01, EP 1** The hospital tracks medical errors and adverse patient events, 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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		LD.03.09.01, EP 3 The leaders provide and encourage the use of systems for blame-free internal reporting of a system or process failure, or the results of a proactive risk assessment. 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 their blameworthy errors. **LD.03.09.01, EP 4** The leaders define patient safety event and communicate this definition throughout the organization. Note: At a minimum, the organization's definition includes those events subject to review as described in the "Sentinel Event Policy" (SE) chapter of this manual. **LD.03.09.01, 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. **LD.03.09.01, 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. **LD.03.09.01, EP 8**	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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. **LD.03.09.01, EP 9** The leaders disseminate lessons learned from comprehensive systematic analyses (for example, root cause analyses), system or process failures, and the results of proactive risk assessments to all staff who provide services for the specific situation. **LD.03.09.01, EP 10** At least once a year, the leaders provide governance with written reports on the following: - All system or process failures - The number and type of sentinel events - Whether the patients and the families were informed of the event - All actions taken to improve safety, both proactively and in response to actual occurrences - For hospitals that use Joint Commission accreditation for deemed status purposes: The determined number of distinct improvement projects to be conducted annually - All results of the analyses related to the adequacy of staffing **PI.03.01.01, EP 4** The hospital analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.	
§482.21(c)(3)	(3) The hospital must take actions aimed at performance improvement and, after	**LD.03.05.01, EP 3** Leaders evaluate the effectiveness of processes for the	**PI.12.01.01, EP 4** The hospital takes action to improve its performance. After

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.	management of change and performance improvement. **PI.04.01.01, EP 2** The hospital acts on improvement priorities. **PI.04.01.01, EP 5** The hospital acts when it does not achieve or sustain planned improvements.	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.
§482.21(d)	§482.21(d) Standard: Performance Improvement Projects As part of its quality assessment and performance improvement program, the hospital must conduct performance improvement projects.	**LD.03.05.01, EP 1** The hospital has a systematic approach to change and performance improvement. **LD.03.07.01, EP 1** Performance improvement occurs hospitalwide. **LD.03.07.01, EP 2** As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities and patient health outcomes - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities - Identify the frequency of data collection for performance improvement activities - Reprioritize performance improvement activities in response to changes in the internal or external environment	**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 required to participate in a quality improvement organization cooperative project, but its own projects are required to be of comparable effort.
§482.21(d)(1)	(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.	**LD.03.05.01, EP 1** The hospital has a systematic approach to change and performance improvement. **LD.03.05.01, EP 2**	**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

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		Structures for managing change and performance improvement do the following: - Foster the safety of the patient and the quality of care, treatment, and services - Support both safety and quality throughout the hospital - Adapt to changes in the environment **LD.03.07.01, EP 2** As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities and patient health outcomes - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities - Identify the frequency of data collection for performance improvement activities - Reprioritize performance improvement activities in response to changes in the internal or external environment **LD.03.09.01, 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. **LD.03.09.01, EP 10** At least once a year, the leaders provide governance with written reports on the following: - All system or process failures - The number and type of sentinel events - Whether the patients and the families were informed 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 required to participate in a quality improvement organization cooperative project, but its own projects are required to be of comparable effort.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		the event - All actions taken to improve safety, both proactively and in response to actual occurrences - For hospitals that use Joint Commission accreditation for deemed status purposes: The determined number of distinct improvement projects to be conducted annually - All results of the analyses related to the adequacy of staffing	
§482.21(d)(2)	(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 measurable improvement in indicators related to health outcomes.	**IM.02.02.03, EP 2** The hospital's storage and retrieval systems 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. **LD.03.07.01, EP 1** Performance improvement occurs hospitalwide. **LD.03.07.01, EP 2** As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities and patient health outcomes - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities - Identify the frequency of data collection for performance improvement activities - Reprioritize performance improvement activities in response to changes in the internal or external environment	**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 required to participate in a quality improvement organization cooperative project, but its own projects are required to be of comparable effort.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		LD.03.09.01, EP 1 The leaders implement a hospitalwide patient safety program as follows: - One or more qualified individuals or an interdisciplinary group manage the safety program. - All departments, programs, and services within the hospital participate in the safety program. - The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as close calls [“near misses”] or good catches) to hazardous conditions and sentinel events.	
§482.21(d)(3)	(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.	**LD.03.07.01, EP 2** As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities and patient health outcomes - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities - Identify the frequency of data collection for performance improvement activities - Reprioritize performance improvement activities in response to changes in the internal or external environment **LD.03.09.01, EP 10** At least once a year, the leaders provide governance with written reports on the following: - All system or process failures - The number and type of sentinel events - Whether the patients and the families were informed of	**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.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		the event - All actions taken to improve safety, both proactively and in response to actual occurrences - For hospitals that use Joint Commission accreditation for deemed status purposes: The determined number of distinct improvement projects to be conducted annually - All results of the analyses related to the adequacy of staffing **PI.04.01.01, EP 5** The hospital acts when it does not achieve or sustain planned improvements.	
§482.21(d)(4)	(4) A hospital is not required to participate in a QIO cooperative project, but its own projects are required to be of comparable effort.	**LD.01.03.01, EP 21** For hospitals that use Joint Commission accreditation for deemed status purposes: 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, and include services provided under contract. (For more information on contracted services, see Standard LD.04.03.09) Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital is not required to participate in a quality improvement organization (QIO) cooperative project, but its own projects are required to be of comparable effort. **LD.03.09.01, EP 11** 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	**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 required to participate in a quality improvement organization cooperative project, but its own projects are required to be of comparable effort. **PI.14.01.01, EP 1** The hospital acts on improvement priorities.

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		and Drug Administration (FDA) MedWatch. Mandatory programs are often state initiated. **PI.04.01.01, EP 2** The hospital acts on improvement priorities. **PI.04.01.01, EP 5** The hospital acts when it does not achieve or sustain planned improvements.	
§482.21(e)	§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:		
§482.21(e)(1)	(1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained.	**LD.01.03.01, EP 5** The governing body provides for the resources needed to maintain safe, quality care, treatment, and services. **LD.01.03.01, EP 6** The governing body works with the senior managers and leaders of the organized medical staff to annually evaluate the hospital's performance in relation to its mission, vision, and goals. **LD.03.05.01, EP 1** The hospital has a systematic approach to change and performance improvement. **LD.03.07.01, EP 1** Performance improvement occurs hospitalwide.	**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 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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		LD.03.07.01, EP 2 As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities and patient health outcomes - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities - Identify the frequency of data collection for performance improvement activities - Reprioritize performance improvement activities in response to changes in the internal or external environment **LD.03.09.01, EP 1** The leaders implement a hospitalwide patient safety program as follows: - One or more qualified individuals or an interdisciplinary group manage the safety program. - All departments, programs, and services within the hospital participate in the safety program. - The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as close calls [“near misses”] or good catches) to hazardous conditions and sentinel events. **LD.03.09.01, EP 2** 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,	projects is conducted annually **PI.14.01.01, EP 1** The hospital acts on improvement priorities.

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		containing the risk to others, and preserving factual information for subsequent analysis. **LD.03.09.01, EP 3** The leaders provide and encourage the use of systems for blame-free internal reporting of a system or process failure, or the results of a proactive risk assessment. 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 their blameworthy errors. **LD.03.09.01, EP 4** The leaders define patient safety event and communicate this definition throughout the organization. Note: At a minimum, the organization's definition includes those events subject to review as described in the "Sentinel Event Policy" (SE) chapter of this manual. **LD.03.09.01, 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. **LD.03.09.01, 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 conscientious health care workers who are involved in sentinel events	

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		are themselves victims of the event and require support. Support systems provide staff with additional 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. **LD.03.09.01, 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. **LD.03.09.01, 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. **LD.03.09.01, EP 9** The leaders disseminate lessons learned from comprehensive systematic analyses (for example, root cause analyses), system or process failures, and the results of proactive risk assessments to all staff who provide services for the specific situation. **LD.03.09.01, EP 10** At least once a year, the leaders provide governance with written reports on the following: - All system or process failures - The number and type of sentinel events - Whether the patients and the families were informed of	

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		the event - All actions taken to improve safety, both proactively and in response to actual occurrences - For hospitals that use Joint Commission accreditation for deemed status purposes: The determined number of distinct improvement projects to be conducted annually - All results of the analyses related to the adequacy of staffing **LD.04.03.09, EP 6** Leaders monitor contracted services by evaluating these services in relation to the hospital's expectations. **MM.08.01.01, EP 1** As part of its evaluation of the effectiveness of medication management, the hospital does the following: - Collects data on the performance of its medication management system - Analyzes data on its medication management system - Compares data over time to identify risk points, levels of performance, patterns, trends, and variations of its medication management system Note: This element of performance is also applicable to sample medications. **MM.08.01.01, EP 5** Based on analysis of its data, as well as review of the literature for new technologies and best practices, the hospital identifies opportunities for improvement in its medication management system. **MM.08.01.01, EP 6**	

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		When opportunities are identified for improvement of the medication management system, the hospital does the following: - Takes action on improvement opportunities identified as priorities for its medication management system - Evaluates its actions to confirm that they resulted in improvements Note: This element of performance is also applicable to sample medications. **MM.08.01.01, EP 8** The hospital takes additional action when planned improvements for its medication management processes are either not achieved or not sustained. **PI.01.01.01, EP 4** The hospital collects data on the following: Surgeries in which the postoperative diagnosis (clinical or pathological) was unexpected and could indicate that a clinically significant diagnostic error occurred. Note: The hospital's medical staff determine which unexpected postoperative diagnoses are clinically significant. Examples may include but are not limited to the following: - A preoperative pathology or cytology report was interpreted as a malignancy, but no malignancy was found in the surgical specimen. - A patient underwent surgery for acute appendicitis, but the appendix was normal on the postsurgical pathology exam. - An operation was performed because of a presumed malignancy based on a radiology report, but no malignancy was found.	

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		PI.01.01.01, EP 5 The hospital collects data on the following: Adverse events related to using moderate or deep sedation or anesthesia. **PI.01.01.01, EP 7** The hospital collects data on the following: All reported and confirmed transfusion reactions. **PI.01.01.01, EP 12** The hospital collects data on the following: Significant medication errors. **PI.01.01.01, EP 13** The hospital collects data on the following: Significant adverse drug reactions. **PI.03.01.01, EP 3** The hospital uses statistical tools and techniques to analyze and display data. **PI.03.01.01, EP 4** The hospital analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations. **PI.03.01.01, EP 8** The hospital uses the results of data analysis to identify improvement opportunities. **PI.04.01.01, EP 2** The hospital acts on improvement priorities.	

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		PI.04.01.01, EP 5 The hospital acts when it does not achieve or sustain planned improvements.	
§482.21(e)(2)	(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.	**LD.03.05.01, EP 3** Leaders evaluate the effectiveness of processes for the management of change and performance improvement. **LD.03.07.01, EP 2** As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities and patient health outcomes - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities - Identify the frequency of data collection for performance improvement activities - Reprioritize performance improvement activities in response to changes in the internal or external environment **LD.03.09.01, EP 1** The leaders implement a hospitalwide patient safety program as follows: - One or more qualified individuals or an interdisciplinary group manage the safety program. - All departments, programs, and services within the hospital participate in the safety program. - The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as close calls [“near misses”] or	**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 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

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		good catches) to hazardous conditions and sentinel events.	
§482.21(e)(3)	(3) That clear expectations for safety are established.	**LD.03.07.01, EP 2** As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities and patient health outcomes - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities - Identify the frequency of data collection for performance improvement activities - Reprioritize performance improvement activities in response to changes in the internal or external environment **LD.03.09.01, EP 1** The leaders implement a hospitalwide patient safety program as follows: - One or more qualified individuals or an interdisciplinary group manage the safety program. - All departments, programs, and services within the hospital participate in the safety program. - The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as close calls [“near misses”] or good catches) to hazardous conditions and sentinel events.	**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 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
§482.21(e)(4)	(4) That adequate resources are allocated for measuring, assessing, improving, and sustaining the hospital's performance and reducing risk to patients.	**LD.01.03.01, EP 5** The governing body provides for the resources needed to maintain safe, quality care, treatment, and services. **LD.04.01.05, EP 4**	**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:

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		Staff are held accountable for their responsibilities. **LD.04.01.11, EP 5** The leaders provide for equipment, information systems, supplies, and other resources.	- 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 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
§482.21(e)(5)	(5) That the determination of the number of distinct improvement projects is conducted annually.	**LD.03.07.01, EP 2** As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities and patient health outcomes - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities - Identify the frequency of data collection for performance improvement activities - Reprioritize performance improvement activities in response to changes in the internal or external environment **LD.03.09.01, EP 10** At least once a year, the leaders provide governance with written reports on the following: - All system or process failures - The number and type of sentinel events - Whether the patients and the families were informed of the event	**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 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

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		- All actions taken to improve safety, both proactively and in response to actual occurrences - For hospitals that use Joint Commission accreditation for deemed status purposes: The determined number of distinct improvement projects to be conducted annually - All results of the analyses related to the adequacy of staffing	
§482.21(f)	(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 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:	**LD.01.03.01, EP 14** 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 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. 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. Each separately certified hospital subject to the system governing body demonstrates that the unified and integrated quality assessment and performance improvement program has 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 in each hospital - Establishes and implements policies and procedures	**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 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

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		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	separately certified hospitals meets the requirements for quality assessment and performance improvement at 42 CFR 482.21.
§482.21(f)(1)	(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	**LD.01.03.01, EP 14** 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 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. 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. Each separately certified hospital subject to the system governing body demonstrates that the unified and integrated quality assessment and performance improvement program has 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 in each hospital - Establishes and implements policies and procedures to make certain that the needs and concerns of each of	**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 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

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		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	separately certified hospitals meets the requirements for quality assessment and performance improvement at 42 CFR 482.21.
§482.21(f)(2)	(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.	**LD.01.03.01, EP 14** 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 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. 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. Each separately certified hospital subject to the system governing body demonstrates that the unified and integrated quality assessment and performance improvement program has 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 in each hospital - Establishes and implements policies and procedures to make certain that the needs and concerns of each of its separately certified hospitals, regardless of practice	**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 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.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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	
§482.22	§482.22 Condition of Participation: Medical staff The hospital must have 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.	**LD.01.01.01, EP 3** The governing body identifies those responsible for the provision of care, treatment, and services. **LD.01.05.01, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: There is a single organized medical staff. **LD.01.05.01, EP 6** The organized medical staff is accountable to the governing body for the quality of care provided to patients. **MS.01.01.01, EP 1** The organized medical staff develops medical staff bylaws, rules and regulations, and policies. **MS.01.01.01, EP 2** The organized medical staff adopts and amends medical staff bylaws. Adoption or amendment of medical staff bylaws cannot be delegated. After adoption or amendment by the organized medical staff, the proposed bylaws are submitted to the governing body for action. Bylaws become effective only upon governing body approval. (See the "Leadership" [LD] chapter for requirements regarding the governing body's authority and conflict management processes. See Element of Performance 17 for information on which medical staff	**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.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		members are eligible to vote.) **MS.01.01.01, EP 5** The medical staff complies with the medical staff bylaws, rules and regulations, and policies. **MS.01.01.01, EP 6** The organized medical staff enforces the medical staff bylaws, rules and regulations, and policies by recommending action to the governing body in certain circumstances and taking action in others. **MS.01.01.01, EP 7** The governing body upholds the medical staff bylaws, rules and regulations, and policies that have been approved by the governing body.	
§482.22(a)	§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.	**MS.01.01.01, EP 12** The medical staff bylaws include the following requirements: The structure of the medical staff. **MS.01.01.01, EP 13** The medical staff bylaws include the following requirements: Qualifications for appointment to the medical staff. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: 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 other licensed practitioners who are determined to be eligible for appointment by the governing body.	**MS.14.01.01, EP 2** The medical staff bylaws include the qualifications for appointment and reappointment to the medical staff. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff is composed of doctors of medicine or osteopathy. In accordance with state law, including scope of practice laws, the medical staff may also include other categories of physicians, as listed at 42 CFR 482.12(c)(1), and other licensed practitioners who the governing body determines are eligible for appointment. Note 2: Gender, race, creed, and national origin are not used in making decisions regarding the granting or denying of medical staff membership.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		MS.07.01.01, EP 1 The organized medical staff develops criteria for medical staff membership. Note: Medical staff membership and professional privileges are not dependent solely upon certification, fellowship, or membership in a specialty body or society. **MS.07.01.01, EP 5** Membership is recommended by the medical staff and granted by the governing body.	
§482.22(a)(1)	(1) The medical staff must periodically conduct appraisals of its members.	**MS.01.01.01, EP 5** The medical staff complies with the medical staff bylaws, rules and regulations, and policies. **MS.01.01.01, EP 6** The organized medical staff enforces the medical staff bylaws, rules and regulations, and policies by recommending action to the governing body in certain circumstances and taking action in others. **MS.01.01.01, EP 14** The medical staff bylaws include the following requirements: The process for privileging and re-privileging physicians and other licensed practitioners. **MS.03.01.01, EP 2** Physicians and other licensed practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.	**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.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		MS.06.01.05, EP 3 All of the criteria used are consistently evaluated for all physicians and other licensed practitioners holding that privilege. **MS.06.01.05, EP 7** The hospital queries the National Practitioner Data Bank (NPDB) in accordance with applicable law and regulation. **MS.06.01.05, EP 8** Peer recommendation includes written information regarding the physician's or other licensed practitioner's current: - Medical/clinical knowledge - Technical and clinical skills - Clinical judgment - Interpersonal skills - Communication skills - Professionalism Note: Peer recommendation may be in the form of written documentation reflecting informed opinions on each applicant's scope and level of performance, or a written peer evaluation of physician- or other licensed practitioner-specific data collected from various sources for the purpose of validating current competence. **MS.06.01.05, EP 9** Before recommending privileges, the organized medical staff also evaluates the following: - Challenges to any licensure or registration - Voluntary and involuntary relinquishment of any	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		license or registration - Voluntary and involuntary termination of medical staff membership - Voluntary and involuntary limitation, reduction, or loss of clinical privileges - Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant - Documentation as to the applicant's health status - Relevant physician- or other licensed practitioner-specific data as compared to aggregate data, when available - Morbidity and mortality data, when available **MS.06.01.05, EP 10** The hospital has a process to determine whether there is sufficient clinical performance information to make a decision to grant, limit, or deny the requested privilege. **MS.06.01.05, EP 12** Information regarding each physician's or other licensed practitioner's scope of privileges is updated as changes in clinical privileges are made. **MS.06.01.07, EP 8** The governing body or delegated governing body committee has final authority for granting, renewing, or denying privileges. **MS.06.01.07, EP 9** Privileges are granted for a period not to exceed three years or for the period required by law and regulation if shorter.	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		MS.06.01.09, EP 1 Requesting physicians and other licensed practitioners are notified regarding the granting decision. **MS.06.01.09, EP 2** In the case of privilege denial, the applicant is informed of the reason for denial. **MS.06.01.09, EP 3** The decision to grant, deny, revise, or revoke privilege(s) is disseminated and made available to all appropriate internal and external persons or entities, as defined by the hospital and applicable law. **MS.06.01.09, EP 4** The process to disseminate all granting, modification, or restriction decisions is approved by the organized medical staff. **MS.08.01.01, EP 1** A period of focused professional practice evaluation is implemented for all initially requested privileges. **MS.08.01.01, EP 4** Focused professional practice evaluation is consistently implemented in accordance with the criteria and requirements defined by the organized medical staff. **MS.08.01.01, EP 6** The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of a physician's or other	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		licensed practitioner's current clinical competence, practice behavior, and ability to perform the requested privilege. Note: Other existing privileges in good standing should not be affected by this decision. **MS.08.01.03, EP 1** The process for the ongoing professional practice evaluation includes the following: There is a clearly defined process in place that facilitates the evaluation of each physician's or other licensed practitioner's professional practice. **MS.08.01.03, EP 2** The process for the ongoing professional practice evaluation includes the following: The type of data to be collected is determined by individual departments and approved by the organized medical staff. **MS.08.01.03, EP 3** The process for the ongoing professional practice evaluation includes the following: Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s). **MS.09.01.01, EP 1** The hospital, based on recommendations by the organized medical staff and approval by the governing body, has a clearly defined process for collecting, investigating, and addressing clinical practice concerns. **MS.09.01.01, EP 2**	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Reported concerns regarding a privileged physician's or other licensed practitioner's professional practice are uniformly investigated and addressed, as defined by the hospital and applicable law.	
§482.22(a)(2)	(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.	**MS.01.01.01, EP 13** The medical staff bylaws include the following requirements: Qualifications for appointment to the medical staff. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: 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 other licensed practitioners who are determined to be eligible for appointment by the governing body. **MS.02.01.01, EP 11** The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on, at least, all of the following: The delineation of privileges for each physician and other licensed practitioner privileged through the medical staff process. **MS.06.01.03, EP 1** The hospital credentials applicants using a clearly defined process. **MS.06.01.03, EP 2** The credentialing process is based on recommendations by the organized medical staff.	**MS.17.01.03, EP 4** The medical staff examines the credentials of all candidates eligible for medical staff membership and makes recommendations to the governing body on the appointment of these candidates, in accordance with state law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations. A candidate who has been recommended by the medical staff and who has been appointed by the governing body is subject to all medical staff bylaws, rules, and regulations. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: A candidate who has been recommended by the medical staff and who has been appointed by the governing body is also subject to 42 CFR 482.22(a).

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		MS.06.01.03, EP 4 The credentialing process is outlined in the medical staff bylaws. **MS.06.01.03, EP 6** 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: - The applicant's current licensure at the time of initial granting, renewal, and revision of privileges, and at the time of license expiration - The applicant's relevant training - The applicant's current competence **MS.06.01.05, EP 1** 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. **MS.06.01.05, EP 2** The hospital, based on recommendations by the organized medical staff and approval by the governing body, establishes criteria that determine a physician's or other licensed practitioner's ability to provide patient care, treatment, and services within the scope of the privilege(s) requested. Evaluation of all of the following are included in the criteria: - Current licensure and/or certification, as appropriate, verified with the primary source - The applicant's specific relevant training, verified with	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		the primary source - Evidence of physical ability to perform the requested privilege - Data from professional practice review by an organization(s) that currently privileges the applicant (if available) - Peer and/or faculty recommendation - When renewing privileges, review of the physician's or other licensed practitioner's performance within the hospital **MS.06.01.05, EP 8** Peer recommendation includes written information regarding the physician's or other licensed practitioner's current: - Medical/clinical knowledge - Technical and clinical skills - Clinical judgment - Interpersonal skills - Communication skills - Professionalism Note: Peer recommendation may be in the form of written documentation reflecting informed opinions on each applicant's scope and level of performance, or a written peer evaluation of physician- or other licensed practitioner-specific data collected from various sources for the purpose of validating current competence. **MS.06.01.05, EP 9** Before recommending privileges, the organized medical staff also evaluates the following: - Challenges to any licensure or registration	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Voluntary and involuntary relinquishment of any license or registration - Voluntary and involuntary termination of medical staff membership - Voluntary and involuntary limitation, reduction, or loss of clinical privileges - Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant - Documentation as to the applicant's health status - Relevant physician- or other licensed practitioner-specific data as compared to aggregate data, when available - Morbidity and mortality data, when available **MS.06.01.05, EP 12** Information regarding each physician's or other licensed practitioner's scope of privileges is updated as changes in clinical privileges are made. **MS.06.01.07, EP 8** The governing body or delegated governing body committee has final authority for granting, renewing, or denying privileges. **MS.06.01.09, EP 1** Requesting physicians and other licensed practitioners are notified regarding the granting decision. **MS.06.01.09, EP 2** In the case of privilege denial, the applicant is informed of the reason for denial.	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		MS.06.01.09, EP 3 The decision to grant, deny, revise, or revoke privilege(s) is disseminated and made available to all appropriate internal and external persons or entities, as defined by the hospital and applicable law. **MS.06.01.09, EP 4** The process to disseminate all granting, modification, or restriction decisions is approved by the organized medical staff. **MS.07.01.01, EP 1** The organized medical staff develops criteria for medical staff membership. Note: Medical staff membership and professional privileges are not dependent solely upon certification, fellowship, or membership in a specialty body or society. **MS.07.01.01, EP 2** The professional criteria are designed to assure the medical staff and governing body that patients will receive quality care, treatment, and services. **MS.07.01.01, EP 3** The organized medical staff uses the criteria in appointing members to the medical staff and appointment does not exceed three years or the period required by law and regulation if shorter. **MS.07.01.01, EP 5** Membership is recommended by the medical staff and granted by the governing body.	

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§482.22(a)(3)	(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:	**MS.13.01.01, EP 1** All physicians or other licensed practitioners who are responsible for the patient's care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms: - The originating site fully credentials and privileges the physician or other licensed practitioner according to Standards MS.06.01.03 through MS.06.01.13. Or - The originating site privileges physicians or other licensed practitioners using credentialing information from the distant site if the distant site is a Joint Commission–accredited or a Medicare-participating organization. The distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services. Or - The originating site may choose to use the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met: - The distant site is a Joint Commission–accredited or a Medicare-participating organization. - The physician or other licensed practitioner is privileged at the distant site for those services to be provided at the originating site. - For hospitals that use Joint Commission accreditation for deemed status purposes: The distant site provides the originating site with a current list of the physician's or other licensed practitioner's privileges. - The originating site has evidence of an internal	**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 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

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		review of the physician's or other licensed practitioner's performance of these privileges and sends to the distant site information that is useful to assess the physician's or other licensed practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided and complaints about the distant site physician or other licensed practitioner from patients, physicians or other licensed practitioners, or staff at the originating site. This occurs in a way consistent with any hospital policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law. - The distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services. Note 1: In the case of an accredited ambulatory care organization, the hospital must verify that the distant site made its decision using the process described in Standards MS.06.01.03 through MS.06.01.07 (excluding EP 2 from MS.06.01.03). This is equivalent to meeting Standard HR.02.01.03 in the Comprehensive Accreditation Manual for Ambulatory Care. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: As indicated at LD.04.03.09, EP 23, the originating site makes certain that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at	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).

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		42 CFR 482.12(a)(1) through (a)(9) and 482.22(a)(1) through (a)(4). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A.	
§482.22(a)(3)(i)	(i) The distant-site hospital providing the telemedicine services is a Medicare-participating hospital.	**LD.04.03.09, EP 23** 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.06.01.01 through MS.06.01.13). - The governing body of the originating site grants	**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 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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		privileges to a distant site physician or other licensed practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site. **MS.13.01.01, EP 1** All physicians or other licensed practitioners who are responsible for the patient's care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms: - The originating site fully credentials and privileges the physician or other licensed practitioner according to Standards MS.06.01.03 through MS.06.01.13. Or - The originating site privileges physicians or other licensed practitioners using credentialing information from the distant site if the distant site is a Joint Commission–accredited or a Medicare-participating organization. The distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services. Or - The originating site may choose to use the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met: - The distant site is a Joint Commission–accredited or a Medicare-participating organization. - The physician or other licensed practitioner is privileged at the distant site for those services to be provided at the originating site.	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).

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- For hospitals that use Joint Commission accreditation for deemed status purposes: The distant site provides the originating site with a current list of the physician's or other licensed practitioner's privileges. - The originating site has evidence of an internal review of the physician's or other licensed practitioner's performance of these privileges and sends to the distant site information that is useful to assess the physician's or other licensed practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided and complaints about the distant site physician or other licensed practitioner from patients, physicians or other licensed practitioners, or staff at the originating site. This occurs in a way consistent with any hospital policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law. - The distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services. Note 1: In the case of an accredited ambulatory care organization, the hospital must verify that the distant site made its decision using the process described in Standards MS.06.01.03 through MS.06.01.07 (excluding EP 2 from MS.06.01.03). This is equivalent to meeting Standard HR.02.01.03 in the Comprehensive Accreditation Manual for Ambulatory Care. Note 2: For hospitals that use Joint Commission	

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		accreditation for deemed status purposes: As indicated at LD.04.03.09, EP 23, the originating site makes certain 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). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A.	
§482.22(a)(3)(ii)	(ii) The individual distant-site physician or practitioner is privileged at the distant-site hospital providing the telemedicine services, which provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital.	**MS.13.01.01, EP 1** All physicians or other licensed practitioners who are responsible for the patient's care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms: - The originating site fully credentials and privileges the physician or other licensed practitioner according to Standards MS.06.01.03 through MS.06.01.13. Or - The originating site privileges physicians or other licensed practitioners using credentialing information from the distant site if the distant site is a Joint Commission–accredited or a Medicare-participating organization. The distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services. Or - The originating site may choose to use the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met: - The distant site is a Joint Commission–accredited or	**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 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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		a Medicare-participating organization. - The physician or other licensed practitioner is privileged at the distant site for those services to be provided at the originating site. - For hospitals that use Joint Commission accreditation for deemed status purposes: The distant site provides the originating site with a current list of the physician's or other licensed practitioner's privileges. - The originating site has evidence of an internal review of the physician's or other licensed practitioner's performance of these privileges and sends to the distant site information that is useful to assess the physician's or other licensed practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided and complaints about the distant site physician or other licensed practitioner from patients, physicians or other licensed practitioners, or staff at the originating site. This occurs in a way consistent with any hospital policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law. - The distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services. Note 1: In the case of an accredited ambulatory care organization, the hospital must verify that the distant site made its decision using the process described in Standards MS.06.01.03 through MS.06.01.07 (excluding	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).

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		EP 2 from MS.06.01.03). This is equivalent to meeting Standard HR.02.01.03 in the Comprehensive Accreditation Manual for Ambulatory Care. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: As indicated at LD.04.03.09, EP 23, the originating site makes certain 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). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A.	
§482.22(a)(3)(iii)	(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.	**MS.13.01.01, EP 1** All physicians or other licensed practitioners who are responsible for the patient's care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms: - The originating site fully credentials and privileges the physician or other licensed practitioner according to Standards MS.06.01.03 through MS.06.01.13. Or - The originating site privileges physicians or other licensed practitioners using credentialing information from the distant site if the distant site is a Joint Commission–accredited or a Medicare-participating organization. The distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services. Or - The originating site may choose to use the	**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 distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital

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		credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met: - The distant site is a Joint Commission–accredited or a Medicare-participating organization. - The physician or other licensed practitioner is privileged at the distant site for those services to be provided at the originating site. - For hospitals that use Joint Commission accreditation for deemed status purposes: The distant site provides the originating site with a current list of the physician's or other licensed practitioner's privileges. - The originating site has evidence of an internal review of the physician's or other licensed practitioner's performance of these privileges and sends to the distant site information that is useful to assess the physician's or other licensed practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided and complaints about the distant site physician or other licensed practitioner from patients, physicians or other licensed practitioners, or staff at the originating site. This occurs in a way consistent with any hospital policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law. - The distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services.	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).

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		Note 1: In the case of an accredited ambulatory care organization, the hospital must verify that the distant site made its decision using the process described in Standards MS.06.01.03 through MS.06.01.07 (excluding EP 2 from MS.06.01.03). This is equivalent to meeting Standard HR.02.01.03 in the Comprehensive Accreditation Manual for Ambulatory Care. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: As indicated at LD.04.03.09, EP 23, the originating site makes certain 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). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A.	
§482.22(a)(3)(iv)	(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	**MS.13.01.01, EP 1** All physicians or other licensed practitioners who are responsible for the patient's care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms: - The originating site fully credentials and privileges the physician or other licensed practitioner according to Standards MS.06.01.03 through MS.06.01.13. Or - The originating site privileges physicians or other licensed practitioners using credentialing information from the distant site if the distant site is a Joint Commission–accredited or a Medicare-participating organization. The distant-site physician or other licensed practitioner has a license that is issued or recognized by	**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

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	hospital has received about the distant-site physician or practitioner.	the state in which the patient is receiving telemedicine services. Or - The originating site may choose to use the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met: - The distant site is a Joint Commission–accredited or a Medicare-participating organization. - The physician or other licensed practitioner is privileged at the distant site for those services to be provided at the originating site. - For hospitals that use Joint Commission accreditation for deemed status purposes: The distant site provides the originating site with a current list of the physician's or other licensed practitioner's privileges. - The originating site has evidence of an internal review of the physician's or other licensed practitioner's performance of these privileges and sends to the distant site information that is useful to assess the physician's or other licensed practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided and complaints about the distant site physician or other licensed practitioner from patients, physicians or other licensed practitioners, or staff at the originating site. This occurs in a way consistent with any hospital policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law.	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) through (a)(7) and 482.22(a)(1) through (a)(2).

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		- The distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services. Note 1: In the case of an accredited ambulatory care organization, the hospital must verify that the distant site made its decision using the process described in Standards MS.06.01.03 through MS.06.01.07 (excluding EP 2 from MS.06.01.03). This is equivalent to meeting Standard HR.02.01.03 in the Comprehensive Accreditation Manual for Ambulatory Care. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: As indicated at LD.04.03.09, EP 23, the originating site makes certain 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). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A.	
§482.22(a)(4)	4) When telemedicine services are furnished to the hospital's patients through an agreement with a distant-site telemedicine entity, 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 telemedicine entity when making recommendations on privileges for the	**LD.04.03.09, EP 1** Clinical leaders and medical staff have an opportunity to provide advice about the sources of clinical services to be provided through contractual agreement. **LD.04.03.09, EP 2** The hospital describes, in writing, the nature and scope of services provided through contractual agreements. **LD.04.03.09, EP 3** Designated leaders approve contractual agreements.	**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

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	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:	**LD.04.03.09, EP 4** Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: In most cases, each physician and other licensed practitioner providing services through a contractual agreement must be credentialed and privileged by the hospital using their services following the process described in the "Medical Staff" (MS) chapter. Note 2: For hospitals that do not use Joint Commission accreditation for deemed status purposes: When the hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following: - Verify that all physicians and other licensed practitioners who will be providing patient care, treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges. - Specify in the written agreement that the contracted organization will ensure that all contracted services provided by physicians and other licensed practitioners will be within the scope of their privileges. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders who monitor the contracted services are the governing body. **LD.04.03.09, EP 5** Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services. Note: A written description of the expectations can be	- 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 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).

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		provided either as part of the written agreement or in addition to it. **LD.04.03.09, EP 6** Leaders monitor contracted services by evaluating these services in relation to the hospital's expectations. **LD.04.03.09, EP 23** 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	

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		"Medical Staff" (MS) chapter (Standards MS.06.01.01 through MS.06.01.13). - The governing body of the originating site grants privileges to a distant site physician or other licensed practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site. **MS.13.01.01, EP 1** All physicians or other licensed practitioners who are responsible for the patient's care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms: - The originating site fully credentials and privileges the physician or other licensed practitioner according to Standards MS.06.01.03 through MS.06.01.13. Or - The originating site privileges physicians or other licensed practitioners using credentialing information from the distant site if the distant site is a Joint Commission–accredited or a Medicare-participating organization. The distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services. Or - The originating site may choose to use the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met: - The distant site is a Joint Commission–accredited or a Medicare-participating organization.	

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		- The physician or other licensed practitioner is privileged at the distant site for those services to be provided at the originating site. - For hospitals that use Joint Commission accreditation for deemed status purposes: The distant site provides the originating site with a current list of the physician's or other licensed practitioner's privileges. - The originating site has evidence of an internal review of the physician's or other licensed practitioner's performance of these privileges and sends to the distant site information that is useful to assess the physician's or other licensed practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided and complaints about the distant site physician or other licensed practitioner from patients, physicians or other licensed practitioners, or staff at the originating site. This occurs in a way consistent with any hospital policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law. - The distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services. Note 1: In the case of an accredited ambulatory care organization, the hospital must verify that the distant site made its decision using the process described in Standards MS.06.01.03 through MS.06.01.07 (excluding EP 2 from MS.06.01.03). This is equivalent to meeting	

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		Standard HR.02.01.03 in the Comprehensive Accreditation Manual for Ambulatory Care. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: As indicated at LD.04.03.09, EP 23, the originating site makes certain 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). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A.	
§482.22(a)(4)(i)	(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).	**LD.04.03.09, EP 2** The hospital describes, in writing, the nature and scope of services provided through contractual agreements. **LD.04.03.09, EP 4** Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: In most cases, each physician and other licensed practitioner providing services through a contractual agreement must be credentialed and privileged by the hospital using their services following the process described in the "Medical Staff" (MS) chapter. Note 2: For hospitals that do not use Joint Commission accreditation for deemed status purposes: When the hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following: - Verify that all physicians and other licensed practitioners who will be providing patient care,	**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 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

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		treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges. - Specify in the written agreement that the contracted organization will ensure that all contracted services provided by physicians and other licensed practitioners will be within the scope of their privileges. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders who monitor the contracted services are the governing body. **LD.04.03.09, EP 23** 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	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).

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		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.06.01.01 through MS.06.01.13). - The governing body of the originating site grants privileges to a distant site physician or other licensed practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site. **MS.13.01.01, EP 1** All physicians or other licensed practitioners who are responsible for the patient's care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms: - The originating site fully credentials and privileges the physician or other licensed practitioner according to Standards MS.06.01.03 through MS.06.01.13. Or - The originating site privileges physicians or other licensed practitioners using credentialing information from the distant site if the distant site is a Joint Commission–accredited or a Medicare-participating organization. The distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services. Or - The originating site may choose to use the credentialing and privileging decision from the distant	

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		site to make a final privileging decision if all the following requirements are met: - The distant site is a Joint Commission–accredited or a Medicare-participating organization. - The physician or other licensed practitioner is privileged at the distant site for those services to be provided at the originating site. - For hospitals that use Joint Commission accreditation for deemed status purposes: The distant site provides the originating site with a current list of the physician's or other licensed practitioner's privileges. - The originating site has evidence of an internal review of the physician's or other licensed practitioner's performance of these privileges and sends to the distant site information that is useful to assess the physician's or other licensed practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided and complaints about the distant site physician or other licensed practitioner from patients, physicians or other licensed practitioners, or staff at the originating site. This occurs in a way consistent with any hospital policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law. - The distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services. Note 1: In the case of an accredited ambulatory care	

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		organization, the hospital must verify that the distant site made its decision using the process described in Standards MS.06.01.03 through MS.06.01.07 (excluding EP 2 from MS.06.01.03). This is equivalent to meeting Standard HR.02.01.03 in the Comprehensive Accreditation Manual for Ambulatory Care. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: As indicated at LD.04.03.09, EP 23, the originating site makes certain 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). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A.	
§482.22(a)(4)(ii)	(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.	**MS.13.01.01, EP 1** All physicians or other licensed practitioners who are responsible for the patient's care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms: - The originating site fully credentials and privileges the physician or other licensed practitioner according to Standards MS.06.01.03 through MS.06.01.13. Or - The originating site privileges physicians or other licensed practitioners using credentialing information from the distant site if the distant site is a Joint Commission–accredited or a Medicare-participating organization. The distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine	**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.

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		services. Or - The originating site may choose to use the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met: - The distant site is a Joint Commission–accredited or a Medicare-participating organization. - The physician or other licensed practitioner is privileged at the distant site for those services to be provided at the originating site. - For hospitals that use Joint Commission accreditation for deemed status purposes: The distant site provides the originating site with a current list of the physician's or other licensed practitioner's privileges. - The originating site has evidence of an internal review of the physician's or other licensed practitioner's performance of these privileges and sends to the distant site information that is useful to assess the physician's or other licensed practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided and complaints about the distant site physician or other licensed practitioner from patients, physicians or other licensed practitioners, or staff at the originating site. This occurs in a way consistent with any hospital policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law. - The distant-site physician or other licensed	- 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) through (a)(7) and 482.22(a)(1) through (a)(2).

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		practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services. Note 1: In the case of an accredited ambulatory care organization, the hospital must verify that the distant site made its decision using the process described in Standards MS.06.01.03 through MS.06.01.07 (excluding EP 2 from MS.06.01.03). This is equivalent to meeting Standard HR.02.01.03 in the Comprehensive Accreditation Manual for Ambulatory Care. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: As indicated at LD.04.03.09, EP 23, the originating site makes certain 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). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A.	
§482.22(a)(4)(iii)	(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 such telemedicine services is located.	**MS.13.01.01, EP 1** All physicians or other licensed practitioners who are responsible for the patient's care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms: - The originating site fully credentials and privileges the physician or other licensed practitioner according to Standards MS.06.01.03 through MS.06.01.13. Or - The originating site privileges physicians or other licensed practitioners using credentialing information from the distant site if the distant site is a Joint	**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

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		Commission–accredited or a Medicare-participating organization. The distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services. Or - The originating site may choose to use the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met: - The distant site is a Joint Commission–accredited or a Medicare-participating organization. - The physician or other licensed practitioner is privileged at the distant site for those services to be provided at the originating site. - For hospitals that use Joint Commission accreditation for deemed status purposes: The distant site provides the originating site with a current list of the physician's or other licensed practitioner's privileges. - The originating site has evidence of an internal review of the physician's or other licensed practitioner's performance of these privileges and sends to the distant site information that is useful to assess the physician's or other licensed practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided and complaints about the distant site physician or other licensed practitioner from patients, physicians or other licensed practitioners, or staff at the originating site. This occurs in a way consistent with any	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 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).

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		hospital policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law. - The distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services. Note 1: In the case of an accredited ambulatory care organization, the hospital must verify that the distant site made its decision using the process described in Standards MS.06.01.03 through MS.06.01.07 (excluding EP 2 from MS.06.01.03). This is equivalent to meeting Standard HR.02.01.03 in the Comprehensive Accreditation Manual for Ambulatory Care. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: As indicated at LD.04.03.09, EP 23, the originating site makes certain 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). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A.	
§482.22(a)(4)(iv)	(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	**MS.13.01.01, EP 1** All physicians or other licensed practitioners who are responsible for the patient's care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms: - The originating site fully credentials and privileges the physician or other licensed practitioner according to Standards MS.06.01.03 through MS.06.01.13.	**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

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	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.	Or - The originating site privileges physicians or other licensed practitioners using credentialing information from the distant site if the distant site is a Joint Commission–accredited or a Medicare-participating organization. The distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services. Or - The originating site may choose to use the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met: - The distant site is a Joint Commission–accredited or a Medicare-participating organization. - The physician or other licensed practitioner is privileged at the distant site for those services to be provided at the originating site. - For hospitals that use Joint Commission accreditation for deemed status purposes: The distant site provides the originating site with a current list of the physician's or other licensed practitioner's privileges. - The originating site has evidence of an internal review of the physician's or other licensed practitioner's performance of these privileges and sends to the distant site information that is useful to assess the physician's or other licensed practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services	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 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).

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		provided and complaints about the distant site physician or other licensed practitioner from patients, physicians or other licensed practitioners, or staff at the originating site. This occurs in a way consistent with any hospital policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law. - The distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services. Note 1: In the case of an accredited ambulatory care organization, the hospital must verify that the distant site made its decision using the process described in Standards MS.06.01.03 through MS.06.01.07 (excluding EP 2 from MS.06.01.03). This is equivalent to meeting Standard HR.02.01.03 in the Comprehensive Accreditation Manual for Ambulatory Care. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: As indicated at LD.04.03.09, EP 23, the originating site makes certain 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). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A.	
§482.22(b)	§482.22(b) Standard: Medical Staff Organization and Accountability The medical staff must be well organized and accountable to the governing body for the	**LD.01.05.01, EP 4** The governing body approves the structure of the organized medical staff. **LD.01.05.01, EP 6**	**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.

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	quality of the medical care provided to the patients.	The organized medical staff is accountable to the governing body for the quality of care provided to patients.	
§482.22(b)(1)	(1) The medical staff must be organized in a manner approved by the governing body.	**LD.01.05.01, EP 4** The governing body approves the structure of the organized medical staff. **MS.01.01.01, EP 12** The medical staff bylaws include the following requirements: The structure of the medical staff.	**LD.11.02.01, EP 2** The governing body approves the structure of the organized medical staff.
§482.22(b)(2)	(2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy	**MS.02.01.01, EP 4** The majority of voting medical staff executive committee members are fully licensed doctors of medicine or osteopathy actively practicing in the hospital.	**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 eligible for membership on the medical staff executive committee.
§482.22(b)(3)	(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)	(i) An individual doctor of medicine or osteopathy.	**LD.01.05.01, EP 7** 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.	**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)(ii)	(ii) A doctor of dental surgery or dental medicine, when permitted by State law of the State in which the hospital is located.	**LD.01.05.01, EP 7** 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	**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.

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		podiatric medicine is responsible for the organization and conduct of the medical staff.	
§482.22(b)(3)(iii)	(iii) A doctor of podiatric medicine, when permitted by State law of the State in which the hospital is located.	**LD.01.05.01, EP 7** 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.	**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)(4)	(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)	(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 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;	**MS.01.01.01, EP 12** The medical staff bylaws include the following requirements: The structure of the medical staff. **MS.01.01.01, EP 17** The medical staff bylaws include the following requirements: A description of those members of the medical staff who are eligible to vote. **MS.01.01.05, 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, the following occurs: Each separately accredited hospital	**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 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.

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		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 either to accept the unified and integrated medical staff structure or to opt out of such a structure and maintain a separate and distinct medical staff for their hospital.	
§482.22(b)(4)(ii)	(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;	**MS.01.01.01, EP 5** The medical staff complies with the medical staff bylaws, rules and regulations, and policies. **MS.01.01.01, EP 6** The organized medical staff enforces the medical staff bylaws, rules and regulations, and policies by recommending action to the governing body in certain circumstances and taking action in others. **MS.01.01.01, EP 7** The governing body upholds the medical staff bylaws, rules and regulations, and policies that have been approved by the governing body. **MS.01.01.01, EP 12** The medical staff bylaws include the following requirements: The structure of the medical staff. **MS.01.01.01, EP 13** The medical staff bylaws include the following requirements: Qualifications for appointment to the medical staff. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical	**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.

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		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 other licensed practitioners who are determined to be eligible for appointment by the governing body. **MS.01.01.01, EP 14** The medical staff bylaws include the following requirements: The process for privileging and re-privileging physicians and other licensed practitioners. **MS.01.01.01, EP 15** For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff bylaws include the following requirements: A statement of the duties and privileges related to each category of the medical staff (for example, active, courtesy). Note: Solely for the purposes of this element of performance, The Joint Commission interprets the word "privileges" to mean the duties and prerogatives of each category, and not the clinical privileges to provide patient care, treatment, and services related to each category. Each member of the medical staff is to have specific clinical privileges to provide care, treatment, and services authorized through the processes specified in Standards MS.06.01.03, MS.06.01.05, and MS.06.01.07. **MS.01.01.01, EP 17** The medical staff bylaws include the following requirements: A description of those members of the	

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		medical staff who are eligible to vote. **MS.01.01.01, EP 22** The medical staff bylaws include the following requirements: That the medical executive committee includes physicians and may include other licensed practitioners. **MS.01.01.01, EP 26** The medical staff bylaws include the following requirements: The process for credentialing and re-credentialing physicians and other licensed practitioners. **MS.01.01.01, EP 27** The medical staff bylaws include the following requirements: The process for appointment and re-appointment to membership on the medical staff. **MS.01.01.01, EP 34** The medical staff bylaws include the following requirements: The fair hearing and appeal process (refer to Standard MS.10.01.01), which at a minimum shall include: - The process for scheduling hearings and appeals - The process for conducting hearings and appeals **MS.01.01.01, EP 37** 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	

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		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)(iii)	(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	**MS.01.01.05, 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 differences in patient populations and services offered in each hospital.	**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 differences in patient populations and services offered in each hospital.
§482.22(b)(4)(iv)	(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.	**MS.01.01.05, 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 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 given due consideration. **MS.01.01.05, EP 4** 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	**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 develops and implements policies and procedures and mechanisms to make certain that the needs and concerns expressed by members of the medical staff at each of its separately accredited hospitals, regardless of practice or location, are duly considered and addressed.

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		following occurs: The unified and integrated medical staff has mechanisms in place to make certain that issues localized to particular hospitals within the system are duly considered and addressed.	
§482.22(c)	§482.22(c) Standard: Medical Staff Bylaws The medical staff must adopt and enforce bylaws to carry out its responsibilities. The bylaws must:	**MS.01.01.01, EP 1** The organized medical staff develops medical staff bylaws, rules and regulations, and policies. **MS.01.01.01, EP 2** The organized medical staff adopts and amends medical staff bylaws. Adoption or amendment of medical staff bylaws cannot be delegated. After adoption or amendment by the organized medical staff, the proposed bylaws are submitted to the governing body for action. Bylaws become effective only upon governing body approval. (See the "Leadership" [LD] chapter for requirements regarding the governing body's authority and conflict management processes. See Element of Performance 17 for information on which medical staff members are eligible to vote.) **MS.01.01.01, EP 5** The medical staff complies with the medical staff bylaws, rules and regulations, and policies. **MS.01.01.01, EP 6** The organized medical staff enforces the medical staff bylaws, rules and regulations, and policies by recommending action to the governing body in certain circumstances and taking action in others.	
§482.22(c)(1)	(1) Be approved by the governing body.	**MS.01.01.01, EP 2** The organized medical staff adopts and amends medical staff bylaws. Adoption or amendment of medical staff	**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

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		bylaws cannot be delegated. After adoption or amendment by the organized medical staff, the proposed bylaws are submitted to the governing body for action. Bylaws become effective only upon governing body approval. (See the "Leadership" [LD] chapter for requirements regarding the governing body's authority and conflict management processes. See Element of Performance 17 for information on which medical staff members are eligible to vote.) **MS.01.01.01, EP 7** The governing body upholds the medical staff bylaws, rules and regulations, and policies that have been approved by the governing body.	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 - 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)(2)	(2) Include a statement of the duties and privileges of each category of medical staff (e.g., active, courtesy, etc.)	**MS.01.01.01, EP 15** For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff bylaws include the following requirements: A statement of the duties and privileges related to each category of the medical staff (for example, active, courtesy).	**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)

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		Note: Solely for the purposes of this element of performance, The Joint Commission interprets the word "privileges" to mean the duties and prerogatives of each category, and not the clinical privileges to provide patient care, treatment, and services related to each category. Each member of the medical staff is to have specific clinical privileges to provide care, treatment, and services authorized through the processes specified in Standards MS.06.01.03, MS.06.01.05, and MS.06.01.07.	- 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)(3)	(3) Describe the organization of the medical staff.	**MS.01.01.01, EP 12** The medical staff bylaws include the following requirements: The structure of the medical staff.	**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

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			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)(4)	(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.	**MS.01.01.01, EP 13** The medical staff bylaws include the following requirements: Qualifications for appointment to the medical staff. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: 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 other licensed practitioners who are determined to be eligible for appointment by the	**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

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		governing body. **MS.07.01.01, EP 1** The organized medical staff develops criteria for medical staff membership. Note: Medical staff membership and professional privileges are not dependent solely upon certification, fellowship, or membership in a specialty body or society.	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)(5)	(5) Include a requirement that --		
§482.22(c)(5)(i)	(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.	**MS.01.01.01, EP 16** For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff bylaws include the following requirements: The requirements for completing and documenting medical histories and physical examinations. 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. Note: For more information on performing the medical history and physical examination, refer to MS.03.01.01, EPs 6–11. For more information on completion time of	**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 patient examinations as described in PC.11.02.01, EP 3 - Assessments in lieu of medical history and physical examinations for patients as described in PC.11.02.01, EP 4 Note: The medical history and physical examination are completed and documented by a physician (as defined in section 1861(r) of the Social Security Act), an oral and maxillofacial surgeon, or other qualified licensed practitioner in accordance with state law and hospital policy.

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		the history and physical examination, refer to Standard PC.01.02.03, EPs 4 and 5. **MS.03.01.01, EP 9** As permitted by state law and policy, the organized medical staff may choose to allow practitioners who are not licensed to practice independently to perform part or all of a patient's medical history and physical examination under the supervision of, or through appropriate delegation by, a specific qualified doctor of medicine or osteopathy who is accountable for the patient's medical history and physical examination. **PC.01.02.03, EP 4** The patient receives a medical history and physical examination 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 any specific outpatient surgical or procedural services for which an assessment is performed instead. Note 2: For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text. **PC.01.02.03, EP 5** For a medical history and physical examination that was completed within 30 days prior to registration or	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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 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 any specific outpatient surgical or procedural services for which an assessment is performed instead. Note 2: For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text.	
§482.22(c)(5)(ii)	(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® of the Act), an oral and maxillofacial surgeon, or other qualified	**MS.01.01.01, EP 16** For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff bylaws include the following requirements: The requirements for completing and documenting medical histories and physical examinations. 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. Note: For more information on performing the medical history and physical examination, refer to MS.03.01.01, EPs 6–11. For more information on completion time of the history and physical examination, refer to Standard PC.01.02.03, EPs 4 and 5.	**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 patient examinations as described in PC.11.02.01, EP 3 - Assessments in lieu of medical history and physical examinations for patients as described in PC.11.02.01, EP 4 Note: The medical history and physical examination are completed and documented by a physician (as defined in section 1861(r) of the Social Security Act), an oral and maxillofacial surgeon, or other qualified licensed practitioner in accordance with state law and hospital policy.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	licensed individual in accordance with State law and hospital policy.	**PC.01.02.03, EP 4** The patient receives a medical history and physical examination 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 any specific outpatient surgical or procedural services for which an assessment is performed instead. Note 2: For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text. **PC.01.02.03, EP 5** 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 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 any specific outpatient surgical or procedural services for which an assessment is performed instead. Note 2: For law and regulation guidance pertaining to the medical history and physical examination, refer to	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text.	
§482.22(c)(5)(iii)	(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 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.	**MS.01.01.01, EP 38** For hospitals that use Joint Commission accreditation for deemed status purposes: When the medical staff has chosen to allow an assessment, in lieu of a comprehensive medical history and physical examination, for patients receiving specific outpatient surgical or procedural services, the medical staff bylaws specify that an assessment of the patient is 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. Note: For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(i), (ii), (iii), and (v). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text.	**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 patient examinations as described in PC.11.02.01, EP 3 - Assessments in lieu of medical history and physical examinations for patients as described in PC.11.02.01, EP 4 Note: The medical history and physical examination are completed and documented by a physician (as defined in section 1861(r) of the Social Security Act), an oral and maxillofacial surgeon, or other qualified licensed practitioner in accordance with state law and hospital policy.
§482.22(c)(5)(iv)	(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	**MS.03.01.01, EP 19** For hospitals that use Joint Commission accreditation for deemed status purposes: 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	**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

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	of (c)(5)(i) and (ii) of this section for all patients.	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 Note: For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(iii). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text.	- 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. 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 42 CFR 482.22(c)(5)(iii), refer to https://www.ecfr.gov/.
§482.22(c)(5)(v)	(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:	**MS.03.01.01, EP 19** For hospitals that use Joint Commission accreditation for deemed status purposes: 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 Note: For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(iii). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text.	**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. 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 42 CFR 482.22(c)(5)(iii), refer to https://www.ecfr.gov/.
§482.22(c)(5)(v)(A)	(A) Patient age, diagnoses, the type and number of surgeries and procedures	**MS.03.01.01, EP 19** For hospitals that use Joint Commission accreditation	**MS.16.01.01, EP 10** If the medical staff chooses to develop and maintain a policy for

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	scheduled to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure.	for deemed status purposes: 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 Note: For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(iii). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text.	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. 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 42 CFR 482.22(c)(5)(iii), refer to https://www.ecfr.gov/.
§482.22(c)(5)(v)(B)	(B) Nationally recognized guidelines and standards of practice for assessment of specific types of patients prior to specific outpatient surgeries and procedures.	**MS.03.01.01, EP 19** For hospitals that use Joint Commission accreditation for deemed status purposes: 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	**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

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		- Applicable state and local health and safety laws Note: For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(iii). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text.	services. 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 42 CFR 482.22(c)(5)(iii), refer to https://www.ecfr.gov/.
§482.22(c)(5)(v)(C)	(C) Applicable state and local health and safety laws.	**MS.03.01.01, EP 19** For hospitals that use Joint Commission accreditation for deemed status purposes: 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 Note: For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(iii). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text.	**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. 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 42 CFR 482.22(c)(5)(iii), refer to https://www.ecfr.gov/.
§482.22(c)(6)	(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	**LD.04.03.09, EP 23** 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.	**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

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	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).	- 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.06.01.01 through MS.06.01.13). - The governing body of the originating site grants privileges to a distant site physician or other licensed practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site. **MS.01.01.01, EP 14** The medical staff bylaws include the following requirements: The process for privileging and re-privileging physicians and other licensed practitioners. **MS.13.01.01, EP 1** All physicians or other licensed practitioners who are	- 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).

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		responsible for the patient's care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms: - The originating site fully credentials and privileges the physician or other licensed practitioner according to Standards MS.06.01.03 through MS.06.01.13. Or - The originating site privileges physicians or other licensed practitioners using credentialing information from the distant site if the distant site is a Joint Commission–accredited or a Medicare-participating organization. The distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services. Or - The originating site may choose to use the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met: - The distant site is a Joint Commission–accredited or a Medicare-participating organization. - The physician or other licensed practitioner is privileged at the distant site for those services to be provided at the originating site. - For hospitals that use Joint Commission accreditation for deemed status purposes: The distant site provides the originating site with a current list of the physician's or other licensed practitioner's privileges. - The originating site has evidence of an internal review of the physician's or other licensed practitioner's performance of these privileges and sends to the distant	

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		site information that is useful to assess the physician's or other licensed practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided and complaints about the distant site physician or other licensed practitioner from patients, physicians or other licensed practitioners, or staff at the originating site. This occurs in a way consistent with any hospital policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law. - The distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services. Note 1: In the case of an accredited ambulatory care organization, the hospital must verify that the distant site made its decision using the process described in Standards MS.06.01.03 through MS.06.01.07 (excluding EP 2 from MS.06.01.03). This is equivalent to meeting Standard HR.02.01.03 in the Comprehensive Accreditation Manual for Ambulatory Care. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: As indicated at LD.04.03.09, EP 23, the originating site makes certain 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). For the language of the Medicare	

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		Conditions of Participation pertaining to telemedicine, see Appendix A.	
§482.23	§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.	**LD.04.03.01, EP 2** The hospital provides essential services, including the following: - Diagnostic radiology - Dietary - Emergency - Medical records - Nuclear medicine - Nursing care - Pathology and clinical laboratory - Pharmaceutical - Physical rehabilitation - Respiratory care - Social work Note 1: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to "Appendix A: Medicare Requirements for Hospitals" (AXA). Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The diagnostic radiology services provided by the hospital, as well as staff qualifications, meet professionally approved standards. **NR.02.03.01, EP 4**	**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.

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		The nurse executive is responsible for the provision of nursing services 24 hours a day, 7 days a week. **NR.02.03.01, EP 7** A registered nurse provides or supervises the nursing services 24 hours a day, 7 days a week. Note: 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.	
§482.23(a)	§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, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital.	**LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **NR.01.01.01, EP 1** The nurse executive functions at the senior leadership level to provide effective leadership and to coordinate leaders to deliver nursing care, treatment, and services. **NR.01.01.01, EP 5** The hospital defines the nurse executive's authority and responsibility in a written contract, written agreement, letter, memorandum, job or position description, or other document. **NR.01.02.01, EP 2** The nurse executive is currently licensed as a registered professional nurse in the state in which they practice, in accordance with law and regulation.	**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 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

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		NR.02.01.01, EP 2 The nurse executive coordinates the following: - The development of hospitalwide programs, policies, and procedures that address how nursing care needs of the patient population are assessed, met, and evaluated. Note: Examples of patient populations include pediatric, diabetic, and geriatric patients. - The development of an effective, ongoing program to measure, analyze, and improve the quality of nursing care, treatment, and services. **NR.02.01.01, EP 4** The nurse executive directs the following: - The implementation of hospitalwide plans to provide nursing care, treatment, and services. - The implementation of hospitalwide programs, policies, and procedures that address how nursing care needs of the patient population are assessed, met, and evaluated. Note: Examples of patient populations include pediatric, diabetic, and geriatric patients. - The implementation of an effective, ongoing program to measure, analyze, and improve the quality of nursing care, treatment, and services. **NR.02.03.01, EP 2** The nurse executive implements nursing policies, procedures, and standards that describe and guide how the staff provide nursing care, treatment, and services. **NR.02.03.01, EP 3** The nurse executive provides access to all nursing	

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		policies, procedures, and standards to the nursing staff. **NR.02.03.01, EP 4** The nurse executive is responsible for the provision of nursing services 24 hours a day, 7 days a week. **NR.02.03.01, EP 6** The nurse executive or designee exercises final authority over staff who provide nursing care, treatment, and services.	
§482.23(b)	§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.	**LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **NR.02.02.01, EP 1** The nurse executive, registered nurses, and other designated nursing staff write and approve the following before implementation: - Standards of nursing practice for the hospital - Nursing standards of patient care, treatment, and services - Nursing policies and procedures - Nurse staffing plan(s) **NR.02.03.01, EP 4** The nurse executive is responsible for the provision of nursing services 24 hours a day, 7 days a week. **NR.02.03.01, EP 7** A registered nurse provides or supervises the nursing	**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.

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		services 24 hours a day, 7 days a week. Note: 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.	
§482.23(b)(1)	(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.	**LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **NR.02.03.01, EP 4** The nurse executive is responsible for the provision of nursing services 24 hours a day, 7 days a week. **NR.02.03.01, EP 7** A registered nurse provides or supervises the nursing services 24 hours a day, 7 days a week. Note: 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.	**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)(2)	(2) The nursing service must have a procedure to ensure that hospital nursing personnel for whom licensure is required have valid and current licensure.	**HR.01.01.01, EP 2** The hospital verifies and documents the following: - Credentials of staff using the primary source when licensure, certification, or registration is required by law and regulation to practice their profession. This is done at the time of hire and at the time credentials are renewed.	**HR.11.01.03, EP 3** The hospital develops and implements a procedure to verify and document the following: - 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.

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		- 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.	- 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.
§482.23(b)(3)	(3) A registered nurse must supervise and evaluate the nursing care for each patient.	**NR.02.01.01, EP 2** The nurse executive coordinates the following: - The development of hospitalwide programs, policies, and procedures that address how nursing care needs of the patient population are assessed, met, and evaluated. Note: Examples of patient populations include pediatric, diabetic, and geriatric patients. - The development of an effective, ongoing program to measure, analyze, and improve the quality of nursing care, treatment, and services. **NR.02.01.01, EP 4** The nurse executive directs the following: - The implementation of hospitalwide plans to provide nursing care, treatment, and services. - The implementation of hospitalwide programs,	**NR.11.01.01, EP 4** A registered nurse supervises and evaluates the nursing care for each patient.

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		policies, and procedures that address how nursing care needs of the patient population are assessed, met, and evaluated. Note: Examples of patient populations include pediatric, diabetic, and geriatric patients. - The implementation of an effective, ongoing program to measure, analyze, and improve the quality of nursing care, treatment, and services. **NR.02.03.01, EP 4** The nurse executive is responsible for the provision of nursing services 24 hours a day, 7 days a week. **NR.02.03.01, EP 7** A registered nurse provides or supervises the nursing services 24 hours a day, 7 days a week. Note: 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. **PC.01.02.03, EP 6** A registered nurse completes a nursing assessment within 24 hours after the patient's inpatient admission. **PC.01.02.05, EP 1** Based on the initial assessment, a registered nurse determines the patient's need for nursing care, as required by hospital policy and law and regulation. **PC.02.01.01, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes: A registered nurse	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		supervises and evaluates the nursing care for each patient. **PC.03.01.01, EP 5** A registered nurse supervises perioperative nursing care. Note: Qualified registered nurses may perform circulating duties in the operating room. In accordance with state law and regulation and hospital policy, licensed practical nurses and surgical technologists may assist the circulating registered nurse in performing circulatory duties as long as the registered nurse supervises these staff and is immediately available to respond to emergencies.	
§482.23(b)(4)	(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.	**NR.02.03.01, EP 2** The nurse executive implements nursing policies, procedures, and standards that describe and guide how the staff provide nursing care, treatment, and services. **PC.01.02.03, EP 3** Each patient is reassessed as necessary based on their plan for care or changes in their condition. Note: Reassessments may also be based on the patient's diagnosis; desire for care, treatment, and services; response to previous care, treatment, and services; discharge planning needs; and/or their setting requirements. **PC.01.02.03, EP 6** A registered nurse completes a nursing assessment within 24 hours after the patient's inpatient admission. **PC.01.02.05, EP 1**	**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 plan of care plan, which may be a part of an interdisciplinary plan of care, 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.

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		Based on the initial assessment, a registered nurse determines the patient's need for nursing care, as required by hospital policy and law and regulation. **PC.01.03.01, EP 1** The hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. **PC.01.03.01, EP 5** The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals. Note: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The patient's goals include both short- and long-term goals. **PC.01.03.01, EP 23** The hospital revises plans and goals for care, treatment, and services based on the patient's needs.	
§482.23(b)(5)	(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.	**HR.01.01.01, 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 of 1988 (CLIA '88), under Subpart M: "Personnel for Nonwaived Testing" §493.1351-	**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.

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		§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 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital. The provision of care and staff qualifications are in accordance with national acceptable standards of practice and also meet the requirements of 409.17. See Appendix A for 409.17 requirements. 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. Note 5: For hospitals that use Joint Commission accreditation for deemed status purposes: Staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing. **HR.01.06.01, EP 1** The hospital defines the competencies it requires of its staff who provide patient care, treatment, or services.	

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		HR.01.06.01, EP 3 An individual with the educational background, experience, or knowledge related to the skills being reviewed assesses competence. Note: When a suitable individual cannot be found to assess staff competence, the hospital can utilize an outside individual for this task. If a suitable individual inside or outside the hospital cannot be found, the hospital may consult the competency guidelines from an appropriate professional organization to make its assessment. **HR.01.06.01, EP 5** Staff competence is initially assessed and documented as part of orientation. **HR.01.06.01, EP 6** Staff competence is assessed and documented once every three years, or more frequently as required by hospital policy or in accordance with law and regulation. **NR.02.01.01, EP 2** The nurse executive coordinates the following: - The development of hospitalwide programs, policies, and procedures that address how nursing care needs of the patient population are assessed, met, and evaluated. Note: Examples of patient populations include pediatric, diabetic, and geriatric patients. - The development of an effective, ongoing program to measure, analyze, and improve the quality of nursing care, treatment, and services.	

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		NR.02.01.01, EP 4 The nurse executive directs the following: - The implementation of hospitalwide plans to provide nursing care, treatment, and services. - The implementation of hospitalwide programs, policies, and procedures that address how nursing care needs of the patient population are assessed, met, and evaluated. Note: Examples of patient populations include pediatric, diabetic, and geriatric patients. - The implementation of an effective, ongoing program to measure, analyze, and improve the quality of nursing care, treatment, and services. **NR.02.03.01, EP 2** The nurse executive implements nursing policies, procedures, and standards that describe and guide how the staff provide nursing care, treatment, and services. **NR.02.03.01, EP 8** For hospitals that use Joint Commission accreditation for deemed status purposes: A registered nurse assigns the nursing care for each patient to other nursing personnel in accordance with the patient's needs and the qualifications and competence of the nursing staff available.	
§482.23(b)(6)	(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	**HR.01.04.01, EP 1** The hospital orients its staff to the key safety content it identifies before staff provides care, treatment, and services. Completion of this orientation is documented. Note: Key safety content may include specific processes and procedures related to the provision of care,	**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).

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	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).	treatment, or services; the environment of care; and infection control. **HR.01.06.01, EP 3** An individual with the educational background, experience, or knowledge related to the skills being reviewed assesses competence. Note: When a suitable individual cannot be found to assess staff competence, the hospital can utilize an outside individual for this task. If a suitable individual inside or outside the hospital cannot be found, the hospital may consult the competency guidelines from an appropriate professional organization to make its assessment. **HR.01.06.01, EP 5** Staff competence is initially assessed and documented as part of orientation. **LD.04.03.09, EP 2** The hospital describes, in writing, the nature and scope of services provided through contractual agreements. **LD.04.03.09, EP 6** Leaders monitor contracted services by evaluating these services in relation to the hospital's expectations. **LD.04.03.09, EP 7** Leaders take steps to improve contracted services that do not meet expectations. Note: Examples of improvement efforts to consider include the following: - Increase monitoring of the contracted services	**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).

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		- Provide consultation or training to the contractor - Renegotiate the contract terms - Apply defined penalties - Terminate the contract **NR.02.01.01, EP 4** The nurse executive directs the following: - The implementation of hospitalwide plans to provide nursing care, treatment, and services. - The implementation of hospitalwide programs, policies, and procedures that address how nursing care needs of the patient population are assessed, met, and evaluated. Note: Examples of patient populations include pediatric, diabetic, and geriatric patients. - The implementation of an effective, ongoing program to measure, analyze, and improve the quality of nursing care, treatment, and services. **NR.02.03.01, EP 2** The nurse executive implements nursing policies, procedures, and standards that describe and guide how the staff provide nursing care, treatment, and services. **NR.02.03.01, EP 3** The nurse executive provides access to all nursing policies, procedures, and standards to the nursing staff.	
§482.23(b)(7)	(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:	**NR.02.03.01, EP 9** 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	**NPG.12.02.01, EP 7** 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,

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		are as follows: - 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 - Approved by the director of nursing - Reviewed at least once every three years	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)	(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;	**NR.02.03.01, EP 9** 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 are as follows: - 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 - Approved by the director of nursing - Reviewed at least once every three years	**NPG.12.02.01, EP 7** 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)(ii)	(ii) Establish alternative staffing plans;	**NR.02.03.01, EP 9** 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 are as follows: - Establish criteria that such outpatient departments need to meet, taking into account the types of services	**NPG.12.02.01, EP 7** 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

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		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 - Approved by the director of nursing - Reviewed at least once every three years	- Describe alternative staffing plans - Are approved by the director of nursing - Are reviewed at least once every three years
§482.23(b)(7)(iii)	(iii) Be approved by the director of nursing;	**NR.02.03.01, EP 9** 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 are as follows: - 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 - Approved by the director of nursing - Reviewed at least once every three years	**NPG.12.02.01, EP 7** 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)(iv)	(iv) Be reviewed at least once every 3 years.	**NR.02.03.01, EP 9** 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 are as follows: - 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	**NPG.12.02.01, EP 7** 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

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		- Describe alternative staffing plans - Approved by the director of nursing - Reviewed at least once every three years	
§482.23(c)	(c) Standard: Preparation and administration of drugs.	**MM.05.01.09, EP 2** Information on medication labels is displayed in a standardized format, in accordance with law and regulation and standards of practice. Note: This element of performance is also applicable to sample medications. **MM.05.01.09, EP 3** All medications prepared in the hospital are correctly labeled with the following: - Medication name, strength, and amount (if not apparent from the container) Note: This is also applicable to sample medications. - Expiration date when not used within 24 hours - Expiration date and time when expiration occurs in less than 24 hours - The date prepared and the diluent for all compounded intravenous admixtures and parenteral nutrition formulas **MM.05.01.09, EP 10** When an individualized medication(s) is prepared by someone other than the person administering the medication, the label includes the following: - The patient's name - The location where the medication is to be delivered - Directions for use and applicable accessory and cautionary instructions **MM.05.01.11, EP 2**	

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		The hospital dispenses medications and maintains records in accordance with law and regulation, licensure, and professional standards of practice. Note 1: Dispensing practices and recordkeeping include antidiversion strategies. Note 2: This element of performance is also applicable to sample medications. **MM.05.01.11, EP 3** The hospital dispenses medications within time frames it defines to meet patient needs. **MM.06.01.01, EP 1** Only authorized clinical staff administer medications. The hospital defines, in writing, those who are authorized to administer medication, with or without supervision, in accordance with law and regulation. Note: This does not prohibit self-administration of medications by patients, when indicated. **MM.06.01.01, EP 3** Before administration, the individual administering the medication does the following: - Verifies that the medication selected matches the medication order and product label - Visually inspects the medication for particulates, discoloration, or other loss of integrity - Verifies that the medication has not expired - Verifies that no contraindications exist - Verifies that the medication is being administered at the proper time, in the prescribed dose, and by the correct route - Discusses any unresolved concerns about the	

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		medication with the patient's physician or other licensed practitioner, prescriber (if different from the physician or other licensed practitioner), and/or staff involved with the patient's care, treatment, and services **MM.06.01.01, EP 9** Before administering a new medication, the patient or family is informed about any potential clinically significant adverse drug reactions or other concerns regarding administration of a new medication.	
§482.23(c)(1)	(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.	**HR.01.06.01, EP 1** The hospital defines the competencies it requires of its staff who provide patient care, treatment, or services. **HR.01.06.01, EP 3** An individual with the educational background, experience, or knowledge related to the skills being reviewed assesses competence. Note: When a suitable individual cannot be found to assess staff competence, the hospital can utilize an outside individual for this task. If a suitable individual inside or outside the hospital cannot be found, the hospital may consult the competency guidelines from an appropriate professional organization to make its assessment. **HR.01.06.01, EP 5** Staff competence is initially assessed and documented as part of orientation. **HR.01.06.01, EP 6** Staff competence is assessed and documented once every three years, or more frequently as required by	**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. - 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).

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		hospital policy or in accordance with law and regulation. **MM.04.01.01, EP 1** The hospital follows a written policy that identifies the specific types of medication orders that it deems acceptable for use. Note: There are several different types of medication orders. Medication orders commonly used include the following: - As needed (PRN) orders: Orders acted on based on the occurrence of a specific indication or symptom - Standing orders: A prewritten medication order and specific instructions from the physician or other licensed practitioner to administer a medication to a person in clearly defined circumstances - Automatic stop orders: Orders that include a date or time to discontinue a medication - Titrating orders: Orders in which the dose is either progressively increased or decreased in response to the patient's status - Taper orders: Orders in which the dose is decreased by a particular amount with each dosing interval - Range orders: Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or patient's status - Signed and held orders: New prewritten (held) medication orders and specific instructions from a physician or other licensed practitioner to administer medication(s) to a patient in clearly defined circumstances that become active upon the release of the orders on a specific date(s) and time(s) - Orders for compounded drugs or drug mixtures not commercially available	

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		- Orders for medication-related devices (for example, nebulizers, catheters) - Orders for investigational medications - Orders for herbal products - Orders for medications at discharge or transfer **MM.04.01.01, EP 2** The hospital follows a written policy that defines the following: - The 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 - The precautions for ordering medications with look-alike or sound-alike names - Actions to take when medication orders are incomplete, illegible, or unclear - For medication titration orders, required elements include 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: 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). **MM.05.01.01, EP 1** Before dispensing or removing medications from floor	

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		stock or from an automated storage and distribution device, a pharmacist reviews all medication orders or prescriptions unless a physician or other licensed practitioner controls the ordering, preparation, and administration of the medication or when a delay would harm the patient in an urgent situation (including sudden changes in a patient's clinical status), in accordance with law and regulation. Note 1: The Joint Commission permits emergency departments to broadly apply two exceptions in regard to Standard MM.05.01.01, EP 1. These exceptions are intended to minimize treatment delays and patient backup. The first exception allows medications ordered by a physician or other licensed practitioner to be administered by staff who are permitted to do so by virtue of education, training, and organization policy (such as a registered nurse) and in accordance with law and regulation. A physician or other licensed practitioner is not required to remain at the bedside when the medication is administered. However, a physician or other licensed practitioner must be available to provide immediate intervention should a patient experience an adverse drug event. The second exception allows medications to be administered in urgent situations when a delay in doing so would harm the patient. Note 2: A hospital's radiology service (including hospital-associated ambulatory radiology) will be expected to define, through protocol or policy, the role of the physician or other licensed practitioner in the direct supervision of a patient during and after IV contrast media is administered including the physician or other licensed practitioner's timely intervention in the	

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		event of a patient emergency. **MM.05.01.01, EP 4** All medication orders are reviewed for the following: - Patient allergies or potential sensitivities - Existing or potential interactions between the medication ordered and food and medications the patient is currently taking - The appropriateness of the medication, dose, frequency, and route of administration - Current or potential impact as indicated by laboratory values - Therapeutic duplication - Other contraindications **MM.05.01.01, EP 11** After the medication order has been reviewed, all concerns, issues, or questions are clarified with the individual prescriber before dispensing. **PC.02.01.03, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: 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: Outpatient services may be ordered by a physician or other licensed practitioner not appointed to the medical staff as long as the practitioner meets the following:	

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		- Responsible for the care of the patient - Licensed to practice in the state where the practitioner provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements - Acting within the practitioner's 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 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.	
§482.23(c)(1)(i)	(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.	**MS.03.01.01, EP 2** Physicians and other licensed practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.	**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. - On the orders contained within preprinted and electronic

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			standing orders, order sets, and protocols for patient orders only if such orders meet the requirements of 42 CFR 482.24(c)(3).
§482.23(c)(1)(ii)	(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).	**MM.04.01.01, EP 15** For hospitals that use Joint Commission accreditation for deemed status purposes: Processes for the use of preprinted and electronic standing orders, order sets, and protocols for medication orders include the following: - Review and approval of standing orders and protocols by the medical staff and the hospital's nursing and pharmacy leadership - Evaluation of established standing orders and protocols for consistency with nationally recognized and evidence-based guidelines - Regular review of such standing orders and protocols by the medical staff and the hospital's nursing and pharmacy leadership to determine the continuing usefulness and safety of the standing orders and protocols - Dating, timing, and authenticating of standing orders and protocols by the ordering physician or other licensed practitioner or another licensed practitioner responsible for the patient's care in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations. **MS.03.01.01, EP 2** Physicians and other licensed practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.	**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. - 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).

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§482.23(c)(2)	(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.	**LD.04.01.07, EP 1** Leaders review, approve, and manage the implementation of policies and procedures that guide and support patient care, treatment, and services. **MM.06.01.01, EP 1** Only authorized clinical staff administer medications. The hospital defines, in writing, those who are authorized to administer medication, with or without supervision, in accordance with law and regulation. Note: This does not prohibit self-administration of medications by patients, when indicated. **MS.03.01.01, EP 2** Physicians and other licensed practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.	**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)(3)	(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.	**HR.01.02.07, EP 2** Staff who provide patient care, treatment, and services practice within the scope of their license, certification, or registration and as required by law and regulation. **MM.04.01.01, EP 2** The hospital follows a written policy that defines the following: - The 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 - The precautions for ordering medications with look-	**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, hospital policy, and medical staff bylaws, rules, and regulations. Note: Influenza and pneumococcal vaccines may be administered per physician-approved hospital policy after an assessment of contraindications.

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		alike or sound-alike names - Actions to take when medication orders are incomplete, illegible, or unclear - For medication titration orders, required elements include 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: 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). **MM.04.01.01, EP 14** The hospital requires an order from a doctor of medicine or osteopathy or, as permitted by law and regulation, a hospital-specific protocol(s) approved by a doctor of medicine or osteopathy to administer influenza and pneumococcal vaccines. **PC.02.01.03, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: 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: Outpatient services may be ordered by a physician or other licensed practitioner not appointed to	

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		the medical staff as long as the practitioner meets the following: - Responsible for the care of the patient - Licensed to practice in the state where the practitioner provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements - Acting within the practitioner's 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 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.01.02.01, EP 4** Entries in the medical record are authenticated by the author. Information introduced into the medical record through transcription or dictation is authenticated by the author. Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key. Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or	

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		regulation or hospital policy. For electronic records, electronic signatures will be date-stamped. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: All orders, including verbal orders, are dated and authenticated by the ordering physician or other licensed practitioner who is responsible for the care of the patient, and who, in accordance with hospital policy; law and regulation; and medical staff bylaws, rules, and regulations, is authorized to write orders. **RC.01.02.01, EP 5** The individual identified by the signature stamp or method of electronic authentication is the only individual who uses it. **RC.02.01.01, EP 2** The medical record contains the following clinical information: - The reason(s) for admission for care, treatment, and services - The patient's initial diagnosis, diagnostic impression(s), or condition(s) - Any findings of assessments and reassessments - Any allergies to food - Any allergies to medications - Any conclusions or impressions drawn from the patient's medical history and physical examination - Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric hospitals using Joint Commission accreditation for deemed status purposes:	

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		The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival - Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration Note 1: 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. Note 2: For the definition and a further explanation of block charting, refer to the Glossary. - Any access site for medication, administration devices used, and rate of administration - Any adverse drug reactions - Treatment goals, plan of care, and revisions to the plan of care - Results of diagnostic and therapeutic tests and procedures - Any medications dispensed or prescribed on discharge - Discharge diagnosis - Discharge plan and discharge planning evaluation	

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		RC.02.03.07, EP 4 Verbal orders are authenticated within the time frame specified by law and regulation.	
§482.23(c)(3)(i)	(i) If verbal orders are used, they are to be used infrequently.	**MM.04.01.01, EP 6** The hospital minimizes the use of verbal and telephone medication orders.	**MM.14.01.01, EP 2** The hospital minimizes the use of verbal medication orders.
§482.23(c)(3)(ii)	(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.	**HR.01.02.07, EP 2** Staff who provide patient care, treatment, and services practice within the scope of their license, certification, or registration and as required by law and regulation. **RC.02.03.07, EP 1** The hospital identifies, in writing, the staff who are authorized to receive and record verbal orders, in accordance with law and regulation. **RC.02.03.07, EP 2** Only authorized staff receive and record verbal orders. **RC.02.03.07, EP 3** Documentation of verbal orders includes the date and the names of individuals who gave, received, recorded, and implemented the orders. **RC.02.03.07, EP 4** Verbal orders are authenticated within the time frame specified by law and regulation. **RC.02.03.07, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes: Documentation of verbal orders includes the time the verbal order was received.	**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.

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§482.23(c)(3)(iii)	(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.	**RC.01.02.01, EP 1** Only authorized individuals make entries in the medical record. **RC.01.02.01, EP 2** The hospital defines the types of entries in the medical record made by licensed practitioners that require countersigning, in accordance with law and regulation. **RC.01.02.01, EP 3** The author of each medical record entry is identified in the medical record. **RC.01.02.01, EP 4** Entries in the medical record are authenticated by the author. Information introduced into the medical record through transcription or dictation is authenticated by the author. Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key. Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or hospital policy. For electronic records, electronic signatures will be date-stamped. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: All orders, including verbal orders, are dated and authenticated by the ordering physician or other licensed practitioner who is responsible for the care of the patient, and who, in accordance with hospital policy; law and regulation; and	**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, hospital policy, and medical staff bylaws, rules, and regulations. Note: Influenza and pneumococcal vaccines may be administered per physician-approved hospital policy after an assessment of contraindications.

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		medical staff bylaws, rules, and regulations, is authorized to write orders.	
§482.23(c)(4)	(4) Blood transfusions and intravenous medications must be administered in accordance with State law and approved medical staff policies and procedures.	**LD.04.01.07, EP 1** Leaders review, approve, and manage the implementation of policies and procedures that guide and support patient care, treatment, and services. **MM.06.01.01, EP 1** Only authorized clinical staff administer medications. The hospital defines, in writing, those who are authorized to administer medication, with or without supervision, in accordance with law and regulation. Note: This does not prohibit self-administration of medications by patients, when indicated. **PC.02.01.01, EP 15** For hospitals that use Joint Commission accreditation for deemed status purposes: Blood transfusions and intravenous medications are administered in accordance with state law and approved medical staff policies and procedures.	**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)(5)	(5) There must be a hospital procedure for reporting transfusion reactions, adverse drug reactions, and errors in administration of drugs.	**MM.07.01.03, EP 1** The hospital follows a written process to respond to actual or potential adverse drug events, significant adverse drug reactions, and medication errors. Note: This element of performance is also applicable to sample medications. **MM.07.01.03, EP 3** The hospital complies with internal and external reporting requirements for actual or potential adverse drug events, significant adverse drug reactions, and medication errors.	**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. Note: This element of performance is also applicable to sample medications.

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		Note: This element of performance is also applicable to sample medications. **PI.01.01.01, EP 7** The hospital collects data on the following: All reported and confirmed transfusion reactions. **PI.01.01.01, EP 12** The hospital collects data on the following: Significant medication errors. **PI.01.01.01, EP 13** The hospital collects data on the following: Significant adverse drug reactions.	
§482.23(c)(6)	(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.06.01.03, EP 1** If self-administration of medications is allowed, the hospital follows written processes that guide the safe and accurate self-administration of medications or the administration of medications by a family member (refer to the Glossary for the definition of family). The processes address training, supervision, and documentation.	**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)(i)	(i) If the hospital allows a patient to self-administer specific hospital-issued medications, then the hospital must have policies and procedures in place to:		
§482.23(c)(6)(i)(A)	(A) Ensure that a practitioner responsible for the care of the patient has issued an order, consistent with hospital policy, permitting self-administration.	**MM.06.01.03, EP 1** If self-administration of medications is allowed, the hospital follows written processes that guide the safe and accurate self-administration of medications or the administration of medications by a family member (refer to the Glossary for the definition of family). The	**MM.16.01.01, EP 4** If the hospital allows a patient to self-administer specific hospital-issued medications, the hospital has policies and procedures in place that address the following: - Making certain that an order is issued by a licensed practitioner responsible for the patient's care and that it is consistent with the

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		processes address training, supervision, and documentation. **PC.02.01.03, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: 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: Outpatient services may be ordered by a physician or other licensed practitioner not appointed to the medical staff as long as the practitioner meets the following: - Responsible for the care of the patient - Licensed to practice in the state where the practitioner provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements - Acting within the practitioner's 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 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	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.

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		staff and acting in accordance with state law governing dietitians and nutrition professionals.	
§482.23(c)(6)(i)(B)	(B) Assess the capacity of the patient (or the patient's caregiver/support person where appropriate) to self-administer the specified medication(s).	**MM.06.01.03, EP 7** The hospital determines that the patient or the family member who administers the medication is competent at medication administration before allowing them to administer medications.	**MM.16.01.01, EP 4** If the hospital allows a patient to self-administer specific hospital-issued medications, the hospital has policies and procedures in place that address the following: - Making certain that an order is issued by a licensed 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.
§482.23(c)(6)(i)(C)	(C) Instruct the patient (or the patient's caregiver/support person where appropriate) in the safe and accurate administration of the specified medication(s).	**MM.06.01.03, EP 3** The hospital educates patients and families involved in self-administration about the following: - Medication name, type, and reason for use - How to administer medication, including process, time, frequency, route, and dose - Anticipated actions and potential side effects of the medication administered - Monitoring the effects of the medication	**MM.16.01.01, EP 4** If the hospital allows a patient to self-administer specific hospital-issued medications, the hospital has policies and procedures in place that address the following: - Making certain that an order is issued by a licensed 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.

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§482.23(c)(6)(i)(D)	(D) Address the security of the medication(s) for each patient.	**MM.03.01.01, EP 2** The hospital stores medications according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions. Note: This element of performance is also applicable to sample medications. **MM.03.01.01, EP 3** The hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area to prevent diversion, and locked when necessary, 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. **MM.06.01.03, EP 1** If self-administration of medications is allowed, the hospital follows written processes that guide the safe and accurate self-administration of medications or the administration of medications by a family member (refer to the Glossary for the definition of family). The processes address training, supervision, and documentation.	**MM.16.01.01, EP 4** If the hospital allows a patient to self-administer specific hospital-issued medications, the hospital has policies and procedures in place that address the following: - Making certain that an order is issued by a licensed 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.
§482.23(c)(6)(i)(E)	(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.	**MM.06.01.03, EP 1** If self-administration of medications is allowed, the hospital follows written processes that guide the safe and accurate self-administration of medications or the administration of medications by a family member (refer to the Glossary for the definition of family). The	**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

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		processes address training, supervision, and documentation. **RC.02.01.01, EP 2** The medical record contains the following clinical information: - The reason(s) for admission for care, treatment, and services - The patient's initial diagnosis, diagnostic impression(s), or condition(s) - Any findings of assessments and reassessments - Any allergies to food - Any allergies to medications - Any conclusions or impressions drawn from the patient's medical history and physical examination - Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric hospitals using Joint Commission accreditation for deemed status purposes: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival - Any progress notes - All orders	- 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 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

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		- Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration Note 1: 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. Note 2: For the definition and a further explanation of block charting, refer to the Glossary. - Any access site for medication, administration devices used, and rate of administration - Any adverse drug reactions - Treatment goals, plan of care, and revisions to the plan of care - Results of diagnostic and therapeutic tests and procedures - Any medications dispensed or prescribed on discharge - Discharge diagnosis - Discharge plan and discharge planning evaluation	Note: Medical records are completed within 30 days following discharge, including final diagnosis.
§482.23(c)(6)(ii)	(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)	(A) Ensure that a practitioner responsible for the care of the patient has issued an order, consistent with hospital policy, permitting self-administration of medications the patient brought into the hospital.	**MM.03.01.05, EP 1** The hospital defines when medications brought into the hospital by patients, their families, or licensed practitioners can be administered. Note: This element of performance is also applicable to sample medications. **PC.02.01.03, EP 1** For hospitals that use Joint Commission accreditation	**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) -

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		for deemed status purposes: 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: Outpatient services may be ordered by a physician or other licensed practitioner not appointed to the medical staff as long as the practitioner meets the following: - Responsible for the care of the patient - Licensed to practice in the state where the practitioner provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements - Acting within the practitioner's 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 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.	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 - 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.
§482.23(c)(6)(ii)(B)	(B) Assess the capacity of the patient (or the patient's caregiver/support person where appropriate) to self-administer the specified	**MM.06.01.03, EP 1** If self-administration of medications is allowed, the hospital follows written processes that guide the safe	**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

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	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).	and accurate self-administration of medications or the administration of medications by a family member (refer to the Glossary for the definition of family). The processes address training, supervision, and documentation. **MM.06.01.03, EP 7** The hospital determines that the patient or the family member who administers the medication is competent at medication administration before allowing them to administer medications.	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 - 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.
§482.23(c)(6)(ii)(C)	(C) Identify the specified medication(s) and visually evaluate the medication(s) for integrity.	**MM.03.01.05, EP 2** Before use or administration of a medication brought into the hospital by a patient, their family, or a licensed practitioner, the hospital identifies the medication and visually evaluates the medication's integrity. Note: This element of performance is also applicable to sample medications.	**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 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.
§482.23(c)(6)(ii)(D)	(D) Address the security of the medication(s) for each patient.	**MM.03.01.01, EP 2** The hospital stores medications according to the	**MM.16.01.01, EP 5** If the hospital allows a patient to self-administer medications not

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		manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions. Note: This element of performance is also applicable to sample medications. **MM.03.01.01, EP 3** The hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area to prevent diversion, and locked when necessary, 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. **MM.06.01.03, EP 1** If self-administration of medications is allowed, the hospital follows written processes that guide the safe and accurate self-administration of medications or the administration of medications by a family member (refer to the Glossary for the definition of family). The processes address training, supervision, and documentation.	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 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.
§482.23(c)(6)(ii)(E)	(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.	**MM.06.01.03, EP 1** If self-administration of medications is allowed, the hospital follows written processes that guide the safe and accurate self-administration of medications or the administration of medications by a family member (refer to the Glossary for the definition of family). The processes address training, supervision, and documentation.	**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

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		RC.02.01.01, EP 2 The medical record contains the following clinical information: - The reason(s) for admission for care, treatment, and services - The patient's initial diagnosis, diagnostic impression(s), or condition(s) - Any findings of assessments and reassessments - Any allergies to food - Any allergies to medications - Any conclusions or impressions drawn from the patient's medical history and physical examination - Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric hospitals using Joint Commission accreditation for deemed status purposes: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival - Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength,	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 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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		dose, route, date and time of administration Note 1: 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. Note 2: For the definition and a further explanation of block charting, refer to the Glossary. - Any access site for medication, administration devices used, and rate of administration - Any adverse drug reactions - Treatment goals, plan of care, and revisions to the plan of care - Results of diagnostic and therapeutic tests and procedures - Any medications dispensed or prescribed on discharge - Discharge diagnosis - Discharge plan and discharge planning evaluation	
§482.24	§482.24 Condition of Participation: Medical Record Services 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.	**LD.04.01.05, EP 2** Programs, services, sites, or departments providing patient care are directed by one or more qualified professionals or by a qualified licensed practitioner with clinical privileges. **LD.04.01.05, EP 3** The hospital defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: This includes the full-time employee who directs and manages dietary services. **LD.04.03.01, EP 2**	**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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		The hospital provides essential services, including the following: - Diagnostic radiology - Dietary - Emergency - Medical records - Nuclear medicine - Nursing care - Pathology and clinical laboratory - Pharmaceutical - Physical rehabilitation - Respiratory care - Social work Note 1: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to "Appendix A: Medicare Requirements for Hospitals" (AXA). Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The diagnostic radiology services provided by the hospital, as well as staff qualifications, meet professionally approved standards. **RC.01.01.01, EP 1** The hospital defines the components of a complete medical record.	- Dietetic **RC.11.01.01, EP 1** The hospital maintains a medical record for every inpatient and outpatient in the hospital.

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		RC.01.01.01, EP 5 The medical record includes the following: - Information needed to support the patient's diagnosis and condition - Information needed to justify the patient's care, treatment, and services - Information that documents the course and result of the patient's care, treatment, and services - 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.	
§482.24(a)	§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.	**HR.01.01.01, 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 of 1988 (CLIA '88), 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,	**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

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		occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists (as defined in 42 CFR 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital. The provision of care and staff qualifications are in accordance with national acceptable standards of practice and also meet the requirements of 409.17. See Appendix A for 409.17 requirements. 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. Note 5: For hospitals that use Joint Commission accreditation for deemed status purposes: Staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing. **IM.02.02.03, EP 2** The hospital's storage and retrieval systems 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. **IM.02.02.03, EP 3**	**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.

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		The hospital disseminates data and information in useful formats within time frames that are defined by the hospital and consistent with law and regulation. **LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.04.03.01, EP 2** The hospital provides essential services, including the following: - Diagnostic radiology - Dietary - Emergency - Medical records - Nuclear medicine - Nursing care - Pathology and clinical laboratory - Pharmaceutical - Physical rehabilitation - Respiratory care - Social work Note 1: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. For	

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		more information on 42 CFR 482.55, refer to "Appendix A: Medicare Requirements for Hospitals" (AXA). Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The diagnostic radiology services provided by the hospital, as well as staff qualifications, meet professionally approved standards.	
§482.24(b)	§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.	**IM.02.01.03, EP 1** The hospital follows a written policy that addresses the security of health information, including access, use, and disclosure. **IM.02.01.03, EP 2** The hospital implements a written policy addressing the following: - The integrity of health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction - The intentional destruction of health information - When and by whom the removal of health information is permitted Note: Removal refers to those actions that place health information outside the hospital's control. **IM.02.01.03, EP 6** The hospital protects health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction. **IM.02.02.03, EP 2** The hospital's storage and retrieval systems make health information accessible when needed for patient care, treatment, and services.	**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 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.

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		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. **MS.03.01.01, EP 6** The organized medical staff specifies the minimal content of medical histories and physical examinations, which may vary by setting or level of care, treatment, and services. **MS.03.01.01, EP 7** The organized medical staff monitors the quality of medical histories and physical examinations. **MS.05.01.03, EP 3** The organized medical staff participates in the following activities: Accurate, timely, and legible completion of patient's medical records. **RC.01.01.01, EP 1** The hospital defines the components of a complete medical record. **RC.01.01.01, EP 5** The medical record includes the following: - Information needed to support the patient's diagnosis and condition - Information needed to justify the patient's care, treatment, and services - Information that documents the course and result of the patient's care, treatment, and services - Information about the patient's care, treatment, and	

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		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.01.02.01, EP 3** The author of each medical record entry is identified in the medical record. **RC.01.02.01, EP 4** Entries in the medical record are authenticated by the author. Information introduced into the medical record through transcription or dictation is authenticated by the author. Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key. Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or hospital policy. For electronic records, electronic signatures will be date-stamped. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: All orders, including verbal orders, are dated and authenticated by the ordering physician or other licensed practitioner who is responsible for the care of the patient, and who, in accordance with hospital policy; law and regulation; and medical staff bylaws, rules, and regulations, is authorized to write orders.	

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		RC.01.02.01, EP 5 The individual identified by the signature stamp or method of electronic authentication is the only individual who uses it. **RC.01.03.01, EP 1** The hospital defines the time frame for completion of the medical record, which does not exceed 30 days after the patient's discharge. **RC.01.03.01, EP 2** The hospital follows its written policy requiring timely entry of information into the patient's medical record. **RC.01.04.01, EP 1** The hospital conducts an ongoing review of medical records at the point of care, based on the following indicators: presence, timeliness, legibility (whether handwritten or printed), accuracy, authentication, and completeness of data and information. **RC.01.05.01, 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, scans; and other applicable image records.	

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		RC.01.05.01, EP 8 Original medical records are not released unless the hospital is responding to law and regulation.	
§482.24(b)(1)	(1) Medical records must be retained in their original or legally reproduced form for a period of at least 5 years.	**RC.01.05.01, 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, scans; and other applicable image 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)(2)	(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.	**IM.01.01.01, EP 2** The hospital identifies how data and information enter, flow within, and leave the organization. **IM.02.02.03, EP 2** The hospital's storage and retrieval systems 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. **IM.02.02.03, EP 3** The hospital disseminates data and information in useful formats within time frames that are defined by the hospital and consistent with law and regulation.	**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)(3)	(3) The hospital must have a procedure for ensuring the confidentiality of patient	**IM.02.01.01, EP 1** The hospital follows a written policy addressing the	**IM.12.01.01, EP 1** The hospital develops and implements policies and procedures

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	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.	privacy and confidentiality of health information. **IM.02.01.01, EP 3** The hospital uses health information only for purposes permitted by law and regulation or as further limited by its policy on privacy. **IM.02.01.01, EP 4** The hospital discloses health information only as authorized by the patient or as otherwise consistent with law and regulation. **IM.02.01.03, EP 1** The hospital follows a written policy that addresses the security of health information, including access, use, and disclosure. **IM.02.01.03, EP 6** The hospital protects health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction. **RC.01.05.01, EP 8** Original medical records are not released unless the hospital is responding to law and regulation.	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 Note: Removal refers to those actions that place health information outside the hospital's control.
§482.24(c)	§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.	**RC.01.01.01, EP 5** The medical record includes the following: - Information needed to support the patient's diagnosis and condition - Information needed to justify the patient's care, treatment, and services	**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

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		- Information that documents the course and result of the patient's care, treatment, and services - 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.02.01.01, EP 2** The medical record contains the following clinical information: - The reason(s) for admission for care, treatment, and services - The patient's initial diagnosis, diagnostic impression(s), or condition(s) - Any findings of assessments and reassessments - Any allergies to food - Any allergies to medications - Any conclusions or impressions drawn from the patient's medical history and physical examination - Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric hospitals using Joint Commission accreditation for deemed status purposes: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports	- 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 - 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)

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		- Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival - Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration Note 1: 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. Note 2: For the definition and a further explanation of block charting, refer to the Glossary. - Any access site for medication, administration devices used, and rate of administration - Any adverse drug reactions - Treatment goals, plan of care, and revisions to the plan of care - Results of diagnostic and therapeutic tests and procedures - Any medications dispensed or prescribed on discharge - Discharge diagnosis - Discharge plan and discharge planning evaluation	- 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.
§482.24(c)(1)	(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.	**RC.01.01.01, EP 5** The medical record includes the following: - Information needed to support the patient's diagnosis and condition - Information needed to justify the patient's care, treatment, and services - Information that documents the course and result of	**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 promptly completed, properly filed and retained, and readily accessible.

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		the patient's care, treatment, and services - 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.01.01.01, EP 7** All entries in the medical record are dated. **RC.01.01.01, EP 13** For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed. **RC.01.02.01, EP 2** The hospital defines the types of entries in the medical record made by licensed practitioners that require countersigning, in accordance with law and regulation. **RC.01.02.01, EP 3** The author of each medical record entry is identified in the medical record. **RC.01.02.01, EP 4** Entries in the medical record are authenticated by the author. Information introduced into the medical record through transcription or dictation is authenticated by the author. Note 1: Authentication can be verified through electronic signatures, written signatures or initials,	

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		rubber-stamp signatures, or computer key. Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or hospital policy. For electronic records, electronic signatures will be date-stamped. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: All orders, including verbal orders, are dated and authenticated by the ordering physician or other licensed practitioner who is responsible for the care of the patient, and who, in accordance with hospital policy; law and regulation; and medical staff bylaws, rules, and regulations, is authorized to write orders. **RC.01.02.01, EP 5** The individual identified by the signature stamp or method of electronic authentication is the only individual who uses it. **RC.01.04.01, EP 1** The hospital conducts an ongoing review of medical records at the point of care, based on the following indicators: presence, timeliness, legibility (whether handwritten or printed), accuracy, authentication, and completeness of data and information.	
§482.24(c)(2)	(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	**PC.02.01.03, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: 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	**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.

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	policies, and medical staff bylaws, rules, and regulations.	policies; and medical staff bylaws, rules, and regulations. Note 1: Outpatient services may be ordered by a physician or other licensed practitioner not appointed to the medical staff as long as the practitioner meets the following: - Responsible for the care of the patient - Licensed to practice in the state where the practitioner provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements - Acting within the practitioner's 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 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.01.01.01, EP 7** All entries in the medical record are dated. **RC.01.01.01, EP 13** For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed.	

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		RC.01.02.01, EP 2 The hospital defines the types of entries in the medical record made by licensed practitioners that require countersigning, in accordance with law and regulation. **RC.01.02.01, EP 3** The author of each medical record entry is identified in the medical record. **RC.01.02.01, EP 4** Entries in the medical record are authenticated by the author. Information introduced into the medical record through transcription or dictation is authenticated by the author. Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key. Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or hospital policy. For electronic records, electronic signatures will be date-stamped. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: All orders, including verbal orders, are dated and authenticated by the ordering physician or other licensed practitioner who is responsible for the care of the patient, and who, in accordance with hospital policy; law and regulation; and medical staff bylaws, rules, and regulations, is authorized to write orders. **RC.01.02.01, EP 5**	

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		The individual identified by the signature stamp or method of electronic authentication is the only individual who uses it. **RC.02.03.07, EP 3** Documentation of verbal orders includes the date and the names of individuals who gave, received, recorded, and implemented the orders. **RC.02.03.07, EP 4** Verbal orders are authenticated within the time frame specified by law and regulation. **RC.02.03.07, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes: Documentation of verbal orders includes the time the verbal order was received.	
§482.24(c)(3)	(3) Hospitals may use pre-printed and electronic standing orders, order sets, and protocols for patient orders only if the hospital:		
§482.24(c)(3)(i)	(i) Establishes that such orders and protocols have been reviewed and approved by the medical staff and the hospital's nursing and pharmacy leadership;	**MM.04.01.01, EP 15** For hospitals that use Joint Commission accreditation for deemed status purposes: Processes for the use of preprinted and electronic standing orders, order sets, and protocols for medication orders include the following: - Review and approval of standing orders and protocols by the medical staff and the hospital's nursing and pharmacy leadership - Evaluation of established standing orders and protocols for consistency with nationally recognized and evidence-based guidelines	**RC.12.01.01, EP 5** The hospital uses preprinted and electronic standing orders, order sets, and protocols for patient orders only if 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

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		- Regular review of such standing orders and protocols by the medical staff and the hospital's nursing and pharmacy leadership to determine the continuing usefulness and safety of the standing orders and protocols - Dating, timing, and authenticating of standing orders and protocols by the ordering physician or other licensed practitioner or another licensed practitioner responsible for the patient's care in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations.	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)(ii)	(ii) Demonstrates that such orders and protocols are consistent with nationally recognized and evidence-based guidelines;	**MM.04.01.01, EP 15** For hospitals that use Joint Commission accreditation for deemed status purposes: Processes for the use of preprinted and electronic standing orders, order sets, and protocols for medication orders include the following: - Review and approval of standing orders and protocols by the medical staff and the hospital's nursing and pharmacy leadership - Evaluation of established standing orders and protocols for consistency with nationally recognized and evidence-based guidelines - Regular review of such standing orders and protocols by the medical staff and the hospital's nursing and pharmacy leadership to determine the continuing usefulness and safety of the standing orders and protocols - Dating, timing, and authenticating of standing orders and protocols by the ordering physician or other licensed practitioner or another licensed practitioner responsible for the patient's care in accordance with	**RC.12.01.01, EP 5** The hospital uses preprinted and electronic standing orders, order sets, and protocols for patient orders only if 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.

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		professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations.	
§482.24(c)(3)(iii)	(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	**MM.04.01.01, EP 15** For hospitals that use Joint Commission accreditation for deemed status purposes: Processes for the use of preprinted and electronic standing orders, order sets, and protocols for medication orders include the following: - Review and approval of standing orders and protocols by the medical staff and the hospital's nursing and pharmacy leadership - Evaluation of established standing orders and protocols for consistency with nationally recognized and evidence-based guidelines - Regular review of such standing orders and protocols by the medical staff and the hospital's nursing and pharmacy leadership to determine the continuing usefulness and safety of the standing orders and protocols - Dating, timing, and authenticating of standing orders and protocols by the ordering physician or other licensed practitioner or another licensed practitioner responsible for the patient's care in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations.	**RC.12.01.01, EP 5** The hospital uses preprinted and electronic standing orders, order sets, and protocols for patient orders only if 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)(iv)	(iv) Ensures that such 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	**MM.04.01.01, EP 15** For hospitals that use Joint Commission accreditation for deemed status purposes: Processes for the use of preprinted and electronic standing orders, order sets, and protocols for medication orders include the following:	**RC.12.01.01, EP 5** The hospital uses preprinted and electronic standing orders, order sets, and protocols for patient orders only if 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

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	accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.	- Review and approval of standing orders and protocols by the medical staff and the hospital's nursing and pharmacy leadership - Evaluation of established standing orders and protocols for consistency with nationally recognized and evidence-based guidelines - Regular review of such standing orders and protocols by the medical staff and the hospital's nursing and pharmacy leadership to determine the continuing usefulness and safety of the standing orders and protocols - Dating, timing, and authenticating of standing orders and protocols by the ordering physician or other licensed practitioner or another licensed practitioner responsible for the patient's care in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations.	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)(4)	(4) All records must document the following, as appropriate:		
§482.24(c)(4)(i)	(i) Evidence of--		
§482.24(c)(4)(i)(A)	(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.	**PC.01.02.03, EP 4** The patient receives a medical history and physical examination 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 any specific outpatient surgical or procedural services for which an assessment is performed instead. Note 2: For law and regulation guidance pertaining to	**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

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		the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text. **PC.01.02.03, EP 7** For hospitals that use Joint Commission accreditation for deemed status purposes: When the medical staff has chosen to allow an assessment (in lieu of a comprehensive medical history and physical examination) for patients receiving specific outpatient surgical or procedural services, the assessment of the patient is 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. (For more information, refer to Standard MS.03.01.01) Note: For further regulatory guidance, refer to 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 "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text. **RC.01.03.01, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital records the patient's medical history and physical examination, including updates, in the medical record within 24 hours after registration or inpatient admission but prior to surgery or a procedure requiring anesthesia services. **RC.02.01.03, EP 3** The patient's medical history and physical examination	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 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.

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		are recorded in the medical record before an operative or other high-risk procedure is performed.	
§482.24(c)(4)(i)(B)	(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.	**PC.01.02.03, EP 5** 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 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 any specific outpatient surgical or procedural services for which an assessment is performed instead. Note 2: For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text. **PC.01.02.03, EP 7** For hospitals that use Joint Commission accreditation for deemed status purposes: When the medical staff has chosen to allow an assessment (in lieu of a comprehensive medical history and physical examination) for patients receiving specific outpatient surgical or procedural services, the assessment of the patient is 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. (For more	**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 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 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.

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		information, refer to Standard MS.03.01.01) Note: For further regulatory guidance, refer to 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 "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text. **RC.01.03.01, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital records the patient's medical history and physical examination, including updates, in the medical record within 24 hours after registration or inpatient admission but prior to surgery or a procedure requiring anesthesia services.	
§482.24(c)(4)(i)(C)	(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.	**PC.01.02.03, EP 7** For hospitals that use Joint Commission accreditation for deemed status purposes: When the medical staff has chosen to allow an assessment (in lieu of a comprehensive medical history and physical examination) for patients receiving specific outpatient surgical or procedural services, the assessment of the patient is 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. (For more information, refer to Standard MS.03.01.01) Note: For further regulatory guidance, refer to 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 "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text.	**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 comprehensive medical history and physical examination, or any update to it, prior to specific outpatient surgical or procedural services.
§482.24(c)(4)(ii)	(ii) Admitting diagnosis.	**RC.02.01.01, EP 2** The medical record contains the following clinical information: - The reason(s) for admission for care, treatment, and	**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

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		services - The patient's initial diagnosis, diagnostic impression(s), or condition(s) - Any findings of assessments and reassessments - Any allergies to food - Any allergies to medications - Any conclusions or impressions drawn from the patient's medical history and physical examination - Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric hospitals using Joint Commission accreditation for deemed status purposes: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival - Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration Note 1: 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.	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 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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Note 2: For the definition and a further explanation of block charting, refer to the Glossary. - Any access site for medication, administration devices used, and rate of administration - Any adverse drug reactions - Treatment goals, plan of care, and revisions to the plan of care - Results of diagnostic and therapeutic tests and procedures - Any medications dispensed or prescribed on discharge - Discharge diagnosis - Discharge plan and discharge planning evaluation	- 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.
§482.24(c)(4)(iii)	(iii) Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.	**RC.02.01.01, EP 2** The medical record contains the following clinical information: - The reason(s) for admission for care, treatment, and services - The patient's initial diagnosis, diagnostic impression(s), or condition(s) - Any findings of assessments and reassessments - Any allergies to food - Any allergies to medications - Any conclusions or impressions drawn from the patient's medical history and physical examination - Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric hospitals using Joint Commission accreditation for deemed status purposes: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric	**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

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		diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival - Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration Note 1: 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. Note 2: For the definition and a further explanation of block charting, refer to the Glossary. - Any access site for medication, administration devices used, and rate of administration - Any adverse drug reactions - Treatment goals, plan of care, and revisions to the plan of care - Results of diagnostic and therapeutic tests and procedures - Any medications dispensed or prescribed on discharge - Discharge diagnosis - Discharge plan and discharge planning evaluation	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.
§482.24(c)(4)(iv)	(iv) Documentation of complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia.	**RC.02.01.01, EP 2** The medical record contains the following clinical information: - The reason(s) for admission for care, treatment, and 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

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		- The patient's initial diagnosis, diagnostic impression(s), or condition(s) - Any findings of assessments and reassessments - Any allergies to food - Any allergies to medications - Any conclusions or impressions drawn from the patient's medical history and physical examination - Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric hospitals using Joint Commission accreditation for deemed status purposes: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival - Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration Note 1: 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. Note 2: For the definition and a further explanation of	- 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 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

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		block charting, refer to the Glossary. - Any access site for medication, administration devices used, and rate of administration - Any adverse drug reactions - Treatment goals, plan of care, and revisions to the plan of care - Results of diagnostic and therapeutic tests and procedures - Any medications dispensed or prescribed on discharge - Discharge diagnosis - Discharge plan and discharge planning evaluation **RC.02.01.03, EP 8** The medical record contains the following postoperative information: - The patient's vital signs and level of consciousness - Any medications, including intravenous fluids and any administered blood, blood products, and blood components - Any unanticipated events or complications (including blood transfusion reactions) and the management of those events	course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis.
§482.24(c)(4)(v)	(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.	**RC.02.01.01, EP 4** As needed to provide care, treatment, and services, the medical record contains the following additional information: - Any advance directives - Any informed consent, when required by hospital policy 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	**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.

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		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. - Any records of communication with the patient, such as telephone calls or e-mail - Any patient-generated information **RI.01.03.01, EP 1** The hospital follows a written policy on informed consent that describes the following: - The specific care, treatment, and services that require informed consent - Circumstances that would allow for exceptions to obtaining informed consent - The process used to obtain informed consent - The physician or other licensed practitioner permitted to conduct the informed consent discussion in accordance with law and regulation - How informed consent is documented in the patient record Note: Documentation may be recorded in a form, in progress notes, or elsewhere in the record. - When a surrogate decision-maker may give informed consent **RI.01.03.01, EP 2** The informed consent process includes a discussion about the following: - The patient's proposed care, treatment, and services. - Potential benefits, risks, and side effects of the patient's proposed care, treatment, and services; the	

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		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.	
§482.24(c)(4)(vi)	(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.	**RC.02.01.01, EP 2** The medical record contains the following clinical information: - The reason(s) for admission for care, treatment, and services - The patient's initial diagnosis, diagnostic impression(s), or condition(s) - Any findings of assessments and reassessments - Any allergies to food - Any allergies to medications - Any conclusions or impressions drawn from the patient's medical history and physical examination - Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric hospitals using Joint Commission accreditation for deemed status purposes: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and 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 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

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		- The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival - Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration Note 1: 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. Note 2: For the definition and a further explanation of block charting, refer to the Glossary. - Any access site for medication, administration devices used, and rate of administration - Any adverse drug reactions - Treatment goals, plan of care, and revisions to the plan of care - Results of diagnostic and therapeutic tests and procedures - Any medications dispensed or prescribed on discharge - Discharge diagnosis - Discharge plan and discharge planning evaluation	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.
§482.24(c)(4)(vii)	(vii) Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care.	**RC.02.04.01, EP 3** In order to provide information to other caregivers and facilitate the patient's continuity of care, the medical record contains a concise discharge summary that includes the following: - The reason for hospitalization - The procedures performed - The care, treatment, and services provided - The patient's condition and disposition at discharge	**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

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		- Information provided to the patient and family - Provisions for follow-up care Note 1: A discharge summary is not required when a patient is seen for minor problems or interventions, as defined by the medical staff. In this instance, a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care. Note 2: When a patient is transferred to a different level of care within the hospital, and caregivers change, a transfer summary may be substituted for the discharge summary. If the caregivers do not change, a progress note may be used. Note 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The record of each patient discharged needs to include a discharge summary with the above information. The exceptions in Notes 1 and 2 are not applicable. All patients discharged need to have a discharge summary.	- 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, 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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§482.24(c)(4)(viii)	(viii) Final diagnosis with completion of medical records within 30 days following discharge.	**RC.01.03.01, EP 1** The hospital defines the time frame for completion of the medical record, which does not exceed 30 days after the patient's discharge. **RC.02.01.01, EP 2** The medical record contains the following clinical information: - The reason(s) for admission for care, treatment, and services - The patient's initial diagnosis, diagnostic impression(s), or condition(s) - Any findings of assessments and reassessments - Any allergies to food - Any allergies to medications - Any conclusions or impressions drawn from the patient's medical history and physical examination - Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric hospitals using Joint Commission accreditation for deemed status purposes: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival	**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 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

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		- Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration Note 1: 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. Note 2: For the definition and a further explanation of block charting, refer to the Glossary. - Any access site for medication, administration devices used, and rate of administration - Any adverse drug reactions - Treatment goals, plan of care, and revisions to the plan of care - Results of diagnostic and therapeutic tests and procedures - Any medications dispensed or prescribed on discharge - Discharge diagnosis - Discharge plan and discharge planning evaluation	- 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.
§482.24(d)	§482.24(d) 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—		
§482.24(d)(1)	(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	**IM.02.02.07, EP 1** 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) has a fully operational	**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

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	hospital's exchange of patient health information.	notification capacity and is used in accordance with applicable state and federal laws and regulations for the exchange of patient health information.	accordance with applicable state and federal laws and regulations for the exchange of patient health information.
§482.24(d)(2)	(2) The system sends notifications that must include at least patient name, treating practitioner name, and sending institution name.	**IM.02.02.07, 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 least the patient's name, treating licensed practitioner's name, and sending institution's name.	**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.
§482.24(d)(3)	(3) To the extent permissible under applicable federal and state law and regulations, and not inconsistent with the patient's expressed privacy preferences, the system sends notifications directly, or through an intermediary that facilitates exchange of health information, at the time of:	**IM.02.02.07, EP 3** 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, at the time of the patient's emergency department registration or inpatient admission.	**IM.13.01.05, EP 3** 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, at the following times, when applicable: - The patient's emergency department registration - The patient's inpatient admission
§482.24(d)(3)(i)	(i) The patient's registration in the hospital's emergency department (if applicable).	**IM.02.02.07, EP 3** 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, at the time of the patient's emergency department registration or inpatient admission.	**IM.13.01.05, EP 3** 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, at the following times, when applicable: - The patient's emergency department registration - The patient's inpatient admission
§482.24(d)(3)(ii)	(ii) The patient's admission to the hospital's inpatient services (if applicable).	**IM.02.02.07, EP 3** For hospitals that use Joint Commission accreditation	**IM.13.01.05, EP 3** For hospitals that use Joint Commission accreditation for deemed

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		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, at the time of the patient's emergency department registration or inpatient admission.	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, at the following times, when applicable: - The patient's emergency department registration - The patient's inpatient admission
§482.24(d)(4)	(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:	**IM.02.02.07, 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.	**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.
§482.24(d)(4)(i)	(i) The patient's discharge or transfer from the hospital's emergency department (if applicable).	**IM.02.02.07, 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.	**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.
§482.24(d)(4)(ii)	(ii) The patient's discharge or transfer from the hospital's inpatient services (if applicable).	**IM.02.02.07, EP 4** For hospitals that use Joint Commission accreditation for deemed status purposes: In accordance with the	**IM.13.01.05, EP 4** For hospitals that use Joint Commission accreditation for deemed status purposes: In accordance with the patient's expressed

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		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.	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.
§482.24(d)(5)	(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 entities, which need to receive notification of the patient's status for treatment, care coordination, or quality improvement purposes:	**IM.02.02.07, EP 5** For hospitals that use Joint Commission accreditation for 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 services 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: - The patient's established primary care licensed practitioner - The 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	**IM.13.01.05, EP 5** For hospitals that use Joint Commission accreditation for 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 the hospital has a process to send patient event notifications while working within the constraints of its technology infrastructure. There may be instances in which the hospital (or its intermediary) cannot identify an applicable recipient for a patient event notification despite establishing processes for identifying recipients. In addition, some recipients may not be able to receive patient event notifications in a manner consistent with the hospital system's capabilities.

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		patient event notifications in a manner consistent with a hospital system's capabilities.	
§482.24(d)(5)(i)	(i) The patient's established primary care practitioner;	**IM.02.02.07, EP 5** For hospitals that use Joint Commission accreditation for 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 services 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: - The patient's established primary care licensed practitioner - The 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.	**IM.13.01.05, EP 5** For hospitals that use Joint Commission accreditation for 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 the hospital has a process to send patient event notifications while working within the constraints of its technology infrastructure. There may be instances in which the hospital (or its intermediary) cannot identify an applicable recipient for a patient event notification despite establishing processes for identifying recipients. In addition, some recipients may not be able to receive patient event notifications in a manner consistent with the hospital system's capabilities.
§482.24(d)(5)(ii)	(ii) The patient's established primary care practice group or entity; or	**IM.02.02.07, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital makes a reasonable effort to confirm that its electronic health	**IM.13.01.05, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital makes a reasonable effort to confirm that its electronic health records system (or other

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		records system (or other electronic administrative system) sends the notifications to all applicable post-acute care services 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: - The patient's established primary care licensed practitioner - The 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.	electronic administrative system) sends the notifications to all applicable post–acute care service providers and suppliers, as well as any of the following who need to receive notification of the patient's status for treatment, care coordination, or quality improvement purposes: - Patient's established primary care licensed practitioner - Patient's established primary care practice group or entity - Other licensed practitioners, or other practice groups or entities, identified by the patient as primarily responsible for the patient's care Note: The term "reasonable effort" means that the hospital has a process to send patient event notifications while working within the constraints of its technology infrastructure. There may be instances in which the hospital (or its intermediary) cannot identify an applicable recipient for a patient event notification despite establishing processes for identifying recipients. In addition, some recipients may not be able to receive patient event notifications in a manner consistent with the hospital system's capabilities.
§482.24(d)(5)(iii)	(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.	**IM.02.02.07, EP 5** For hospitals that use Joint Commission accreditation for 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 services 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:	**IM.13.01.05, EP 5** For hospitals that use Joint Commission accreditation for 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

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		- The patient's established primary care licensed practitioner - The 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.	- Patient's established primary care practice group or entity - Other licensed practitioners, or other practice groups or entities, identified by the patient as primarily responsible for the patient's care Note: The term "reasonable effort" means that the hospital has a process to send patient event notifications while working within the constraints of its technology infrastructure. There may be instances in which the hospital (or its intermediary) cannot identify an applicable recipient for a patient event notification despite establishing processes for identifying recipients. In addition, some recipients may not be able to receive patient event notifications in a manner consistent with the hospital system's capabilities.
§482.25	§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.	**LD.04.01.07, EP 1** Leaders review, approve, and manage the implementation of policies and procedures that guide and support patient care, treatment, and services. **LD.04.03.01, EP 2** The hospital provides essential services, including the following: - Diagnostic radiology - Dietary - Emergency - Medical records - Nuclear medicine - Nursing care - Pathology and clinical laboratory - Pharmaceutical	**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. **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.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Physical rehabilitation - Respiratory care - Social work Note 1: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to "Appendix A: Medicare Requirements for Hospitals" (AXA). Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The diagnostic radiology services provided by the hospital, as well as staff qualifications, meet professionally approved standards. **MM.03.01.01, EP 19** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a pharmacy directed by a registered pharmacist or a supervised drug storage area, in accordance with law and regulation. Note: This element of performance is also applicable to sample medications.	
§482.25	Element Deleted	**LD.04.03.01, EP 2** The hospital provides essential services, including the following: - Diagnostic radiology - Dietary - Emergency	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Medical records - Nuclear medicine - Nursing care - Pathology and clinical laboratory - Pharmaceutical - Physical rehabilitation - Respiratory care - Social work Note 1: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The diagnostic radiology services provided by the hospital, as well as staff qualifications, meet professionally approved standards. **MM.03.01.01, EP 19** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a pharmacy directed by a registered pharmacist or a supervised drug storage area, in accordance with law and regulation. Note: This element of performance is also applicable to sample medications.	

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§482.25(a)	§482.25(a) Standard: Pharmacy Management and Administration The pharmacy or drug storage area must be administered in accordance with accepted professional principles.	**LD.03.08.01, EP 1** The hospital's design of new or modified services or processes incorporates the following: - The needs of patients, staff, and others - The results of performance improvement activities - Information about potential risks to patients - Evidence-based information in the decision-making process - Information about sentinel events Note 1: A proactive risk assessment is one of several ways to assess potential risks to patients. For suggested components, refer to the "Proactive Risk Assessment" section at the beginning of this chapter. Note 2: Evidence-based information could include practice guidelines, successful practices, information from current literature, and clinical standards. **LD.03.10.01, EP 3** When clinical practice guidelines will be used in the design or modification of processes, the following occurs: - The hospital follows criteria to manage guideline selection and implementation. - The leaders of the hospital and the organized medical staff review, approve, and modify the clinical practice guidelines as needed. - The leaders of the hospital manage and evaluate the implementation of the guidelines. **LD.04.01.05, EP 3** The hospital defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments.	**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. **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 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

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		Note: For hospitals that use Joint Commission accreditation for deemed status purposes: This includes the full-time employee who directs and manages dietary services. **MM.03.01.01, EP 2** The hospital stores medications according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions. Note: This element of performance is also applicable to sample medications. **MM.03.01.01, EP 3** The hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area to prevent diversion, and locked when necessary, 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. **MM.03.01.01, EP 4** The hospital follows a written policy addressing the control of medication between receipt by a staff member and administration of the medication, including safe storage, handling, wasting, security, disposition, and return to storage. Note: This element of performance is also applicable to sample medications.	or number of doses are automatically stopped after a reasonable time that is predetermined by the medical staff.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		MM.03.01.01, EP 7 All stored medications and the components used in their preparation are labeled with the contents, expiration date, and any applicable warnings. Note: This element of performance is also applicable to sample medications. **MM.05.01.11, EP 2** The hospital dispenses medications and maintains records in accordance with law and regulation, licensure, and professional standards of practice. Note 1: Dispensing practices and recordkeeping include antidiversion strategies. Note 2: This element of performance is also applicable to sample medications.	
§482.25(a)(1)	(1) A full-time, part-time, or consulting pharmacist must be responsible for developing, supervising, and coordinating all the activities of the pharmacy services.	**HR.01.02.05, EP 28** For hospitals that use Joint Commission accreditation for deemed status purposes: A full-time, part-time, or consulting pharmacist develops, supervises, and coordinates all the activities of the pharmacy department or pharmacy services.	**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)(2)	(2) The pharmaceutical service must have an adequate number of personnel to ensure quality pharmaceutical services, including emergency services.	**LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered.	**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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			- Diagnostic and therapeutic radiology services Note 2: Emergency services staff are qualified in emergency care.
§482.25(a)(3)	(3) Current and accurate records must be kept of the receipt and disposition of all scheduled drugs.	**MM.03.01.01, EP 3** The hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area to prevent diversion, and locked when necessary, 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. **MM.03.01.01, EP 4** The hospital follows a written policy addressing the control of medication between receipt by a staff member and administration of the medication, including safe storage, handling, wasting, security, disposition, and return to storage. Note: This element of performance is also applicable to sample medications. **MM.05.01.11, EP 2** The hospital dispenses medications and maintains records in accordance with law and regulation, licensure, and professional standards of practice. Note 1: Dispensing practices and recordkeeping include antidiversion strategies. Note 2: This element of performance is also applicable to sample medications.	**MM.13.01.01, EP 1** The hospital maintains current and accurate records of the receipt and disposition of all scheduled drugs.
§482.25(b)	§482.25(b) Standard: Delivery of Services In order to provide patient safety, drugs and biologicals must be controlled and	**EC.02.01.01, EP 11** The hospital responds to product notices and recalls.	**MM.11.01.01, EP 1** Drugs and biologicals are procured, stored, controlled, and distributed in accordance with federal and state laws and

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	distributed in accordance with applicable standards of practice, consistent with Federal and State law.	**MM.03.01.01, EP 3** The hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area to prevent diversion, and locked when necessary, 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. **MM.03.01.01, EP 4** The hospital follows a written policy addressing the control of medication between receipt by a staff member and administration of the medication, including safe storage, handling, wasting, security, disposition, and return to storage. Note: This element of performance is also applicable to sample medications. **MM.05.01.01, EP 1** Before dispensing or removing medications from floor stock or from an automated storage and distribution device, a pharmacist reviews all medication orders or prescriptions unless a physician or other licensed practitioner controls the ordering, preparation, and administration of the medication or when a delay would harm the patient in an urgent situation (including sudden changes in a patient's clinical status), in accordance with law and regulation. Note 1: The Joint Commission permits emergency departments to broadly apply two exceptions in regard to Standard MM.05.01.01, EP 1. These exceptions are	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.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		intended to minimize treatment delays and patient backup. The first exception allows medications ordered by a physician or other licensed practitioner to be administered by staff who are permitted to do so by virtue of education, training, and organization policy (such as a registered nurse) and in accordance with law and regulation. A physician or other licensed practitioner is not required to remain at the bedside when the medication is administered. However, a physician or other licensed practitioner must be available to provide immediate intervention should a patient experience an adverse drug event. The second exception allows medications to be administered in urgent situations when a delay in doing so would harm the patient. Note 2: A hospital's radiology service (including hospital-associated ambulatory radiology) will be expected to define, through protocol or policy, the role of the physician or other licensed practitioner in the direct supervision of a patient during and after IV contrast media is administered including the physician or other licensed practitioner's timely intervention in the event of a patient emergency. **MM.05.01.11, EP 2** The hospital dispenses medications and maintains records in accordance with law and regulation, licensure, and professional standards of practice. Note 1: Dispensing practices and recordkeeping include antidiversion strategies. Note 2: This element of performance is also applicable to sample medications.	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		MM.05.01.17, EP 1 The hospital follows a written policy describing how it will retrieve and handle medications within the hospital that are recalled or discontinued for safety reasons by the manufacturer or the US Food and Drug Administration (FDA). Note: This element of performance is also applicable to sample medications. **MM.05.01.17, EP 3** When a medication is recalled or discontinued for safety reasons by the manufacturer or the US Food and Drug Administration (FDA), the hospital notifies the prescribers and those who dispense or administer the medication. Note: This element of performance is also applicable to sample medications. **MM.05.01.17, EP 4** When required by law and regulation or hospital policy, the hospital informs patients that their medication has been recalled or discontinued for safety reasons by the manufacturer or the US Food and Drug Administration (FDA). Note: This element of performance is also applicable to sample medications. **MM.05.01.19, EP 2** When the hospital accepts unused, expired, or returned medications, it follows a process for returning medications to the pharmacy's control which includes procedures for preventing diversion.	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Note: This element of performance is also applicable to sample medications.	
§482.25(b)(1)	(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.	**MM.05.01.01, EP 4** All medication orders are reviewed for the following: - Patient allergies or potential sensitivities - Existing or potential interactions between the medication ordered and food and medications the patient is currently taking - The appropriateness of the medication, dose, frequency, and route of administration - Current or potential impact as indicated by laboratory values - Therapeutic duplication - Other contraindications **MM.05.01.01, EP 11** After the medication order has been reviewed, all concerns, issues, or questions are clarified with the individual prescriber before dispensing. **MM.05.01.07, 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.05.01.07, EP 2** The hospital develops and implements policies and procedures for sterile medication compounding of nonhazardous and hazardous medications in	**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 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.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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.05.01.07, 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.05.01.07, EP 4** The hospital conducts sterile medication compounding of 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.05.01.07, 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.05.01.07, 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 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.

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		MM.05.01.07, 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. **MM.05.01.09, EP 2** Information on medication labels is displayed in a standardized format, in accordance with law and regulation and standards of practice. Note: This element of performance is also applicable to sample medications. **MM.05.01.09, EP 3** All medications prepared in the hospital are correctly labeled with the following: - Medication name, strength, and amount (if not apparent from the container) Note: This is also applicable to sample medications. - Expiration date when not used within 24 hours - Expiration date and time when expiration occurs in less than 24 hours - The date prepared and the diluent for all compounded intravenous admixtures and parenteral nutrition formulas **MM.05.01.09, EP 10** When an individualized medication(s) is prepared by someone other than the person administering the medication, the label includes the following: - The patient's name - The location where the medication is to be delivered	

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		- Directions for use and applicable accessory and cautionary instructions	
§482.25(b)(2)(i)	(2)(i) All drugs and biologicals must be kept in a secure area, and locked when appropriate.	**MM.03.01.01, EP 3** The hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area to prevent diversion, and locked when necessary, 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. **MM.03.01.01, EP 4** The hospital follows a written policy addressing the control of medication between receipt by a staff member and administration of the medication, including safe storage, handling, wasting, security, disposition, and return to storage. Note: This element of performance is also applicable to sample medications. **MM.03.01.01, EP 6** The hospital prevents unauthorized individuals from obtaining medications in accordance with its policy and law and regulation. Note: This element of performance is also applicable to sample medications.	**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 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)	(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.	**MM.03.01.01, EP 3** The hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area to prevent diversion, and locked when necessary, in accordance with law and regulation.	**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 prevent diversion in accordance with law and regulation.

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		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 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)(iii)	(iii) Only authorized personnel may have access to locked areas.	**MM.03.01.01, EP 6** The hospital prevents unauthorized individuals from obtaining medications in accordance with its policy and law and regulation. Note: This element of performance is also applicable to sample medications.	**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 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)(3)	(3) Outdated, mislabeled, or otherwise unusable drugs and biologicals must not be available for patient use.	**MM.03.01.01, EP 8** The hospital removes all expired, damaged, and/or contaminated medications and stores them separately from medications available for administration. Note: This element of performance is also applicable to sample medications.	**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)(4)	(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.	**MM.05.01.13, EP 1** The hospital follows a process for providing medications to meet patient needs when the pharmacy is closed. **MM.05.01.13, EP 2** When non-pharmacist health care professionals are allowed by law or regulation to obtain medications after the pharmacy is closed, the following occurs: - Medications available are limited to those approved by the hospital.	**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.

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		- The hospital stores and secures the medications approved for use outside of the pharmacy. - Only trained, designated prescribers and nurses are permitted access to approved medications - Quality control procedures (such as an independent second check by another individual or a secondary verification built into the system such as bar coding) are in place to prevent medication retrieval errors. - The hospital arranges for a qualified pharmacist to be available either on-call or at another location (for example, at another organization that has 24-hour pharmacy service) to answer questions or provide medications beyond those accessible to non-pharmacy staff.	
§482.25(b)(5)	(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.	**MM.04.01.01, EP 1** The hospital follows a written policy that identifies the specific types of medication orders that it deems acceptable for use. Note: There are several different types of medication orders. Medication orders commonly used include the following: - As needed (PRN) orders: Orders acted on based on the occurrence of a specific indication or symptom - Standing orders: A prewritten medication order and specific instructions from the physician or other licensed practitioner to administer a medication to a person in clearly defined circumstances - Automatic stop orders: Orders that include a date or time to discontinue a medication - Titrating orders: Orders in which the dose is either progressively increased or decreased in response to the patient's status - Taper orders: Orders in which the dose is decreased by	**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 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

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		a particular amount with each dosing interval - Range orders: Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or patient's status - Signed and held orders: New prewritten (held) medication orders and specific instructions from a physician or other licensed practitioner to administer medication(s) to a patient in clearly defined circumstances that become active upon the release of the orders on a specific date(s) and time(s) - Orders for compounded drugs or drug mixtures not commercially available - Orders for medication-related devices (for example, nebulizers, catheters) - Orders for investigational medications - Orders for herbal products - Orders for medications at discharge or transfer **MM.05.01.01, EP 4** All medication orders are reviewed for the following: - Patient allergies or potential sensitivities - Existing or potential interactions between the medication ordered and food and medications the patient is currently taking - The appropriateness of the medication, dose, frequency, and route of administration - Current or potential impact as indicated by laboratory values - Therapeutic duplication - Other contraindications	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.
§482.25(b)(6)	(6) Drug administration errors, adverse drug reactions, and incompatibilities must be immediately reported to the attending	**MM.07.01.03, EP 1** The hospital follows a written process to respond to actual or potential adverse drug events, significant	**MM.17.01.01, EP 2** Medication administration errors, adverse drug reactions, and medication incompatibilities, as defined by the hospital, are

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	physician and, if appropriate, to the hospital's quality assessment and performance improvement program.	adverse drug reactions, and medication errors. Note: This element of performance is also applicable to sample medications. **MM.07.01.03, EP 2** The hospital follows a written process addressing prescriber notification in the event of an adverse drug event, significant adverse drug reaction, or medication error. Note: This element of performance is also applicable to sample medications. **MM.07.01.03, EP 3** The hospital complies with internal and external reporting requirements for actual or potential adverse drug events, significant adverse drug reactions, and medication errors. Note: This element of performance is also applicable to sample medications. **MM.07.01.03, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes: Medication administration errors, adverse drug reactions, and medication incompatibilities as defined by the hospital are immediately reported to the attending physician and as appropriate to the organizationwide quality assessment and performance improvement program. Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). **PI.01.01.01, EP 12**	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 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.

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		The hospital collects data on the following: Significant medication errors. **PI.01.01.01, EP 13** The hospital collects data on the following: Significant adverse drug reactions.	
§482.25(b)(7)	(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.	**MM.01.01.03, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital reports abuses and losses of controlled substances, in accordance with law and regulation, to the individual responsible for the pharmacy department or service and, as appropriate, to the chief executive. Note: This element of performance is also applicable to sample medications.	**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)(8)	(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.	**IM.03.01.01, EP 1** The hospital provides access to knowledge-based information resources 24 hours a day, 7 days a week. **MM.02.01.01, EP 4** 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.	**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)(9)	(9) A formulary system must be established by the medical staff to assure quality pharmaceuticals at reasonable costs.	**MM.02.01.01, EP 1** Members of the medical staff, licensed practitioners, pharmacists, and other staff involved in ordering, dispensing, administering, and/or monitoring the effects	**MM.12.01.01, EP 1** The hospital maintains a formulary that includes medication strength and dosage. The formulary is readily available to those involved in medication management.

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		of medications develop written criteria for determining which medications are available for dispensing or administering to patients. Note: This element of performance is also applicable to sample medications. **MM.02.01.01, EP 2** The hospital develops and approves criteria for selecting medications, which, at a minimum, include the following: - Indications for use - Effectiveness - Drug interactions - Potential for errors and abuse - Adverse drug events - Sentinel event advisories - Population(s) served (for example, pediatrics, geriatrics) - Other risks - Costs Note: This element of performance is also applicable to sample medications. **MM.02.01.01, EP 4** 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.	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.

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§482.26	§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.	**HR.01.01.01, 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 of 1988 (CLIA '88), 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 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital. The provision of care and staff qualifications are in accordance with national acceptable standards of practice and also meet the requirements of 409.17. See Appendix A for 409.17 requirements. 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	**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 services Note 2: Emergency services staff are qualified in emergency care.

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		the Rehabilitation Act of 1973, and Title VI of the Civil Rights Act of 1964. Note 5: For hospitals that use Joint Commission accreditation for deemed status purposes: Staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing. **HR.01.06.01, EP 1** The hospital defines the competencies it requires of its staff who provide patient care, treatment, or services. **LD.01.03.01, EP 3** The governing body approves the hospital's written scope of services. **LD.04.03.01, EP 1** The needs of the population(s) served guide decisions about which services will be provided directly or through referral, consultation, contractual arrangements, or other agreements. Note: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: 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 make sure that the services are immediately available or an agreement needs to be established for transferring patients to a general hospital that participates in the Medicare program. **LD.04.03.01, EP 2** The hospital provides essential services, including the	

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		following: - Diagnostic radiology - Dietary - Emergency - Medical records - Nuclear medicine - Nursing care - Pathology and clinical laboratory - Pharmaceutical - Physical rehabilitation - Respiratory care - Social work Note 1: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The diagnostic radiology services provided by the hospital, as well as staff qualifications, meet professionally approved standards. **LD.04.03.09, EP 2** The hospital describes, in writing, the nature and scope of services provided through contractual agreements. **LD.04.03.09, EP 4**	

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		Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: In most cases, each physician and other licensed practitioner providing services through a contractual agreement must be credentialed and privileged by the hospital using their services following the process described in the "Medical Staff" (MS) chapter. Note 2: For hospitals that do not use Joint Commission accreditation for deemed status purposes: When the hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following: - Verify that all physicians and other licensed practitioners who will be providing patient care, treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges. - Specify in the written agreement that the contracted organization will ensure that all contracted services provided by physicians and other licensed practitioners will be within the scope of their privileges. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders who monitor the contracted services are the governing body. **LD.04.03.09, EP 5** Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services. Note: A written description of the expectations can be provided either as part of the written agreement or in	

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		addition to it. **LD.04.03.09, EP 6** Leaders monitor contracted services by evaluating these services in relation to the hospital's expectations. **LD.04.03.09, EP 7** Leaders take steps to improve contracted services that do not meet expectations. Note: Examples of improvement efforts to consider include the following: - Increase monitoring of the contracted services - Provide consultation or training to the contractor - Renegotiate the contract terms - Apply defined penalties - Terminate the contract **LD.04.03.09, EP 8** When contractual agreements are renegotiated or terminated, the hospital maintains the continuity of patient care.	
§482.26(a)	§482.26(a) Standard: Radiologic Services The hospital must maintain, or have available, radiologic services according to the needs of the patients.	**LD.04.03.01, EP 1** The needs of the population(s) served guide decisions about which services will be provided directly or through referral, consultation, contractual arrangements, or other agreements. Note: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: 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 make sure that the services are immediately available or an agreement needs to be	**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

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		established for transferring patients to a general hospital that participates in the Medicare program. **LD.04.03.01, EP 2** The hospital provides essential services, including the following: - Diagnostic radiology - Dietary - Emergency - Medical records - Nuclear medicine - Nursing care - Pathology and clinical laboratory - Pharmaceutical - Physical rehabilitation - Respiratory care - Social work Note 1: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to "Appendix A: Medicare Requirements for Hospitals" (AXA). Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The diagnostic radiology services provided by the hospital, as well as staff qualifications, meet professionally approved standards.	- 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 services Note 2: Emergency services staff are qualified in emergency care.

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		LD.04.03.09, EP 2 The hospital describes, in writing, the nature and scope of services provided through contractual agreements. **LD.04.03.09, EP 8** When contractual agreements are renegotiated or terminated, the hospital maintains the continuity of patient care.	
§482.26(b)	§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.	**EC.01.01.01, EP 4** The hospital has a written plan for managing the following: The environmental safety of patients and everyone else who enters the hospital's facilities. **EC.01.01.01, EP 6** The hospital has a written plan for managing the following: Hazardous materials and waste. **EC.02.01.01, EP 1** The hospital implements its process to identify safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital's facilities. Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts. **EC.02.01.01, EP 3** The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment.	**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 personal protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers and MRIs). Note 2: Hazardous gases and vapors include but are not limited to ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9)

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		EC.02.02.01, EP 3 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. **EC.02.02.01, EP 7** The hospital minimizes risks associated with selecting and using hazardous energy sources. 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: This includes the use of proper shielding during fluoroscopic procedures. **LD.04.01.07, EP 1** Leaders review, approve, and manage the implementation of policies and procedures that guide and support patient care, treatment, and services.	
§482.26(b)(1)	(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.	**EC.02.02.01, 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. **EC.02.02.01, EP 3** 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.	**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 personal protective equipment to wear

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		EC.02.02.01, EP 6 The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of radioactive materials. **EC.02.02.01, EP 7** The hospital minimizes risks associated with selecting and using hazardous energy sources. 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: This includes the use of proper shielding during fluoroscopic procedures. **EC.02.02.01, EP 8** The hospital minimizes risks associated with disposing of hazardous medications. **EC.02.02.01, EP 11** For managing hazardous materials and waste, the hospital has the permits, licenses, manifests, and safety data sheets required by law and regulation. **EC.02.02.01, EP 12** The hospital labels hazardous materials and waste. Labels identify the contents and hazard warnings. * Footnote *: The Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens and Hazard Communications Standards and the National Fire Protection Association (NFPA) provide details on labeling requirements.	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)

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		EC.02.04.03, EP 1 For hospitals that do not use Joint Commission accreditation for deemed status purposes: Before initial use of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. For hospitals that use Joint Commission accreditation for deemed status purposes: Before initial use and after major repairs or upgrades of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. **EC.02.04.03, EP 3** The hospital inspects, tests, and maintains non-high-risk equipment identified on the medical equipment inventory. These activities are documented. **MM.01.01.03, EP 1** The hospital identifies, in writing, its high-alert and hazardous medications. * Note: This element of performance is also applicable to sample medications. Footnote *: For a list of high-alert medications, see https://www.ismp.org/recommendations. For a list of hazardous drugs, see https://www.cdc.gov/niosh/docs/2016-161/pdfs/2016-161.pdf. **MM.01.01.03, EP 2** The hospital follows a process for managing high-alert and hazardous medications.	

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		Note: This element of performance is also applicable to sample medications.	
§482.26(b)(2)	(2) Periodic inspection of equipment must be made and hazards identified must be promptly corrected.	**EC.02.04.01, EP 2** For hospitals that do not use Joint Commission accreditation for deemed status purposes: The hospital maintains either a written inventory of all medical equipment or a written inventory of selected equipment categorized by physical risk associated with use (including all life-support equipment) and equipment incident history. The hospital evaluates new types of equipment before initial use to determine whether they should be included in the inventory. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital maintains a written inventory of all medical equipment. **EC.02.04.01, EP 4** The hospital identifies the activities and associated frequencies, in writing, for maintaining, inspecting, and testing all medical equipment on the inventory. Note: Activities and associated frequencies for maintaining, inspecting, and testing of medical equipment must have a 100% completion rate. **EC.02.04.03, EP 1** For hospitals that do not use Joint Commission accreditation for deemed status purposes: Before initial use of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. For hospitals that use Joint Commission accreditation	**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 personal protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers and MRIs). Note 2: Hazardous gases and vapors include but are not limited to ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9)

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		for deemed status purposes: Before initial use and after major repairs or upgrades of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. **EC.02.04.03, EP 3** The hospital inspects, tests, and maintains non-high-risk equipment identified on the medical equipment inventory. These activities are documented. **EC.04.01.01, EP 8** Based on its process(es), the hospital reports and investigates the following: Hazardous materials and waste spills and exposures.	
§482.26(b)(3)	(3) Radiation workers must be checked periodically, by the use of exposure meters or badge tests, for amount of radiation exposure.	**EC.02.02.01, EP 3** 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. **EC.02.02.01, EP 7** The hospital minimizes risks associated with selecting and using hazardous energy sources. 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: This includes the use of proper shielding during fluoroscopic procedures. **EC.02.02.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Radiation workers are	**PE.02.01.01, EP 5** Radiation workers are checked periodically, using exposure meters or badge tests, for the amount of radiation exposure.

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		checked periodically, by the use of exposure meters or badge tests, for the amount of radiation exposure.	
§482.26(b)(4)	(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.	**PC.02.01.03, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: 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: Outpatient services may be ordered by a physician or other licensed practitioner not appointed to the medical staff as long as the practitioner meets the following: - Responsible for the care of the patient - Licensed to practice in the state where the practitioner provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements - Acting within the practitioner's 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 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	**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 dietetic 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.

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		staff and acting in accordance with state law governing dietitians and nutrition professionals.	
§482.26(c)	§482.26(c) Standard: Personnel		
§482.26(c)(1)	(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 osteopathy who is qualified by education and experience in radiology.	**LD.04.01.05, EP 3** The hospital defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: This includes the full-time employee who directs and manages dietary services. **MS.01.01.01, EP 36** The medical staff bylaws include the following requirements: If departments of the medical staff exist, the qualifications and roles and responsibilities of the department chair, which are defined by the organized medical staff, include the following: Qualifications: - Certification by an appropriate specialty board or comparable competence affirmatively established through the credentialing process Roles and responsibilities: - Clinically related activities of the department - Administratively related activities of the department, unless otherwise provided by the hospital - Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges - Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided	**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 require a radiologist's specialized knowledge.

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		in the department - Recommending clinical privileges for each member of the department - Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization - Integration of the department or service into the primary functions of the organization - Coordination and integration of interdepartmental and intradepartmental services - Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services - Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services - Determination of the qualifications and competence of department or service staff who provide patient care, treatment, and services but are not licensed to practice independently - Continuous assessment and improvement of the quality of care, treatment, and services - Maintenance of quality control programs, as appropriate - Orientation and continuing education of all persons in the department or service - Recommending space and other resources needed by the department or service Note: For hospitals that use Joint Commission accreditation for deemed status purposes: When departments of the medical staff do not exist, the medical staff is responsible for the development of	

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		policies and procedures that minimize medication errors. The medical staff may delegate this responsibility to the organized pharmaceutical service. **MS.06.01.03, EP 9** 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. **MS.06.01.05, EP 2** The hospital, based on recommendations by the organized medical staff and approval by the governing body, establishes criteria that determine a physician's or other licensed practitioner's ability to provide patient care, treatment, and services within the scope of the privilege(s) requested. Evaluation of all of the following are included in the criteria: - Current licensure and/or certification, as appropriate, verified with the primary source - The applicant's specific relevant training, verified with the primary source - Evidence of physical ability to perform the requested privilege - Data from professional practice review by an organization(s) that currently privileges the applicant (if available) - Peer and/or faculty recommendation - When renewing privileges, review of the physician's or other licensed practitioner's performance within the hospital	

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§482.26(c)(2)	(2) Only personnel designated as qualified by the medical staff may use the radiologic equipment and administer procedures.	**MS.03.01.01, EP 16** 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 HR.01.01.01, EP 32.	**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 HR.11.02.01, EP 7.
§482.26(d)	§482.26(d) Standard: Records Records of radiologic services must be maintained.	**RC.02.01.01, EP 2** The medical record contains the following clinical information: - The reason(s) for admission for care, treatment, and services - The patient's initial diagnosis, diagnostic impression(s), or condition(s) - Any findings of assessments and reassessments - Any allergies to food - Any allergies to medications - Any conclusions or impressions drawn from the patient's medical history and physical examination - Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric hospitals using Joint Commission accreditation for deemed status purposes: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and 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 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

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		- The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival - Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration Note 1: 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. Note 2: For the definition and a further explanation of block charting, refer to the Glossary. - Any access site for medication, administration devices used, and rate of administration - Any adverse drug reactions - Treatment goals, plan of care, and revisions to the plan of care - Results of diagnostic and therapeutic tests and procedures - Any medications dispensed or prescribed on discharge - Discharge diagnosis - Discharge plan and discharge planning evaluation	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.
§482.26(d)(1)	(1) The radiologist or other practitioner who performs radiology services must sign reports of his or her interpretations.	**RC.01.02.01, EP 3** The author of each medical record entry is identified in the medical record. **RC.01.02.01, EP 4** Entries in the medical record are authenticated by the author. Information introduced into the medical record through transcription or dictation is authenticated by the author.	**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

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		Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key. Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or hospital policy. For electronic records, electronic signatures will be date-stamped. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: All orders, including verbal orders, are dated and authenticated by the ordering physician or other licensed practitioner who is responsible for the care of the patient, and who, in accordance with hospital policy; law and regulation; and medical staff bylaws, rules, and regulations, is authorized to write orders. **RC.01.02.01, EP 5** The individual identified by the signature stamp or method of electronic authentication is the only individual who uses it.	- 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, 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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§482.26(d)(2)	(2) The hospital must maintain the following for at least 5 years:	**RC.01.05.01, 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, scans; and other applicable image 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.
§482.26(d)(2)(i)	(i) Copies of reports and printouts	**RC.01.05.01, 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, scans; and other applicable image 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.
§482.26(d)(2)(ii)	(ii) Films, scans, and other image records, as appropriate.	**RC.01.05.01, 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, scans; and other applicable image 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.

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§482.27	§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.	**LD.04.01.01, EP 1** The hospital is licensed, is certified, or has a permit, in accordance with law and regulation, to provide the care, treatment, or services for which the hospital is seeking accreditation from The Joint Commission. Note 1: Each service location that performs laboratory testing (waived or nonwaived) must have a Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate as specified by the federal CLIA regulations (42 CFR 493.55 and 493.3) and applicable state law. Laboratory services meet the applicable requirements at 42 CFR 482.27. Note 2: For more information on how to obtain a CLIA certificate, see http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_Certificate_International_Laboratories.html. **LD.04.01.01, EP 2** The hospital provides care, treatment, and services in accordance with licensure requirements, laws, and 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). (See Appendix A [AXA] for the language of this CMS requirement.) **LD.04.03.01, EP 1** The needs of the population(s) served guide decisions about which services will be provided directly or through referral, consultation, contractual arrangements, or other agreements.	**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.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Note: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: 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 make sure that the services are immediately available or an agreement needs to be established for transferring patients to a general hospital that participates in the Medicare program. **LD.04.03.01, EP 2** The hospital provides essential services, including the following: - Diagnostic radiology - Dietary - Emergency - Medical records - Nuclear medicine - Nursing care - Pathology and clinical laboratory - Pharmaceutical - Physical rehabilitation - Respiratory care - Social work Note 1: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to “Appendix	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		A: Medicare Requirements for Hospitals" (AXA). Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The diagnostic radiology services provided by the hospital, as well as staff qualifications, meet professionally approved standards.	
§482.27(a)	§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.	**LD.04.01.01, EP 1** The hospital is licensed, is certified, or has a permit, in accordance with law and regulation, to provide the care, treatment, or services for which the hospital is seeking accreditation from The Joint Commission. Note 1: Each service location that performs laboratory testing (waived or nonwaived) must have a Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate as specified by the federal CLIA regulations (42 CFR 493.55 and 493.3) and applicable state law. Laboratory services meet the applicable requirements at 42 CFR 482.27. Note 2: For more information on how to obtain a CLIA certificate, see http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_Certificate_International_Laboratories.html. **LD.04.03.01, EP 2** The hospital provides essential services, including the following: - Diagnostic radiology - Dietary - Emergency - Medical records - Nuclear medicine - Nursing care - Pathology and clinical laboratory	**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.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Pharmaceutical - Physical rehabilitation - Respiratory care - Social work Note 1: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to "Appendix A: Medicare Requirements for Hospitals" (AXA). Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The diagnostic radiology services provided by the hospital, as well as staff qualifications, meet professionally approved standards. **LD.04.03.09, EP 2** The hospital describes, in writing, the nature and scope of services provided through contractual agreements. **LD.04.03.09, EP 4** Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: In most cases, each physician and other licensed practitioner providing services through a contractual agreement must be credentialed and privileged by the hospital using their services following the process described in the "Medical Staff" (MS)	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		chapter. Note 2: For hospitals that do not use Joint Commission accreditation for deemed status purposes: When the hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following: - Verify that all physicians and other licensed practitioners who will be providing patient care, treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges. - Specify in the written agreement that the contracted organization will ensure that all contracted services provided by physicians and other licensed practitioners will be within the scope of their privileges. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders who monitor the contracted services are the governing body. **LD.04.03.09, EP 10** Reference and contract laboratory services meet the federal regulations for clinical laboratories and maintain evidence of the same. Note: For law and regulation guidance on the Clinical Laboratory Improvement Amendments of 1988, refer to 42 CFR 493.	
§482.27(a)(1)	(1) Emergency laboratory services must be available 24 hours a day.	**LD.04.03.01, EP 26** For hospitals that use Joint Commission accreditation for deemed status purposes: Emergency laboratory services are available 24 hours a day, 7 days a week.	**LD.13.03.01, EP 13** Emergency laboratory services are available 24 hours a day, 7 days a week.
§482.27(a)(2)	(2) A written description of services provided must be available to the medical staff.	**LD.01.03.01, EP 3** The governing body approves the hospital's written scope of services.	**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.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		LD.04.03.09, EP 2 The hospital describes, in writing, the nature and scope of services provided through contractual agreements.	
§482.27(a)(3)	(3) The laboratory must make provision for proper receipt and reporting of tissue specimens.	**PC.03.01.08, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The laboratory follows written policies and procedures for collecting, preserving, transporting, receiving, and reporting examination results for tissue specimens.	**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)(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.	**PC.03.01.08, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The laboratory follows 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.	**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(b)	§482.27(b) Standard: Potentially Infectious Blood and Blood Components		
§482.27(b)(1)	(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)	(i) Who tested negative at the time of donation but tests reactive for evidence of HIV infection on a later donation;	**PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for	**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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Hospitals" appendix. **PC.05.01.09, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	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)(1)(ii)	(ii) Who tests positive on the supplemental (additional, more specific) test or other follow-up testing required by FDA; and	**PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. **PC.05.01.09, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	**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)(1)(iii)	(iii) For whom the timing of seroconversion cannot be precisely estimated.	**PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written	**PC.15.01.01, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital develops and implements written

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. **PC.05.01.09, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	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)(2)	(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.	**PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. **PC.05.01.09, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42	**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.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	
§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 --	**LD.04.03.09, EP 2** The hospital describes, in writing, the nature and scope of services provided through contractual agreements. **LD.04.03.09, EP 4** Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: In most cases, each physician and other licensed practitioner providing services through a contractual agreement must be credentialed and privileged by the hospital using their services following the process described in the “Medical Staff” (MS) chapter. Note 2: For hospitals that do not use Joint Commission accreditation for deemed status purposes: When the hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following: - Verify that all physicians and other licensed practitioners who will be providing patient care, treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges. - Specify in the written agreement that the contracted organization will ensure that all contracted services provided by physicians and other licensed practitioners will be within the scope of their privileges. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders who monitor the contracted services are the governing body.	**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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		LD.04.03.09, EP 5 Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services. Note: A written description of the expectations can be provided either as part of the written agreement or in addition to it. **PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. **PC.05.01.09, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	
§482.27(b)(3)(i)	(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	**LD.04.03.09, EP 2** The hospital describes, in writing, the nature and scope of services provided through contractual agreements. **LD.04.03.09, EP 4**	**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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	infection on a later donation or who is determined to be at increased risk for transmitting HIV or HCV infection;	Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: In most cases, each physician and other licensed practitioner providing services through a contractual agreement must be credentialed and privileged by the hospital using their services following the process described in the "Medical Staff" (MS) chapter. Note 2: For hospitals that do not use Joint Commission accreditation for deemed status purposes: When the hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following: - Verify that all physicians and other licensed practitioners who will be providing patient care, treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges. - Specify in the written agreement that the contracted organization will ensure that all contracted services provided by physicians and other licensed practitioners will be within the scope of their privileges. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders who monitor the contracted services are the governing body. **LD.04.03.09, EP 5** Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services. Note: A written description of the expectations can be provided either as part of the written agreement or in	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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		addition to it. **PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. **PC.05.01.09, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	
§482.27(b)(3)(ii)	(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;	**LD.04.03.09, EP 2** The hospital describes, in writing, the nature and scope of services provided through contractual agreements. **LD.04.03.09, EP 4** Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: In most cases, each physician and other licensed practitioner providing services through a contractual agreement must be credentialed and privileged by the hospital using their services following	**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

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		the process described in the "Medical Staff" (MS) chapter. Note 2: For hospitals that do not use Joint Commission accreditation for deemed status purposes: When the hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following: - Verify that all physicians and other licensed practitioners who will be providing patient care, treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges. - Specify in the written agreement that the contracted organization will ensure that all contracted services provided by physicians and other licensed practitioners will be within the scope of their privileges. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders who monitor the contracted services are the governing body. **LD.04.03.09, EP 5** Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services. Note: A written description of the expectations can be provided either as part of the written agreement or in addition to it. **PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at	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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. **PC.05.01.09, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	
§482.27(b)(3)(iii)	(iii) Within 3 calendar days after the blood collecting establishment supplied blood and blood components collected from an infectious donor, whenever records are available.	**LD.04.03.09, EP 2** The hospital describes, in writing, the nature and scope of services provided through contractual agreements. **LD.04.03.09, EP 4** Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: In most cases, each physician and other licensed practitioner providing services through a contractual agreement must be credentialed and privileged by the hospital using their services following the process described in the “Medical Staff” (MS) chapter. Note 2: For hospitals that do not use Joint Commission accreditation for deemed status purposes: When the hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following:	**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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Verify that all physicians and other licensed practitioners who will be providing patient care, treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges. - Specify in the written agreement that the contracted organization will ensure that all contracted services provided by physicians and other licensed practitioners will be within the scope of their privileges. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders who monitor the contracted services are the governing body. **LD.04.03.09, EP 5** Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services. Note: A written description of the expectations can be provided either as part of the written agreement or in addition to it. **PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. **PC.05.01.09, EP 2** For hospitals that use Joint Commission accreditation	supplied blood and blood components collected from an infectious donor, whenever records are available

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	
§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.	**PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. **PC.05.01.09, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	**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)(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	**PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42	**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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	blood and blood components from quarantine.	CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. **PC.05.01.09, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	there are no other informative test results, the hospital may release the blood and blood components from quarantine.
§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; and	**PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. **PC.05.01.09, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27.	**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: - Disposes of the blood and blood components - Notifies the transfusion recipients as set forth in 42 CFR 482.27(b)(6)

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		Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	
§482.27(b)(4)(ii)(B)	(B) Notify the transfusion recipients as set forth in paragraph (b)(6) of this section.	**PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. **PC.05.01.09, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	**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: - Disposes of the blood and blood components - Notifies the transfusion recipients as set forth in 42 CFR 482.27(b)(6)
§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).	**PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. **PC.05.01.09, EP 2**	**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).

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		For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	
§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	**PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. **PC.05.01.09, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	**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)(ii)	(ii) A fully funded plan to transfer these records to another hospital or other entity if such hospital ceases operation for any reason.	**PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially	**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

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		infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. **PC.05.01.09, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	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)(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 ask 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	**PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	**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

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	be a need for HIV or HCV testing and counseling.	**PC.05.01.09, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	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 - Documents in the patient's medical record the notification or attempts to give the required notification
§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, legal guardian or relative.	**PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. **PC.05.01.09, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	**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 - Documents in the patient's medical record the notification or attempts to give the required notification
§482.27(b)(6)(iii)	(iii) Document in the patient's medical record the notification or attempts to give the required notification.	**PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written	**PC.15.01.01, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes: When potentially human immunodeficiency virus

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		policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. **PC.05.01.09, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	(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 - Documents in the patient's medical record the notification or attempts to give the required notification
§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—	**PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. **PC.05.01.09, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27.	**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.

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		Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	
§482.27(b)(7)(i)	(i) The patient is located and notified; or	**PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. **PC.05.01.09, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	**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)(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.	**PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. **PC.05.01.09, EP 2**	**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.

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		For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	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)(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.	**PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. **PC.05.01.09, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	**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 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.	**PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially	**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

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		infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. **PC.05.01.09, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	following: - Oral or written information explaining the need for HIV or HCV testing and 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)(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.	**PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. **PC.05.01.09, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42	**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 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

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		CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	
§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.	**PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	**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)(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.	**PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. **PC.05.01.09, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42	**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

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		CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	
§482.27(c)	§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.	**PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. **PC.05.01.09, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	**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 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.	**PC.05.01.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27.	**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

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		Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. **PC.05.01.09, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix.	blood and blood components Note: This applies to lookback activities only related to new blood safety issues that are identified after August 24, 2007.
§482.28	§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.	**HR.01.01.01, 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 of 1988 (CLIA '88), 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	**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

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		audiologists (as defined in 42 CFR 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital. The provision of care and staff qualifications are in accordance with national acceptable standards of practice and also meet the requirements of 409.17. See Appendix A for 409.17 requirements. 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. Note 5: For hospitals that use Joint Commission accreditation for deemed status purposes: Staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing. **HR.01.01.01, EP 2** The hospital verifies and documents the following: - Credentials of staff using the primary source when licensure, certification, or registration is required by law and regulation to practice their profession. 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,	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.

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		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. **HR.01.01.01, EP 3** The hospital verifies and documents that the applicant has the education and experience required by the job responsibilities. **HR.01.02.05, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a qualified dietitian on a full-time, part-time, or consultative basis. **LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.04.01.05, EP 2** Programs, services, sites, or departments providing patient care are directed by one or more qualified	

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		professionals or by a qualified licensed practitioner with clinical privileges. **LD.04.01.05, EP 3** The hospital defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: This includes the full-time employee who directs and manages dietary services. **LD.04.03.01, EP 2** The hospital provides essential services, including the following: - Diagnostic radiology - Dietary - Emergency - Medical records - Nuclear medicine - Nursing care - Pathology and clinical laboratory - Pharmaceutical - Physical rehabilitation - Respiratory care - Social work Note 1: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital	

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		complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to "Appendix A: Medicare Requirements for Hospitals" (AXA). Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The diagnostic radiology services provided by the hospital, as well as staff qualifications, meet professionally approved standards. **LD.04.03.09, EP 1** Clinical leaders and medical staff have an opportunity to provide advice about the sources of clinical services to be provided through contractual agreement. **LD.04.03.09, EP 2** The hospital describes, in writing, the nature and scope of services provided through contractual agreements. **LD.04.03.09, EP 3** Designated leaders approve contractual agreements. **LD.04.03.09, EP 4** Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: In most cases, each physician and other licensed practitioner providing services through a contractual agreement must be credentialed and privileged by the hospital using their services following the process described in the "Medical Staff" (MS) chapter. Note 2: For hospitals that do not use Joint Commission accreditation for deemed status purposes: When the	

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		hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following: - Verify that all physicians and other licensed practitioners who will be providing patient care, treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges. - Specify in the written agreement that the contracted organization will ensure that all contracted services provided by physicians and other licensed practitioners will be within the scope of their privileges. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders who monitor the contracted services are the governing body. **LD.04.03.09, EP 5** Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services. Note: A written description of the expectations can be provided either as part of the written agreement or in addition to it. **LD.04.03.09, EP 6** Leaders monitor contracted services by evaluating these services in relation to the hospital's expectations. **LD.04.03.09, EP 7** Leaders take steps to improve contracted services that do not meet expectations. Note: Examples of improvement efforts to consider include the following:	

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		- Increase monitoring of the contracted services - Provide consultation or training to the contractor - Renegotiate the contract terms - Apply defined penalties - Terminate the contract	
§482.28(a)	§482.28(a) Standard: Organization		
§482.28(a)(1)	(1) The hospital must have a full-time employee who–	**LD.04.01.05, EP 3** The hospital defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: This includes the full-time employee who directs and manages dietary services.	
§482.28(a)(1)(i)	(i) Serves as director of the food and dietetic services;	**LD.04.01.05, EP 2** Programs, services, sites, or departments providing patient care are directed by one or more qualified professionals or by a qualified licensed practitioner with clinical privileges. **LD.04.01.05, EP 3** The hospital defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: This includes the full-time employee who directs and manages dietary services.	**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)(1)(ii)	(ii) Is responsible for daily management of the dietary services; and	**LD.04.01.05, EP 2** Programs, services, sites, or departments providing patient care are directed by one or more qualified professionals or by a qualified licensed practitioner with clinical privileges.	**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.

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		LD.04.01.05, EP 3 The hospital defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: This includes the full-time employee who directs and manages dietary services.	
§482.28(a)(1)(iii)	(iii) Is qualified by experience or training.	**HR.01.01.01, 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 of 1988 (CLIA '88), 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 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital. The provision of	**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.

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		care and staff qualifications are in accordance with national acceptable standards of practice and also meet the requirements of 409.17. See Appendix A for 409.17 requirements. 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. Note 5: For hospitals that use Joint Commission accreditation for deemed status purposes: Staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing. **HR.01.01.01, EP 3** The hospital verifies and documents that the applicant has the education and experience required by the job responsibilities. **LD.04.01.05, EP 2** Programs, services, sites, or departments providing patient care are directed by one or more qualified professionals or by a qualified licensed practitioner with clinical privileges. **LD.04.01.05, EP 3** The hospital defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments. Note: For hospitals that use Joint Commission	

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		accreditation for deemed status purposes: This includes the full-time employee who directs and manages dietary services.	
§482.28(a)(2)	(2) There must be a qualified dietitian, full-time, part-time or on a consultant basis.	**HR.01.01.01, 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 of 1988 (CLIA '88), 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 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital. The provision of care and staff qualifications are in accordance with national acceptable standards of practice and also meet the requirements of 409.17. See Appendix A for 409.17 requirements. Note 4: Qualifications for language interpreters and translators may be met through language proficiency	**NPG.12.01.01, EP 9** The hospital has a qualified dietitian on a full-time, part-time, or consultative basis.

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		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: For hospitals that use Joint Commission accreditation for deemed status purposes: Staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing. **HR.01.01.01, EP 3** The hospital verifies and documents that the applicant has the education and experience required by the job responsibilities. **HR.01.02.05, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a qualified dietitian on a full-time, part-time, or consultative basis. **LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered.	
§482.28(a)(3)	(3) There must be administrative and technical personnel competent in their respective duties.	**HR.01.06.01, EP 1** The hospital defines the competencies it requires of its staff who provide patient care, treatment, or services. **HR.01.06.01, EP 5**	**HR.11.01.01, EP 1** The hospital's food and dietetic services administrative and technical staff are competent to perform their responsibilities.

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		Staff competence is initially assessed and documented as part of orientation. **HR.01.06.01, EP 6** Staff competence is assessed and documented once every three years, or more frequently as required by hospital policy or in accordance with law and regulation.	
§482.28(b)	§482.28(b) Standard: Diets Menus must meet the needs of the patients.	**PC.02.02.03, EP 7** Food and nutrition products are consistent with each patient's care, treatment, and services.	**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)(1)	(1) Individual patient nutritional needs must be met in accordance with recognized dietary practices.	**HR.01.02.05, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a qualified dietitian on a full-time, part-time, or consultative basis. **LD.03.10.01, EP 3** When clinical practice guidelines will be used in the design or modification of processes, the following occurs: - The hospital follows criteria to manage guideline selection and implementation. - The leaders of the hospital and the organized medical staff review, approve, and modify the clinical practice guidelines as needed. - The leaders of the hospital manage and evaluate the implementation of the guidelines. **PC.01.02.01, EP 3** The hospital has defined criteria that identify when nutritional plans are developed.	**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.

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		PC.01.03.01, EP 1 The hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. **PC.02.02.03, EP 7** Food and nutrition products are consistent with each patient's care, treatment, and services. **PC.02.02.03, EP 22** For hospitals that use Joint Commission accreditation for deemed status purposes: A current therapeutic diet manual approved by the dietitian and medical staff is available to all medical, nursing, and food service staff.	
§482.28(b)(2)	(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.	**PC.02.01.03, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: 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: Outpatient services may be ordered by a physician or other licensed practitioner not appointed to the medical staff as long as the practitioner meets the following: - Responsible for the care of the patient - Licensed to practice in the state where the practitioner provides care to the patient or in accordance with Veterans Administration and Department of Defense	**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 dietetic 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.

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		licensure requirements - Acting within the practitioner's 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 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. **PC.02.01.03, EP 7** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital provides care, treatment, and services using the most recent patient order(s).	
§482.28(b)(3)	(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.	**PC.02.02.03, EP 22** For hospitals that use Joint Commission accreditation for deemed status purposes: A current therapeutic diet manual approved by the dietitian and medical staff is available to all medical, nursing, and food service staff.	**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.
§482.30	§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	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30	**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

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	the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.	that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	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(a)	§482.30(a) Standard: Applicability The provisions of this section apply except in either of the following circumstances:		
§482.30(a)(1)	(1) A Utilization and Quality Control Quality Improvement Organization (QIO) has assumed binding review for the hospital.	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: 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	**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

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		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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	review plan requirements under 42 CFR 456.50 through 42 CFR 456.245.
§482.30(a)(2)	(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.	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.	**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

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		Note 1: 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	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.

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§482.30(b)	§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).	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself 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	**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 in 42 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 who was professionally involved in the care of the patient whose case is being reviewed.

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		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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	
§482.30(b)(1)	(1) Except as specified in paragraphs (b)(2) and (3) of this section, the UR committee must be one of the following:		
§482.30(b)(1)(i)	(i) A staff committee of the institution;	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation	**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 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 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).

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		for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	
§482.30(b)(1)(ii)	(ii) A group outside the institution--	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: 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	**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 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 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).

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		CFR 456.50 through 42 CFR 456.245. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	
§482.30(b)(1)(ii)(A)	(A) Established by the local medical society and some or all of the hospitals in the locality; or	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: The hospital does not need to have a utilization review plan if either a Quality Improvement Organization	**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 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 hospital, it is impracticable to have a properly functioning staff committee, the

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		(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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	utilization review committee is established by a group outside the hospital, as specified in 42 CFR 482.30(b)(1)(ii).
§482.30(b)(1)(ii)(B)	(B) Established in a manner approved by CMS.	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation	**LD.13.01.03, EP 3** For hospitals that use Joint Commission accreditation for deemed

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		for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself 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	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 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 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).

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		utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	
§482.30(b)(2)	(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	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself if either a Quality	**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 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 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).

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	
§482.30(b)(3)	(3) The committee or group’s reviews may not be conducted by any individual who--		**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 in 42 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 who was professionally involved in the care of the patient whose case is being reviewed.
§482.30(b)(3)(i)	(i) Has a direct financial interest (for example, an ownership interest) in that hospital; or	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: 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	**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 in 42 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

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		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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	ownership interest) in that hospital or who was professionally involved in the care of the patient whose case is being reviewed.
§482.30(b)(3)(ii)	(ii) Was professionally involved in the care of the patient whose case is being reviewed.	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a	**LD.13.01.03, EP 4** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital’s utilization review committee

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself 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	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 in 42 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 who was professionally involved in the care of the patient whose case is being reviewed.

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		456.50 through 42 CFR 456.245. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	
§482.30(c)	§482.30(c) Standard: Scope and Frequency of Review		
§482.30(c)(1)	(1) The UR plan must provide for review for Medicare and Medicaid patients with respect to the medical necessity of--		**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.
§482.30(c)(1)(i)	(i) Admissions to the institution;	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: 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	**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.

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		meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	
§482.30(c)(1)(ii)	(ii) The duration of stays; and	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: The hospital does not need to have a utilization	**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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	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.

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§482.30(c)(1)(iii)	(iii) Professional services furnished including drugs and biologicals.	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself 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	**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.

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		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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	
§482.30(c)(2)	(2) Review of admissions may be performed before, at, or after hospital admission.	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan.	**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.

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		Note 1: The hospital does not need to implement utilization review activities itself 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	
§482.30(c)(3)	(3) Except as specified in paragraph (e) of this section, reviews may be conducted on a sample basis.	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare	**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.

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		Requirements for Hospitals" (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to "Appendix A: Medicare Requirements for Hospitals" (AXA).	
§482.30(c)(4)	(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:		**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 outlier cases based on extraordinarily high costs, as described in 42 CFR 412.80(a)(1)(ii).

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§482.30(c)(4)(i)	(i) 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	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself 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	**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 outlier cases based on extraordinarily high costs, as described in 42 CFR 412.80(a)(1)(ii).

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		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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	
§482.30(c)(4)(ii)	(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.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan.	**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 outlier cases based on extraordinarily high costs, as described in 42 CFR 412.80(a)(1)(ii).

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		Note 1: The hospital does not need to implement utilization review activities itself 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	
§482.30(d)	§482.30(d) Standard: Determination Regarding Admissions or Continued Stays		
§482.30(d)(1)	(1) The determination that an admission or continued stay is not medically necessary-		
§482.30(d)(1)(i)	(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	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: 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	**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), concurs with the determination or fails 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 patient’s care, as

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		meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	specified in 42 CFR 482.12(c), and affords the practitioner(s) the opportunity to present their views.
§482.30(d)(1)(ii)	(ii) Must be made by at least two members of the UR committee in all other cases.	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: The hospital does not need to have a utilization	**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), concurs with the determination or fails to present

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		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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	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 patient’s care, as specified in 42 CFR 482.12(c), and affords the practitioner(s) the opportunity to present their views.

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§482.30(d)(2)	(2) Before making a determination that an admission or continued stay is not medically 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.	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself 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	**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), concurs with the determination or fails 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 patient’s care, as specified in 42 CFR 482.12(c), and affords the practitioner(s) the opportunity to present their views.

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		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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	
§482.30(d)(3)	(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);	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan.	**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.

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		Note 1: The hospital does not need to implement utilization review activities itself 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	
§482.30(e)	§482.30(e) Standard: Extended Stay Review		
§482.30(e)(1)	(1) In hospitals that are not paid under the prospective payment system, the UR committee must make a periodic review, as specified in the UR plan, or each current inpatient receiving hospital services during a continuous period of extended duration. The scheduling of the periodic reviews may--	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: 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. Note 2: For guidance regarding the requirements at 42	**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.

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		CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	
§482.30(e)(1)(i)	(i) Be the same for all cases; or	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: 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)	**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.

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		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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	
§482.30(e)(1)(ii)	(ii) Differ for different classes of cases.	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30	**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)

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		that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself 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.	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.

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		Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	
§482.30(e)(2)	(2) In hospitals paid under the prospective payment system, the UR committee must review 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.	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself if either a Quality Improvement Organization (QIO) has assumed binding review for the hospital or the Centers for Medicare	**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 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.

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		& 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	
§482.30(e)(3)	(3) The UR committee must make the periodic review no later than 7 days after the day required in the UR plan.	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation	**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 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.

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		for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	
§482.30(f)	§482.30(f) Standard: Review of Professional Services The committee must review professional services provided, to determine medical necessity and to promote the most efficient use of available health facilities and services.	**LD.04.01.01, EP 17** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: 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	**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.

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		CFR 456.50 through 42 CFR 456.245. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). **LD.04.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself 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. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA).	
§482.41	§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.	**EC.02.05.01, EP 1** The hospital designs and installs utility systems according to National Fire Protection Association codes to meet patient care and operational needs. **EC.02.06.01, EP 1** Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.	**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

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		EC.02.06.01, EP 11 Lighting is suitable for care, treatment, and services. **EC.02.06.01, EP 20** Areas used by patients are clean and free of offensive odors. **EC.02.06.01, EP 26** The hospital keeps furnishings and equipment safe and in good repair. **EC.02.06.05, EP 1** When planning for new, altered, or renovated space, the hospital uses one of the following design criteria: - State rules and regulations - The most current edition of the Guidelines for Design and Construction of Hospitals published by the Facility Guidelines Institute When the above rules, regulations, and guidelines do not meet specific design needs, use other reputable standards and guidelines that provide equivalent design criteria. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital complies with National Fire Protection Association requirements, including emergency generator location requirements as follows: - Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6) - Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4)	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.

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		- NFPA 110-2010 when a new structure is built or when an existing structure or building is renovated **EC.02.06.05, EP 2** When planning for demolition, construction, renovation, or general maintenance, the hospital conducts a preconstruction risk assessment for air quality requirements, infection control, utility requirements, noise, vibration, and other hazards that affect care, treatment, and services. Note: See LS.01.02.01 for information on fire safety procedures to implement during construction or renovation. **EC.02.06.05, EP 3** The hospital takes action based on its assessment to minimize risks during demolition, construction, renovation, or general maintenance.	
§482.41(a)	§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 that the safety and well-being of patients are assured.	**EC.01.01.01, EP 4** The hospital has a written plan for managing the following: The environmental safety of patients and everyone else who enters the hospital's facilities. **EC.01.01.01, EP 6** The hospital has a written plan for managing the following: Hazardous materials and waste. **EC.01.01.01, EP 7** The hospital has a written plan for managing the following: Fire safety. **EC.01.01.01, EP 8** The hospital has a written plan for managing the	**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**

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		following: Medical equipment. **EC.01.01.01, EP 9** The hospital has a written plan for managing the following: Utility systems. Note: In circumstances where the program or service is located in a business occupancy not owned by the accredited organization, the plan may only need to address how routine service and maintenance for their utility systems are obtained. **EC.02.01.01, EP 1** The hospital implements its process to identify safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital's facilities. Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts. **EC.02.01.01, EP 3** The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment. **EC.02.01.01, EP 5** The hospital maintains all grounds and equipment. **EC.02.01.01, EP 11** The hospital responds to product notices and recalls.	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. **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.

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		EC.02.02.01, 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. **EC.02.02.01, EP 3** 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. **EC.02.02.01, EP 4** The hospital implements its procedures in response to hazardous material and waste spills or exposures. **EC.02.02.01, EP 5** The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemicals. **EC.02.02.01, EP 8** The hospital minimizes risks associated with disposing of hazardous medications. **EC.02.02.01, EP 10** The hospital monitors levels of hazardous gases and vapors to determine that they are in safe range. Note: Law and regulation determine the frequency of monitoring hazardous gases and vapors as well as acceptable ranges.	

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		EC.02.02.01, EP 11 For managing hazardous materials and waste, the hospital has the permits, licenses, manifests, and safety data sheets required by law and regulation. **EC.02.02.01, EP 12** The hospital labels hazardous materials and waste. Labels identify the contents and hazard warnings. * Footnote *: The Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens and Hazard Communications Standards and the National Fire Protection Association (NFPA) provide details on labeling requirements. **EC.02.04.01, EP 9** The hospital has written procedures to follow when medical equipment fails, including using emergency clinical interventions and backup equipment. **EC.02.05.01, EP 9** 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	

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		additional guidance, see NFPA 101-2012: 18/19.3.4.1; 9.6.1.3; NFPA 72-2010: 10.5.5.2. **EC.02.05.01, EP 10** The hospital has written procedures for responding to utility system disruptions. **EC.02.05.01, EP 11** The hospital's procedures address shutting off the malfunctioning system and notifying staff in affected areas. **EC.02.05.01, EP 12** The hospital's procedures address performing emergency clinical interventions during utility system disruptions. **EC.02.05.01, EP 13** The hospital responds to utility system disruptions as described in its procedures. **EC.02.05.01, EP 17** The hospital maps the distribution of its utility systems. **EC.02.06.01, EP 1** Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided. **EC.02.06.01, EP 26** The hospital keeps furnishings and equipment safe and in good repair.	

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		EC.04.01.01, EP 15 Every 12 months, the hospital evaluates each environment of care management plan, including a review of the plan's objectives, scope, performance, and effectiveness. **EC.04.01.03, EP 2** The hospital uses the results of data analysis to identify opportunities to resolve environmental safety issues. **EC.04.01.05, EP 1** The hospital takes action on the identified opportunities to resolve environmental safety issues.	
§482.41(a)(1)	(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.	**EC.02.05.03, EP 2** The hospital provides emergency power within 10 seconds for the following: Alarm systems, as required by the Life Safety Code. Note: For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99-2012: 6.4.1.1; 6.4.2.2; NFPA 110-2010: 4.1; Table 4.1(b). **EC.02.05.03, EP 3** The hospital provides emergency power within 10 seconds for the following: Exit route and exit sign illumination, as required by the Life Safety Code. Note: For guidance in establishing a reliable emergency system (that is, an essential electrical distribution system), see NFPA 99-2012: 6.4.1.1; 6.4.2.2; NFPA 110-2010: 4.1; Table 4.1(b). **EC.02.05.03, EP 4** New buildings equipped with or requiring the use of life	**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.

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		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. (For full text, refer to NFPA 101-2012: 18.2.9.2; 18.2.10.5; NFPA 99-2012: 6.4.2.2) **EC.02.05.03, EP 5** The hospital provides emergency power within 10 seconds for the following: Emergency communication systems, as required by the Life Safety Code. Note: For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99-2012: 6.4.2.2; NFPA 110-2010: 4.1; Table 4.1(b). **EC.02.05.03, EP 6** The hospital provides emergency power within 10 seconds for the following: Equipment that could cause patient harm when it fails, including life-support systems; blood, bone, and tissue storage systems; medical air compressors; and medical and surgical vacuum systems. Note: For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99-2012: 6.4.1.1; 6.4.2.2; NFPA 110-2010: 4.1; Table 4.1(b). **EC.02.05.03, EP 7** The hospital provides emergency power within 10 seconds for the following: Areas in which loss of power could result in patient harm, including intensive care,	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		emergency rooms, operating rooms, recovery rooms, obstetrical delivery rooms, and nurseries. Note: For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99-2012: 6.4.1.1; 6.4.2; NFPA 110-2010: 4.1; Table 4.1(b). **EC.02.05.03, EP 12** Equipment designated to be powered by emergency power supply is energized by the hospital's design. Staging of equipment startup is permissible. (For full text, refer to NFPA 99-2012: 6.4.2.2) **EC.02.05.03, EP 13** The hospital provides emergency power for elevators selected to provide service to patients during interruption of normal power (at least one for nonambulatory patients). Note: For guidance in establishing a reliable emergency power system for the equipment branch (that is, an essential electrical distribution system), refer to NFPA 99-2012: 6.4.2.2. **EC.02.05.03, EP 16** For hospitals that use Joint Commission accreditation for deemed status purposes: Battery lamps and flashlights are available in areas not serviced by the emergency supply source.	
§482.41(a)(2)	(2) There must be facilities for emergency gas and water supply.	**EC.02.05.01, EP 10** The hospital has written procedures for responding to utility system disruptions. **EC.02.05.01, EP 11**	**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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		The hospital's procedures address shutting off the malfunctioning system and notifying staff in affected areas. **EC.02.05.01, EP 12** The hospital's procedures address performing emergency clinical interventions during utility system disruptions. **EC.02.05.01, EP 13** The hospital responds to utility system disruptions as described in its procedures.	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(b)	§482.41(b) Standard: Life Safety from Fire The hospital must ensure that the life safety from fire requirements are met.	**EC.02.03.01, EP 1** The hospital minimizes the potential for harm from fire, smoke, and other products of combustion. **EC.02.03.01, EP 4** The hospital maintains free and unobstructed access to all exits. Note: This requirement applies to all buildings classified as business occupancy. The "Life Safety" (LS) chapter addresses the requirements for all other occupancy types.	**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 health and safety of the patients. Note 4: All inspecting activities are documented with the name of

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			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(b)(1)	(1) Except as otherwise provided in this section—		
§482.41(b)(1)(i)	(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.	**EC.02.03.03, EP 1** The hospital conducts fire drills once per shift per quarter in each building defined as a health care occupancy by the Life Safety Code. The hospital conducts quarterly fire drills in each building defined as an ambulatory health care occupancy by the Life Safety Code. Note 1: Evacuation of patients during drills is not required. Note 2: When drills are conducted between 9:00 P.M. and 6:00 A.M., the hospital may use a coded announcement to notify staff instead of activating audible alarms. For full text, refer to NFPA 101-2012: 18/19: 7.1.7. Note 3: In leased or rented facilities, drills need be conducted only in areas of the building that the hospital occupies. **EC.02.03.03, EP 3** When quarterly fire drills are required, they are unannounced and held at unexpected times and under varying conditions. Fire drills include transmission of fire alarm signal and simulation of emergency fire conditions. Note 1: When drills are conducted between 9:00 P.M. and 6:00 A.M., the hospital may use a coded announcement to notify staff instead of activating	**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 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.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		audible alarms. Note 2: Fire drills vary by at least one hour for each shift from quarter to quarter, through four consecutive quarters. Note 3: For full text, refer to NFPA 101-2012: 18/19: 7.1; 7.1.7; 7.2; 7.3. **EC.02.03.03, EP 4** Staff who work in buildings where patients are housed or treated participate in drills according to the hospital's fire response plan. **EC.02.03.03, EP 5** The hospital critiques fire drills to evaluate fire safety equipment, fire safety building features, and staff response to fire. The evaluation is documented. **EC.02.03.03, EP 7** The hospital conducts annual fire exit drills for operating rooms/surgical suites. (For full text, refer to NFPA 99-2012: 15.13.3.10.3) Note 1: This drill involves applicable staff and focuses on prevention as well as simulated extinguishment and evacuation. Note 2: An announced annual fire exit drill cannot be used to meet one of the unannounced quarterly fire drills required by NFPA 101-2012: 18/19.7.1.6. **EC.02.03.03, EP 8** For hospitals that have hyperbaric facilities, emergency procedures and fire training drills are conducted annually. (For full text, refer to NFPA 99-2012: 14.2.4.5.4; 14.3.1.4.5)	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Note 1: This drill includes recording the time to evacuate all persons from the area, involves applicable staff, and focuses on prevention as well as simulated extinguishment and evacuation. Response procedures for fires within and outside the hyperbaric chamber address the role of the inside observer, the chamber operator, medical personnel, and other personnel, as applicable. For additional guidance, refer to NFPA 99-2012: B.14.2 and B.14.3. Note 2: If the hospital conducts an unannounced drill, it may serve as one of the required fire drills. **EC.02.03.05, EP 28** Documentation of maintenance, testing, and inspection activities for Standard EC.02.03.05, EPs 1–20, 25 (including fire alarm and fire protection systems) includes the following: - Name of the activity - Date of the activity - Inventory of devices, equipment, or other items - Required frequency of the activity - Name and contact information, including affiliation, of the person who performed the activity - NFPA standard(s) referenced for the activity - Results of the activity Note: For additional guidance on documenting activities, see NFPA 25-2011: 4.3; 4.4; NFPA 72-2010: 14.2.1; 14.2.2; 14.2.3; 14.2.4. **EC.03.01.01, EP 1** Staff responsible for the maintenance, inspection, testing, and use of medical equipment, utility systems and equipment, fire safety systems and equipment, and	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		safe handling of hazardous materials and waste are competent and receive continuing education and training. **EC.03.01.01, EP 2** Staff can describe or demonstrate actions to take in the event of an environment of care incident. **LS.01.01.01, EP 1** The hospital assigns an individual(s) to assess compliance with the Life Safety Code and manage the Statement of Conditions (SOC) when addressing survey-related deficiencies. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital complies with the 2012 Life Safety Code. 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 finds that a fire and safety code imposed by state law adequately protects patients in hospitals. **LS.01.02.01, EP 1** The hospital has a written interim life safety measures (ILSM) policy that covers situations when Life Safety Code deficiencies cannot be immediately corrected or during periods of construction. The policy includes criteria for evaluating when and to what extent the hospital implements LS.01.02.01, EPs 2–15, to compensate for increased life safety risk. The criteria include the assessment process to determine when interim life safety measures are implemented.	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Note: For any Life Safety Code (LSC) deficiency that cannot be immediately corrected during survey, the hospital identifies which ILSMs in its policy will be implemented until the issue is corrected. **LS.01.02.01, EP 2** When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital evacuates the building or notifies the fire department (or other emergency response group) and initiates a fire watch when a fire alarm system is out of service more than 4 out of 24 hours or a sprinkler system is out of service more than 10 hours in a 24-hour period in an occupied building. Notification and fire watch times are documented. (For full text, refer to NFPA 101-2012: 9.6.1.6; 9.7.6; NFPA 25-2011: 15.5.2) **LS.01.02.01, EP 15** The hospital's policy allows the use of other ILSMs not addressed in EPs 2–14. Note: The “other” ILSMs used are documented by selecting “other” and annotating the associated text box in the hospital's Survey-Related Plan for Improvement (SPFI) within the Statement of Conditions™ (SOC). **LS.02.01.10, EP 1** Buildings meet requirements for construction type and height. In Types 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. All new buildings contain approved automatic sprinkler systems. Existing	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		buildings contain approved automatic sprinkler systems as required by the construction type. (For full text, refer to NFPA 101-2012: 18/19.1.6; 18.3.5.1; 19.3.5.3; 18/19.3.5.4; 18/19.3.5.5; 18.3.5.6) **LS.02.01.10, EP 3** Any building undergoing change of use or change of occupancy classification complies with NFPA 101-2012: 43.7, unless permitted by NFPA 101-2012: 18/19.1.1.4.2. **LS.02.01.10, EP 4** When an addition is made to a building, the building is in compliance with NFPA 101-2012: 43.8 and Chapter 18. **LS.02.01.10, EP 5** Buildings without protection from automatic sprinkler systems comply with NFPA 101-2012: 18.4.3.2; 18.4.3.3; and 18.4.3.8. When a nonsprinklered smoke compartment has undergone major rehabilitation, the automatic sprinkler requirements of Chapter 18.3.5 will apply. Note: Major rehabilitation involves the modification of more than 50 percent, or 4500 square feet, of the area of the smoke compartment. (For full text, refer to NFPA 101-2012: 18/19.1.1.4.3.3) **LS.02.01.10, EP 8** When multiple occupancies are identified, they are in accordance with NFPA 101-2012: 18/19.1.3.2 or 18/19.1.3.4, and the most stringent occupancy requirements are followed throughout the building. Note 1: If a two-hour separation is provided in	

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		accordance with NFPA 101-2012: 8.2.1.3, 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 NFPA 101-2012: 18/19.1.6 and Tables 18/19.1.6.1. - The construction type of the areas of the building enclosing the other occupancies are based on NFPA 101-2012: 18/19.1.3.5; 8.2.1.3. Note 2: Outpatient surgical departments must be classified as ambulatory health care occupancy regardless of the number of patients served. (For full text, refer to NFPA 101-2012: 18/19.1.3.4.1) **LS.02.01.10, EP 9** The fire protection ratings for opening protectives in fire barriers and fire-rated smoke barriers are as follows: - Three hours in three-hour barriers - Ninety minutes in two-hour barriers - Forty-five minutes in one-hour barriers - Twenty minutes in thirty-minute barriers (For full text, refer to NFPA 101-2012: 8.3.3.2; 8.3.4; Table 8.3.4.2) Note 1: Labels on fire door assemblies must be maintained in legible condition. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the applicable provisions of the Life Safety Code Tentative Interim Amendment (TIA) 12-1. **LS.02.01.10, EP 10** In existing buildings that are not a high rise and are protected with automatic sprinkler systems, exit stairs	

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		(or new exit stairs connecting three or fewer floors) are fire rated for one hour. In new construction, exit stairs connecting four or more floors are fire rated for two hours. (For full text, refer to NFPA 101-2012: 7.1.3.2.1) **LS.02.01.10, EP 11** Fire-rated doors within walls and floors have functioning hardware, including positive latching devices and self-closing or automatic-closing devices (either kept closed or activated by release device complying with NFPA 101-2012: 7.2.1.8.2). Gaps between meeting edges of door pairs are no more than 1/8 of an inch wide, and undercuts are no larger than 3/4 of an inch. Fire-rated doors within walls do not have unapproved protective plates greater than 16 inches from the bottom of the door. Blocking or wedging open fire-rated doors is prohibited. (For full text, refer to NFPA 101-2012: 8.3.3.1; 7.2.1.8.2; NFPA 80-2010: 4.8.4.1; 5.2.13.3; 6.3.1.7; 6.4.5) **LS.02.01.10, EP 12** Doors requiring a fire rating of 3/4 of an hour or longer are free of coverings, decorations, or other objects applied to the door face, with the exception of informational signs, which are applied with adhesive only. (For full text, refer to NFPA 80-2010: 4.1.4) **LS.02.01.10, EP 13** Ducts penetrating the walls or floors with a fire resistance rating of less than 3 hours are protected by dampers that are fire rated for 1 1/2 hours; ducts penetrating the walls or floors with a fire resistance rating of 3 hours or greater are protected by dampers	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		that are fire rated for 3 hours. (For full text, refer to NFPA 101-2012: 8.3.5.7; 9.2.1; NFPA 90A-2012: 5.4.1; 5.4.2) **LS.02.01.10, EP 14** The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes penetrating the walls or floors are protected with an approved fire-rated material. Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text, refer to NFPA 101-2012: 8.3.5) **LS.02.01.10, EP 15** The hospital meets all other Life Safety Code requirements related to NFPA 101-2012: 18/19.1. **LS.02.01.20, EP 1** Doors in a means of egress are not equipped with a latch or lock that requires the use of a tool or key from the egress side, unless a compliant locking configuration is used, such as a delayed-egress locking system as defined in NFPA 101-2012: 7.2.1.6.1 or access-controlled egress door assemblies as defined in NFPA 101-2012: 7.2.1.6.2. Elevator lobby exit access door locking is allowed if compliant with 7.2.1.6.3. (For full text, refer to NFPA 101-2012: 18/19.2.2.2.4; 18/19.2.2.2.5; 18/19.2.2.2.6) Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the applicable provisions of the Life Safety Code Tentative Interim Amendment (TIA) 12-4. **LS.02.01.20, EP 2**	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Doors to patient sleeping rooms are not locked unless the clinical needs of patients require specialized security or where patients pose a security threat and staff can readily unlock doors at all times. (For full text, refer to NFPA 101-2012: 18/19.2.2.2.2; 18/19.2.2.2.5.1; 18/19.2.2.2.5.2) **LS.02.01.20, EP 3** Horizontal sliding doors permitted by NFPA 101-2012: 7.2.1.14 that are not automatic closing are limited to a single leaf and have a latch or other mechanism to prevent the door from rebounding. (For full text, refer to NFPA 101-2012: 18/19.2.2.2.10.1) **LS.02.01.20, EP 4** Horizontal sliding doors serving an occupant load fewer than 10 are permitted, as long as they comply with NFPA 101-2012: 18/19.2.2.2.10.2 and meet the following criteria: - Area served by the door has no hazards. - Door is operable from either side without special knowledge or effort. - Force required to operate the door in the direction of travel is less than or equal to 30 pounds-force (lbf) to set the door in motion and less than or equal to 15 lbf to close or open to the required width. - Assembly is appropriately fire rated and is self- or automatic-closing by smoke detection per 7.2.1.8; assembly is installed per NFPA 80-2010. - Where required to latch, the door has a latch or other mechanism to prevent the door from rebounding. **LS.02.01.20, EP 5**	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Walls containing horizontal exits are fire rated for two or more hours, extend from the lowest floor slab to the floor or roof slab above, and extend continuously from exterior wall to exterior wall. (For full text, refer to NFPA 101-2012: 7.2.4.3.1; 18/19.2.2.5) **LS.02.01.20, EP 6** Doors in new buildings that are a part of horizontal exits have approved vision panels, are installed without a center mullion, and swing in the opposite direction of one another. Doors in existing construction are not required to swing with egress travel. (For full text, refer to NFPA 101-2012: 18.2.2.5.6; 18.2.2.5.4; 19.2.2.5.3) **LS.02.01.20, EP 7** When horizontal exit walls in new buildings terminate at outside walls at an angle of less than 180 degrees, the outside walls are fire rated for 1 hour for a distance of 10 or more feet. Openings in the walls in the 10-foot span are fire rated for 3/4 of an hour. (For full text, refer to NFPA 101-2012: 7.2.4.3.4) **LS.02.01.20, EP 8** Outside exit stairs are separated from the interior of the building by walls with the same fire rating required for enclosed stairs. The wall extends vertically from the ground to a point 10 feet or more above the top landing of the stairs or roofline (whichever is lower) and extends 10 feet or more horizontally. (For full text, refer to NFPA 101-2012: 18/19.2.2.3; 7.2.2.5.2; 7.2.2.6.3) **LS.02.01.20, EP 9** Stairs and ramps serving as a required means of egress	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		have handrails and guards on both sides in new buildings and on at least one side in existing buildings. Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with NFPA 101-2012: 7.2.5–7.5.12. (For full text, refer to NFPA 101-2012: 18/19.2.2.3; 18/19.2.2.6–18/19.2.2.10; 7.2.2.4; 7.2.5–7.2.12) **LS.02.01.20, EP 10** New stairs serving three or more stories and existing stairs serving five or more stories have signs on each floor landing in the stairwell that identify the story, the stairwell, the top and bottom, and the direction to and story of exit discharge. Floor level information is also presented in tactile lettering. The signs are placed five feet above the floor landing in a position that is easily visible when the door is open or closed. (For full text, refer to NFPA 101-2012: 18/19.2.2.3; 7.2.2.5.4) **LS.02.01.20, EP 11** The capacity of the means of egress is in accordance with NFPA 101-2012: 7.3. (For full text, refer to NFPA 101-2012: 18/19.2.3.1) **LS.02.01.20, EP 12** Exits discharge to the outside at grade level or through an approved exit passageway that is continuous and provides a level walking surface. The exit discharge is a hard-packed, all-weather travel surface that is free from obstructions and terminates at a public way or at an exterior exit discharge. (For full text, refer to NFPA 101-2012: 18/19.2.7; 7.1.7; 7.1.10.1; 7.2.6; 7.7.2)	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		LS.02.01.20, EP 14 Exits, exit accesses, and exit discharges (means of egress) are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text, refer to NFPA 101-2012: 18/19.2.5.1; 7.1.10.1; 7.5.1.1) Note 1: Wheeled equipment (such as equipment and carts currently in use, equipment used for patient lift and transport, and medical emergency equipment not in use) that maintains at least five feet of clear and unobstructed corridor width is allowed, provided there is a fire plan and training program addressing its relocation in a fire or similar emergency. (For full text, refer to NFPA 101-2012: 18/19.2.3.4 (4)) Note 2: Where the corridor width is at least eight feet and the smoke compartment is fully protected by an electrically supervised smoke detection system or is in direct supervision of facility staff, furniture that is securely attached is allowed provided it does not reduce the corridor width to less than six feet, is only on one side of the corridor, does not exceed 50 square feet, is in groupings spaced at least 10 feet apart, and does not restrict access to building service and fire protection equipment. (For full text, refer to NFPA 101-2012: 18/19.2.3.4 (5)) **LS.02.01.20, EP 15** When stair doors are held open and the sprinkler or fire alarm system activates the release of one door in a stairway, all doors serving that stairway close. (For full text, refer to NFPA 101-2012: 18/19.2.2.2.7; 18/19.2.2.2.8)	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		LS.02.01.20, EP 16 Each floor of a building has at least two exits that are remote from each other and accessible from every part of the floor. Each smoke compartment has two distinct egress paths to exits that do not require entry into the same adjacent smoke compartment. (For full text, refer to NFPA 101-2012: 18/19.2.4.1–18/19.2.4.4) **LS.02.01.20, EP 17** Every corridor provides access to at least two approved exits in accordance with NFPA 101-2012: 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. (For full text, refer to NFPA 101-2012: 18/19.2.5.4) **LS.02.01.20, EP 18** In new buildings, exit corridors are at least eight feet wide, unless otherwise permitted by the Life Safety Code. In new psychiatric buildings, exit corridors are at least six feet wide, unless otherwise permitted by the Life Safety Code. (For full text, refer to NFPA 101-2012: 18.2.3.4; 18.2.3.5) **LS.02.01.20, EP 20** 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. (For full text, refer to NFPA 101-2012: 19.2.3.6, 19.2.3.7) **LS.02.01.20, EP 21**	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		New exit access doors and exit doors are of the swinging type and are at least 41 1/2 inches in clear width. In psychiatric hospitals doors are at least 32 inches wide. Doors not subject to patient use, in exit stairway enclosures, or serving newborn nurseries are at least 32 inches in clear width. If using a pair of doors, the doors have a rabbet, bevel, or astragal at the meeting edge, and at least one of the doors provides 32 inches in clear width, while the inactive leaf of the pair is secured with automatic flush bolts. (For full text, refer to NFPA 101-2012: 18.2.3.6; 18.2.3.7) **LS.02.01.20, EP 22** Exit access doors and exit doors are free of mirrors, hangings, or draperies that might conceal, obscure, or confuse the direction of exit. (For full text, refer to NFPA 101-2012: 18/19.2.1; 18/19.2.5.1; 7.1.10.2; 7.5.2.2.1) **LS.02.01.20, EP 23** Doors to new boiler rooms, new heater rooms, and new mechanical equipment rooms located in a means of egress are not held open by an automatic release device. (For full text, refer to NFPA 101-2012: 18.2.2.2.7) **LS.02.01.20, EP 24** The corridor width is not obstructed by wall projections. Note: When corridors are six feet wide or more, it is allowable for certain objects to project into the corridor, such as hand rub dispensers or computer desks that are retractable. The objects must be no more than 36 inches wide and cannot project more than 6 inches into the corridor. These items must be installed at least 48 inches apart and above the handrail height. (For full text,	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		refer to NFPA 101-2012: 18/19.2.3.4) **LS.02.01.20, EP 25** In new buildings, no dead-end corridor is longer than 30 feet, and the common path of travel does not exceed 100 feet. (For full text, refer to NFPA 101-2012: 18.2.5.2) Note: Existing dead-end corridors longer than 30 feet are permitted to be used if it is impractical and unfeasible to alter them. (For full text, refer to NFPA 101-2012: 19.2.5.2) **LS.02.01.20, EP 26** Patient sleeping rooms open directly onto an exit access corridor. Patient sleeping rooms with less than eight beds may have one intervening room to reach an exit access corridor provided the intervening room is equipped with an approved automatic smoke detection system. (For full text, refer to NFPA 101-2012: 18/19.2.5.6.1–18/19.2.5.6.4) **LS.02.01.20, EP 27** Patient sleeping rooms that are larger than 1,000 square feet have at least two exit access doors remotely located from each other. Rooms not used as patient sleeping rooms that are larger than 2,500 square feet have at least two exit access doors remotely located from each other. (For full text, refer to NFPA 101-2012: 18/19.2.5.5) **LS.02.01.20, EP 32** For existing buildings, suites of patient sleeping rooms are limited to 5,000 square feet or less. If the existing building has an approved electrically supervised	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		sprinkler system and total coverage automatic smoke detection system, the suite is permitted to be increased to 7,500 square feet. (For full text, refer to NFPA 101-2012: 9.6.2.9; 19.3.4; 19.3.5.7; 19.3.5.8.) If the suite is provided with direct visual supervision, an approved electrically supervised sprinkler system, and a total coverage (complete) smoke detection system, the suite is permitted to be increased to 10,000 square feet. (For full text, refer to NFPA 101-2012: 9.6.2.9; 19.2.5.7.2.1(D)(1)(a); 19.2.5.7.2.3; 19.3.4; 19.3.5.8) **LS.02.01.20, EP 35** For new buildings, sleeping and non-sleeping patient care suites have a travel distance to an exit access door of 100 feet or less from any point in the suite. The travel distance between any point in the suite and an exit is 200 feet. (For full text, refer to NFPA 101-2012: 18.2.5.7.2.4; 18.2.5.7.3.4) **LS.02.01.20, EP 36** For existing buildings, sleeping and non-sleeping patient care suites have a travel distance to an exit access door of 100 feet or less from any point in the suite. The travel distance between any point in the suite and an exit is either 150 feet if the building is not protected throughout by an approved electrically supervised sprinkler system or 200 feet if the building is fully protected by an approved electrically supervised sprinkler system. (For full text, refer to NFPA 101-2012: 19.2.5.7.2.4; 19.2.5.7.3.4) **LS.02.01.20, EP 37** Travel distances to exits are measured in accordance	

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		with NFPA 101-2012: 7.6. - From any point in the room or suite to the exit is 150 feet or less (200 feet or less if the building is fully sprinklered) - From any point in a room to the room door is 50 feet or less (For full text, refer to NFPA 101-2012: 18/19.2.6) **LS.02.01.20, EP 38** Means of egress are adequately illuminated at all points, including angles and intersections of corridors and passageways, stairways, stairway landings, exit doors, and exit discharges. (For full text, refer to NFPA 101-2012: 18/19.2.8; 7.8.1.1) **LS.02.01.20, EP 39** Illumination in the means of egress, including exit discharges, is arranged so that failure of any single light fixture or bulb will not leave the area in darkness (less than 0.2 foot candles). Emergency lighting of at least 1½-hours duration is provided automatically in accordance with NFPA 101-2012: 7.9. (For full text, refer to NFPA 101-2012: 18/19.2.8; 18/19.2.9.1; 7.8.1.4; 7.9.2) **LS.02.01.20, EP 40** Exit signs are visible when the path to the exit is not readily apparent. Signs are adequately lit and have letters that are four or more inches high (or six inches high if externally lit). Exit and directional signs displayed with continuous illumination are also served by the emergency lighting system unless the building is one story with less than 30 occupants, and the line of exit	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		travel is obvious. (For full text, refer to NFPA 101-2012: 18/19.2.10; 7.10.1.4; 7.10.1.5.1; 7.10.5; 7.10.6; 7.10.7) **LS.02.01.20, EP 41** Signs reading "NO EXIT" are posted on any door, passage, or stairway that is neither an exit nor an access to an exit but may be mistaken for an exit. (For full text, refer to NFPA 101-2012: 18/19.2.10.1; 7.10.8.3) **LS.02.01.20, EP 42** The hospital meets all other Life Safety Code means of egress requirements related to NFPA 101-2012: 18/19.2. **LS.02.01.30, EP 1** In new construction, vertical openings, including exit stairs, are enclosed by one-hour fire-rated walls when connecting three or fewer floors and two-hour fire-rated walls when connecting four or more floors. In existing construction, vertical openings, including exit stairs, are enclosed with a minimum of one-hour fire-rated construction. Note: These vertical openings include, but are not limited to, shafts (including elevator, light and ventilation), communicating stairs, ramps, trash chutes, linen chutes, and utility chases. (For full text, refer to NFPA 101-2012: 8.6; 18/19.3.1; 7.1.3.2.1) **LS.02.01.30, EP 4** Laboratories using quantities of flammable, combustible, or hazardous materials that are considered a severe hazard are in accordance with NFPA 101-2012: 8.7 and NFPA 99 requirements	

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		applicable to administration, maintenance, and testing. (For full text refer to NFPA 101-2012: 18/19.3.2.2; NFPA 99-2012: 15.4) **LS.02.01.30, EP 5** Where residential or commercial cooking equipment is used to prepare meals for less than 31 people in a smoke compartment, one cooking facility is permitted to be open to the corridor provided all criteria in NFPA 101-2012: 18/19.3.2.5 are met. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the applicable provisions of the Life Safety Code Tentative Interim Amendment (TIA) 12-2. **LS.02.01.30, EP 7** Existing wall and ceiling interior finishes are rated Class A or B for limiting smoke development and the spread of flames. Newly installed wall and ceiling interior finishes are rated Class A. (For full text, refer to NFPA 101-2012: 18/19.3.3; 10.2) **LS.02.01.30, EP 8** Newly installed interior floor finishes in corridors of smoke compartments with an approved automatic sprinkler system is at least Class II. Existing floor finishes are not restricted. (For full text, refer to NFPA 101-2012: 18/19.3.3; 10.2.7) **LS.02.01.30, EP 11** Within corridors in smoke compartments that are protected throughout with an approved supervised sprinkler system, partitions are allowed to terminate at	

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		the ceiling if the ceiling is constructed to limit the passage of smoke. The passage of smoke can be limited by an exposed, suspended-grid acoustical tile ceiling with penetrating items such as sprinkler piping and sprinklers that penetrate the ceiling, ducted heating, ventilating, and air conditioning (HVAC) supply and return-air diffusers, speakers, and recessed lighting fixtures. (For full text, refer to NFPA 101-2012: 18/19.3.6.2) **LS.02.01.30, EP 14** In smoke compartments without sprinkler systems, fixed fire windows in corridor walls are 25% or less of the size of the corridor walls in which they are installed. Existing window installations that conform to previously accepted Life Safety Code criteria (such as a size of 1,296 square inches or less, made with wired glass or fire-rated glazing, and set in approved metal frames) are permitted. (For full text, refer to NFPA 101-2012: 19.3.6.2.7; 8.3.3.8; 8.3.3.9; 8.3.3.11) **LS.02.01.30, EP 15** Openings in vision panels or doors in corridor walls (other than in smoke compartments containing patient sleeping rooms) are installed at or below one half the distance from the floor to the ceiling. These openings may not be larger than 80 square inches in new buildings or larger than 20 square inches in existing buildings. Note: Openings may include, but are not limited to, mail slots and pass-through windows in areas such as laboratories, pharmacies, and cashier stations. (For full text, refer to NFPA 101-2012: 18/19.3.6.5)	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		LS.02.01.30, EP 16 Corridors serving adjoining areas are not used for a portion of an air supply, air return, or exhaust air plenum. Note: Incidental air movement between rooms and corridors (such as isolation rooms) because of the need for pressure differentials in hospitals is permitted. In such cases, the direction of airflow is not the focus for this element of performance. For the purpose of fire protection, air transfer should be limited to the amount necessary to maintain positive or negative pressure differentials. (For full text, refer to NFPA 101-2012: 19.5.2.1; NFPA 90A-2012: 4.3.12.1; 4.3.12.1.3.2) **LS.02.01.30, EP 18** In existing buildings, at least two smoke compartments are provided for every story that has more than 30 patients in sleeping rooms. Smoke barriers have a minimum ½-hour fire resistance rating; the maximum size of each smoke compartment is limited to 22,500 square feet. Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. The travel distance from any point within the smoke compartment to a smoke barrier door is no more than 200 feet. (For full text, refer to NFPA 101-2012: 19.3.7.1; 19.3.7.3; 19.3.7.5) **LS.02.01.30, EP 19** Smoke barriers extend from the floor slab to the floor or roof slab above, through any concealed spaces (such as those above suspended ceilings and interstitial spaces),	

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		and extend continuously from exterior wall to exterior wall. All penetrations are properly sealed. (For full text, refer to NFPA 101-2012: 18/19.3.7.3; 8.2.3; 8.5.2; 8.5.6; 8.7) Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. **LS.02.01.30, EP 20** Doors in smoke barriers are self-closing or automatic-closing, constructed of 1 3/4-inch or thicker solid bonded wood core or constructed to resist fire for not less than 20 minutes, and fitted to resist the passage of smoke. The gap between meeting edges of door pairs is no wider than 1/8 of an inch. In new buildings, undercuts are no larger than 3/4 of an inch, and doors in a means of egress swing in the opposite direction. (For full text, refer to NFPA 101-2012: 18.3.7.6; 18/19.3.7.8; 8.5.4.1; NFPA 80-2010: 4.8.4.1; 6.3.1.7.1) **LS.02.01.30, EP 21** In smoke compartments without sprinkler systems, fixed fire windows in smoke barrier doors are 25% or less of the size of the doors in which they are installed. Existing window installations that conform to previously accepted Life Safety Code criteria (such as 1,296 square inches or less, wired glass or fire-rated glazing, and are set in approved metal frames) are permitted. (For full text, refer to NFPA 101-2012: 19.3.7.6; 8.3.3; 8.5.4.5) **LS.02.01.30, EP 22** In new buildings, the smoke damper is not required in the duct passing through a smoke barrier. In existing buildings, ducts that penetrate smoke barriers are	

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		protected by approved smoke dampers that close when a smoke detector is activated. The detector is located either within the duct system or in the area serving the smoke compartment. In existing buildings protected by an approved automatic sprinkler system, the damper is not required in the duct. (For full text, refer to NFPA 101-2012: 18/19.3.7.3; 8.3.5.1; 8.5.5; 8.5.5.7) **LS.02.01.30, EP 23** Approved smoke dampers protect air transfer openings extending through smoke barriers in ceiling spaces that are used as an unducted common plenum for either supply or return air. (For full text, refer to NFPA 101-2012: 18/19.3.7.3; 8.5.5.2) **LS.02.01.30, EP 26** The hospital meets all other Life Safety Code fire and smoke protection requirements related to NFPA 101-2012: 18/19.3. FOR FULL EP MAPPING VIEW HAP CROSSWALK	
§482.41(b)(1)(ii)	(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.	**LS.02.01.30, EP 2** All new hazardous areas have doors that are self-closing or automatic-closing, except for laboratories using flammable or combustible materials deemed less than a severe hazard and storage rooms greater than 50 square feet, but less than 100 square feet that are used for storage of combustible material. Hazardous areas have a fire barrier with a one-hour fire-resistive rating. These areas include, but are not limited to, boiler and fuel-fired heater rooms, central/bulk laundries larger than 100 square feet, paint shops, repair shops, soiled linen rooms, trash collection rooms with containers	**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.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		exceeding 64 gallons, laboratories considered a severe hazard, and storage rooms larger than 100 square feet that contain combustible material. (For full text, refer to NFPA 101-2012: 18.3.2.1; 18.3.2.2; 18.3.2.3; 18.3.2.4; Table 18.3.2.1) Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Doors to rooms containing flammable or combustible materials are provided with positive latching hardware. Roller latches are prohibited on such doors. **LS.02.01.30, EP 3** All existing hazardous areas have doors that are self-closing or automatic-closing. These areas are protected by either a fire barrier with one-hour fire-resistive rating or an approved electrically supervised automatic sprinkler system. Hazardous areas include, but are not limited to, boiler and fuel-fired heater rooms, central/bulk laundries larger than 100 square feet, paint shops, repair shops, soiled linen rooms, trash collection rooms with containers exceeding 64 gallons, laboratories employing flammable or combustible materials deemed less than a severe hazard, and storage rooms greater than 50 square feet used for storage of equipment and combustible supplies. (For full text, refer to NFPA 101-2012: 19.3.2.1; 19.3.2.2; 19.3.2.3; 19.3.2.4) Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Doors to rooms containing flammable or combustible materials are provided with positive latching hardware. Roller latches are prohibited on such doors.	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		LS.02.01.30, EP 12 In new buildings, all corridor doors are constructed to resist the passage of smoke, hinged so that they swing, and the doors do not have ventilating louvers or transfer grills (with the exception of bathrooms, toilets, and sink closets that do not contain flammable or combustible materials). Undercuts are no larger than one inch. Positive latching hardware is required. Roller latches are prohibited. (For full text, refer to NFPA 101-2012: 18.3.6.3.1; 18.3.6.3.5; 18.3.6.4; 18.3.6.5; 18.3.6.3.10; 18.3.6.3.11) **LS.02.01.30, EP 13** In existing buildings, all corridor doors are constructed to resist the passage of smoke and constructed of 1 3/4-inch or thicker solid bonded wood core or constructed of material that resists fire for not less than 20 minutes, and the doors do not have ventilating louvers or transfer grills (with the exception of bathrooms, toilets, and sink closets that do not contain flammable or combustible materials). Positive latching hardware is required. Roller latches are prohibited. (For full text, refer to NFPA 101-2012: 19.3.6.3.1; 19.3.6.3.2; 19.3.6.3.5) Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: Powered corridor doors are equipped with positive latching hardware unless the organization can verify that this equipment is not an option provided by the door manufacturer. In instances where positive latching hardware is not an available option provided by the manufacturer, the device used must be capable of keeping the door fully closed when a force of 5 lbf is applied at the latch edge and in any direction to a sliding	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		or folding door, whether or not power is applied in accordance with NFPA 101-2012: 19.3.6.3.7. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials are not required to have a device capable of keeping the door fully closed if a force of 5 lbf is applied at the latch edge. In these cases, roller latches are permissible. **LS.05.01.30, EP 1** All hazardous areas are enclosed with one-hour fire-rated walls with ¾-hour fire-rated doors; or hazardous areas have sprinkler systems and are constructed to resist the passage of smoke with doors equipped with self-closing or automatic-closing devices. (For full text, refer to NFPA 101-2012: 38/39.3.2; 8.7; NFPA 80-2010: 4.8.4.1; 6.3.1.7; 6.5) **LS.05.01.30, EP 4** The hospital meets all other Life Safety Code fire and smoke protection requirements related to NFPA 101-2012: 38/39.3.	
§482.41(b)(2)	(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.	**LS.01.01.01, EP 2** In time frames defined by the hospital, the hospital performs a building assessment to determine compliance with the “Life Safety” (LS) chapter. **LS.01.01.01, EP 4** When the hospital plans to resolve a deficiency through a Survey-Related Plan for Improvement (SPFI), the hospital meets the 60-day time frame.	**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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Note 1: If the corrective action will exceed the 60-day time frame, the hospital must request a time-limited waiver within 30 days from the end of survey. Note 2: If there are alternative systems, methods, or devices considered equivalent, the hospital may submit an equivalency request using its Statement of Conditions (SOC). Note 3: For further information on waiver and equivalency requests, see https://www.jointcommission.org/resources/patient-safety-topics/the-physical-environment/life-safety-code-information-and-resources/ and NFPA 101-2012: 1.4.	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.
§482.41(b)(3)	(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.	**LS.01.01.01, EP 1** The hospital assigns an individual(s) to assess compliance with the Life Safety Code and manage the Statement of Conditions (SOC) when addressing survey-related deficiencies. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital complies with the 2012 Life Safety Code. 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 finds that a fire and safety code imposed by state law adequately protects patients in hospitals.	**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,

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			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.
§482.41(b)(4)	(4) The hospital must have procedures for the proper routine storage and prompt disposal of trash.	**EC.02.02.01, EP 5** The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemicals. **EC.02.02.01, EP 6** The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of radioactive materials. **EC.02.02.01, EP 19** The hospital has procedures for the proper routine storage and prompt disposal of trash and regulated medical waste.	**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)(5)	(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.	**EC.02.03.01, EP 9** The written fire response plan describes the specific roles of staff at and away from a fire's point of origin, including when and how to sound and report fire alarms, how to contain smoke and fire, how to use a fire extinguisher, how to assist and relocate patients, how to evacuate to areas of refuge, and how staff will cooperate with firefighting authorities. Staff are periodically instructed on and kept informed of their duties under the	**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.

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		plan, including cooperation with firefighting authorities. A copy of the plan is readily available with the telephone operator or security. Note: For full text, refer to NFPA 101-2012: 18/19.7.1; 7.2. **EC.02.03.03, EP 2** The hospital conducts fire drills every 12 months from the date of the last drill in all freestanding buildings classified as business occupancies and in which patients are seen or treated. Note: In leased or rented facilities, drills need be conducted only in areas of the building that the hospital occupies. **HR.01.04.01, EP 1** The hospital orients its staff to the key safety content it identifies before staff provides care, treatment, and services. Completion of this orientation is documented. Note: Key safety content may include specific processes and procedures related to the provision of care, treatment, or services; the environment of care; and infection control.	
§482.41(b)(6)	(6) The hospital must maintain written evidence of regular inspection and approval by State or local fire control agencies.	**LS.01.01.01, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital maintains documentation of any inspections and approvals made by state or local fire control agencies.	**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)(7)	(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;	**LS.02.01.30, EP 6** Alcohol-based hand rubs (ABHR) are stored and handled in accordance with NFPA 101-2012: 8.7.3.1, unless all of the following conditions are met: - Corridor is at least six feet wide.	**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.

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		- ABHR does not exceed 95% alcohol. - Maximum individual dispenser capacity is 0.32 gallons of fluid (0.53 gallons in suites) or 18 ounces of NFPA Level 1–classified aerosols. - Dispensers have a minimum of four feet of horizontal spacing between them. - Dispensers are not installed within one inch of an ignition source. - If floor is carpeted, the building is fully sprinkler protected. - Operation of the dispenser complies with NFPA 101-2012: 18/19.3.2.6(11). - ABHR is protected against inappropriate access. - 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. - Storing more than five gallons of fluid in a single smoke compartment complies with NFPA 30. **LS.05.01.30, EP 3** Alcohol-based hand rubs (ABHR) are stored and handled in accordance with NFPA 101-2012: 8.7.3.1 and as follows: - Corridor clear width of 44 inches is not compromised by dispenser. - ABHR does not exceed 95% alcohol. - Maximum individual dispenser capacity is 0.32 gallons of fluid (0.53 gallons in suites or rooms separated from corridors) or 18 ounces of NFPA Level 1–classified aerosols. - Dispensers have a minimum of 4 feet of horizontal spacing between them.	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Dispensers are not installed within 1 inch of an ignition source. - Operation of the dispensers must comply with the manufacturers' instructions for use. - ABHR is protected against inappropriate access. - Not more than an aggregate of 10 gallons of fluid or 1135 ounces of aerosol are used on a single story or in a single fire compartment outside a storage cabinet, excluding one individual dispenser per room. - Storing more than 5 gallons of fluid on a single story or in a single fire compartment complies with NFPA 30. **LS.05.01.30, EP 4** The hospital meets all other Life Safety Code fire and smoke protection requirements related to NFPA 101-2012: 38/39.3.	
§482.41(b)(8)	(8) When a sprinkler system is shut down for more than 10 hours, the hospital must:	**LS.01.02.01, EP 2** When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital evacuates the building or notifies the fire department (or other emergency response group) and initiates a fire watch when a fire alarm system is out of service more than 4 out of 24 hours or a sprinkler system is out of service more than 10 hours in a 24-hour period in an occupied building. Notification and fire watch times are documented. (For full text, refer to NFPA 101-2012: 9.6.1.6; 9.7.6; NFPA 25-2011: 15.5.2)	
§482.41(b)(8)(i)	(i) Evacuate the building or portion of the building affected by the system outage until the system is back in service, or	**LS.01.02.01, EP 2** When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital evacuates the building or notifies the fire department (or other	**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,

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		emergency response group) and initiates a fire watch when a fire alarm system is out of service more than 4 out of 24 hours or a sprinkler system is out of service more than 10 hours in a 24-hour period in an occupied building. Notification and fire watch times are documented. (For full text, refer to NFPA 101-2012: 9.6.1.6; 9.7.6; NFPA 25-2011: 15.5.2)	or the hospital establishes a fire watch until the system is back in service.
§482.41(b)(8)(ii)	(ii) Establish a fire watch until the system is back in service.	**LS.01.02.01, EP 2** When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital evacuates the building or notifies the fire department (or other emergency response group) and initiates a fire watch when a fire alarm system is out of service more than 4 out of 24 hours or a sprinkler system is out of service more than 10 hours in a 24-hour period in an occupied building. Notification and fire watch times are documented. (For full text, refer to NFPA 101-2012: 9.6.1.6; 9.7.6; NFPA 25-2011: 15.5.2)	**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)(9)	(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.	**LS.02.01.30, EP 24** Every patient sleeping room has an outside window or outside door except newborn nurseries or rooms intended for less than 24-hour stays (such as obstetrical labor beds, recovery beds, and observation beds in the emergency department). Note: Windows in atrium walls are considered outside windows. **LS.02.01.30, EP 25** In new buildings constructed after July 5, 2016, the window sill height in patient sleeping rooms does not exceed 36 inches from the floor, except in special nursing care areas (for example, intensive care units,	**PE.03.01.01, EP 9** Buildings have an outside window or outside door in every sleeping room. For any building constructed after July 5, 2016, the sill height does not exceed 36 inches above the floor. Note 1: Windows in atrium walls are considered outside windows for the purposes of this requirement. Note 2: The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours. Note 3: The sill height in special nursing care areas of new occupancies does not exceed 60 inches.

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		coronary care units, hemodialysis units, and neonatal intensive care units), where window sill height does not exceed 60 inches above the floor.	
§482.41(b)(9)(i)	(i) The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours.	**LS.02.01.30, EP 24** Every patient sleeping room has an outside window or outside door except newborn nurseries or rooms intended for less than 24-hour stays (such as obstetrical labor beds, recovery beds, and observation beds in the emergency department). Note: Windows in atrium walls are considered outside windows. **LS.02.01.30, EP 25** In new buildings constructed after July 5, 2016, the window sill height in patient sleeping rooms does not exceed 36 inches from the floor, except in special nursing care areas (for example, intensive care units, coronary care units, hemodialysis units, and neonatal intensive care units), where window sill height does not exceed 60 inches above the floor.	**PE.03.01.01, EP 9** Buildings have an outside window or outside door in every sleeping room. For any building constructed after July 5, 2016, the sill height does not exceed 36 inches above the floor. Note 1: Windows in atrium walls are considered outside windows for the purposes of this requirement. Note 2: The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours. Note 3: The sill height in special nursing care areas of new occupancies does not exceed 60 inches.
§482.41(b)(9)(ii)	(ii) The sill height in special nursing care areas of new occupancies must not exceed 60 inches	**LS.02.01.30, EP 24** Every patient sleeping room has an outside window or outside door except newborn nurseries or rooms intended for less than 24-hour stays (such as obstetrical labor beds, recovery beds, and observation beds in the emergency department). Note: Windows in atrium walls are considered outside windows. **LS.02.01.30, EP 25** In new buildings constructed after July 5, 2016, the window sill height in patient sleeping rooms does not exceed 36 inches from the floor, except in special	**PE.03.01.01, EP 9** Buildings have an outside window or outside door in every sleeping room. For any building constructed after July 5, 2016, the sill height does not exceed 36 inches above the floor. Note 1: Windows in atrium walls are considered outside windows for the purposes of this requirement. Note 2: The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours. Note 3: The sill height in special nursing care areas of new occupancies does not exceed 60 inches.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		nursing care areas (for example, intensive care units, coronary care units, hemodialysis units, and neonatal intensive care units), where window sill height does not exceed 60 inches above the floor.	
§482.41(c)	(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).	**EC.01.01.01, EP 1** Leaders identify an individual(s) to manage risk, coordinate risk reduction activities in the physical environment, collect deficiency information, and disseminate summaries of actions and results. Note: Deficiencies include injuries, problems, or use errors. **EC.02.01.03, EP 4** 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 the site of intentional expulsion (within 1 foot). When other oxygen delivery equipment is used or oxygen is delivered inside a patient's room, no sources of ignition are within the area of administration (within 15 feet). Solid fuel–burning appliances are 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. (For full text, refer to NFPA 99-2012: 11.5.1.1; Tentative Interim Amendment [TIA] 12-6) **EC.02.03.01, EP 13** The hospital meets all other Health Care Facilities Code fire protection requirements, as related to NFPA 99-2012: Chapter 15. **EC.02.04.03, EP 27**	**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.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		The hospital meets NFPA 99-2012: Health Care Facilities Code requirements related to electrical equipment in the patient care vicinity. (For full text, refer to NFPA 99-2012: Chapter 10) Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the applicable provisions of the Health Care Facilities Code Tentative Interim Amendment (TIA) 12-5. **EC.02.05.01, EP 2** New building systems and modifications to existing building systems are designed to meet the National Fire Protection Association's Categories 1–4 requirements. (For full text, refer to NFPA 99-2012: Chapter 4 for descriptions of the four categories related to gas, vacuum, electrical, and electrical equipment.) **EC.02.05.01, EP 18** Medical gas storage rooms and transfer and manifold rooms comply with NFPA 99-2012: 9.3.7. **EC.02.05.01, EP 19** The emergency power supply system's equipment and environment are maintained per manufacturers' recommendations, including ambient temperature not less than 40°F; ventilation supply and exhaust; and water jacket temperature (when required). (For full text, refer to NFPA 99-2012: 9.3.10) **EC.02.05.05, EP 8** The hospital meets NFPA 99-2012: Health Care Facilities Code requirements related to electrical systems and heating, ventilation, and air conditioning	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		(HVAC). (For full text, refer to NFPA 99-2012: Chapters 6 and 9) Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the applicable provisions of the Health Care Facilities Code Tentative Interim Amendments (TIAs) 12-2 and 12-3. **EC.02.05.09, EP 14** The hospital meets all other NFPA 99-2012: Health Care Facilities Code requirements related to gas and vacuum systems and gas equipment. (For full text, refer to NFPA 99-2012: Chapters 5 and 11) Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the applicable provisions of the Health Care Facilities Code Tentative Interim Amendments (TIAs) 12-4 and 12-6.	
§482.41(c)(1)	(1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to a hospital.	**EC.01.01.01, EP 1** Leaders identify an individual(s) to manage risk, coordinate risk reduction activities in the physical environment, collect deficiency information, and disseminate summaries of actions and results. Note: Deficiencies include injuries, problems, or use errors.	**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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§482.41(c)(2)	(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.	**EC.01.01.01, EP 1** Leaders identify an individual(s) to manage risk, coordinate risk reduction activities in the physical environment, collect deficiency information, and disseminate summaries of actions and results. Note: Deficiencies include injuries, problems, or use errors.	**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(d)	§482.41(d) Standard: Facilities The hospital must maintain adequate facilities for its services.	**EC.02.05.01, EP 18** Medical gas storage rooms and transfer and manifold rooms comply with NFPA 99-2012: 9.3.7. **EC.02.05.01, EP 19** The emergency power supply system’s equipment and environment are maintained per manufacturers’ recommendations, including ambient temperature not less than 40°F; ventilation supply and exhaust; and water jacket temperature (when required). (For full text, refer to NFPA 99-2012: 9.3.10) **LD.04.01.11, EP 3** The interior and exterior space provided for care,	**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.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		treatment, and services meets the needs of patients. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The extent and complexity of facilities must be determined by the services offered.	**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.
§482.41(d)(1)	(1) Diagnostic and therapeutic facilities must be located for the safety of patients.	**LD.04.01.11, EP 3** The interior and exterior space provided for care, treatment, and services meets the needs of patients. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The extent and complexity of facilities must be determined by the services offered.	**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.
§482.41(d)(2)	(2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.	**EC.01.01.01, EP 1** Leaders identify an individual(s) to manage risk, coordinate risk reduction activities in the physical environment, collect deficiency information, and disseminate summaries of actions and results. Note: Deficiencies include injuries, problems, or use errors. **EC.01.01.01, EP 3** The hospital has a library of information regarding inspection, testing, and maintenance of its equipment and systems. Note: This library includes manuals, procedures	**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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		provided by manufacturers, technical bulletins, and other information. **EC.01.01.01, EP 8** The hospital has a written plan for managing the following: Medical equipment. **EC.01.01.01, EP 9** The hospital has a written plan for managing the following: Utility systems. Note: In circumstances where the program or service is located in a business occupancy not owned by the accredited organization, the plan may only need to address how routine service and maintenance for their utility systems are obtained. **EC.02.03.05, EP 1** The hospital tests supervisory signal devices on the inventory in accordance with the following time frames: - 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 - Annually for other supervisory initiating devices The results and completion dates are documented. Note 1: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5. Note 2: Water storage tanks and associated water storage equipment do not require testing.	responsible for the oversight and implementation of the program, including but not limited to development, management, and maintenance activities. **PE.04.01.05, EP 2** The individual or team responsible for the water management program develops the following: - A basic diagram that maps all water supply sources, treatment systems, processing steps, control measures, and end-use points Note: An example would be a flow chart with symbols showing sinks, showers, water fountains, ice machines, and so forth. - A water risk management plan based on the diagram that includes an evaluation of the physical and chemical conditions of each step of the water flow diagram to identify any areas where potentially hazardous conditions may occur (these conditions are most likely to occur in areas with slow or stagnant water) Note: Refer to the Centers for Disease Control and Prevention's "Water Infection Control Risk Assessment (WICRA) for Healthcare Settings" tool as an example for conducting a water-related risk assessment. - A plan for addressing the use of water in 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.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		EC.02.03.05, EP 2 Every 6 months, the hospital tests vane-type and pressure-type water flow devices and valve tamper switches on the inventory. The results and completion dates are documented. Note 1: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5. Note 2: Mechanical water flow devices (including, but not limited to, water motor gongs) should be tested quarterly. The results and completion dates are documented. (For full text, refer to NFPA 25-2011: Table 5.1.1.2) **EC.02.03.05, EP 3** Every 12 months, the hospital tests duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors on the inventory. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5; 17.14. **EC.02.03.05, EP 4** Every 12 months, the hospital tests visual and audible fire alarms, including speakers and door-releasing devices on the inventory. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5. **EC.02.03.05, EP 5** Every 12 months, the hospital tests fire alarm equipment on the inventory for notifying off-site fire responders. The results and completion dates are	**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 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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		documented. Note: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5. **EC.02.03.05, EP 6** For automatic sprinkler systems: The hospital tests electric motor–driven fire pumps monthly and diesel engine–driven fire pumps every week under no-flow conditions. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 25-2011: 8.3.1; 8.3.2. **EC.02.03.05, EP 9** For automatic sprinkler systems: Every 12 months, the hospital tests main drains at system low point or at all system risers. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1. **EC.02.03.05, EP 10** For automatic sprinkler systems: Every quarter, the hospital inspects all fire department water supply connections. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 25-2011: 13.7; Table 13.1.1.2. **EC.02.03.05, EP 11** For automatic sprinkler systems: Every 12 months, the hospital tests fire pumps under flow. Fire pump	additional guidance, consult ANSI/ASHRAE Guideline 12-2020 "Managing the Risk of Legionellosis Associated with Building Water Systems."

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		supervisory signals for “pump running” and “pump power loss” are tested annually. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 25-2011: 8.3.3; 8.3.3.4. **EC.02.03.05, EP 12** Every 5 years, the hospital conducts hydrostatic and water flow tests for standpipe systems. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 25-2011: 6.3.1; 6.3.2; Table 6.1.1.2. **EC.02.03.05, EP 13** Every 6 months, the hospital inspects any automatic fire-extinguishing system in a kitchen. The results and completion dates are documented. Note 1: Discharge of the fire-extinguishing systems is not required. Note 2: For additional guidance on performing inspections, see NFPA 96-2011: 11.2. **EC.02.03.05, EP 14** The hospital tests automatic fire-extinguishing systems as follows: - Carbon dioxide systems every 12 months - Halon systems every 6 months - Other special systems per National Fire Protection Association standards and manufacturers’ recommendations. The results and completion dates are documented. Note 1: Discharge of the fire-extinguishing systems is not required.	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Note 2: For full text, refer to NFPA 12-2011: 4.8.3.2 (for carbon dioxide systems) and NFPA 12A-2009: 6.1 (for halon systems). Note 3: For full text, refer to NFPA 11-2010; NFPA 16-2011; NFPA 17-2009; NFPA 17A-2009 for other extinguishing systems. **EC.02.03.05, EP 15** At least monthly, the hospital inspects portable fire extinguishers. The results and completion dates are documented. Note 1: There are many ways to document the inspections, such as using bar-coding equipment, using check marks on a tag, or using an inventory. Note 2: 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. Note 3: For additional guidance on inspection of fire extinguishers, see NFPA 10-2010: 7.2.2; 7.2.4. **EC.02.03.05, EP 16** Every 12 months, the hospital performs maintenance on portable fire extinguishers, including recharging. Individuals performing annual maintenance on extinguishers are certified. The results and completion dates are documented. Note 1: There are many ways to document the maintenance, such as using bar-coding equipment, using check marks on a tag, or using an inventory. Note 2: For additional guidance on maintaining fire extinguishers, see NFPA 10-2010: 7.1.2; 7.2.2; 7.2.4; 7.3.1.	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		EC.02.03.05, EP 17 The hospital conducts hydrostatic tests on standpipe occupant hoses 5 years after installation and every 3 years thereafter. The results and completion dates are documented. Note: For additional guidance on hydrostatic testing, see NFPA 1962-2008: Chapter 7 and NFPA 25-2011: Chapter 6. **EC.02.03.05, EP 18** The hospital operates fire and smoke dampers one year after installation and then at least every six years to verify that they fully close. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 90A-2012: 5.4.8; NFPA 80-2010: 19.4; NFPA 105-2010: 6.5. **EC.02.03.05, EP 19** Every 12 months, the hospital tests automatic smoke-detection shutdown devices for air-handling equipment. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 90A-2012: 6.4.1. **EC.02.03.05, EP 20** Every 12 months, the hospital tests 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. The results and completion dates are documented. Note: For full text, refer to NFPA 80-2010: 5.2.14.3;	

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		NFPA 105-2010: 5.2.1; 5.2.2. **EC.02.03.05, EP 25** The hospital has annual inspection and testing of fire door assemblies by individuals who can demonstrate knowledge and understanding of the operating components of the door being tested. Testing begins with a pre-test visual inspection; testing includes both sides of the opening. Note 1: 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. Note 2: 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. Note 3: 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. **EC.02.03.05, EP 27** Elevators with firefighters' emergency operations are tested monthly. The test completion dates and results are documented. (For full text, refer to NFPA 101-2012: 9.4.3; 9.4.6) **EC.02.04.01, EP 2** For hospitals that do not use Joint Commission accreditation for deemed status purposes: The hospital maintains either a written inventory of all medical equipment or a written inventory of selected equipment	

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		categorized by physical risk associated with use (including all life-support equipment) and equipment incident history. The hospital evaluates new types of equipment before initial use to determine whether they should be included in the inventory. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital maintains a written inventory of all medical equipment. **EC.02.04.01, EP 3** The hospital identifies high-risk medical equipment on the inventory for which there is a risk of serious injury or death to a patient or staff member should the equipment fail. Note: High-risk medical equipment includes life-support equipment. **EC.02.04.01, EP 4** The hospital identifies the activities and associated frequencies, in writing, for maintaining, inspecting, and testing all medical equipment on the inventory. Note: Activities and associated frequencies for maintaining, inspecting, and testing of medical equipment must have a 100% completion rate. **EC.02.04.01, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's activities and frequencies for inspecting, testing, and maintaining the following items must be in accordance with manufacturers' recommendations: - Equipment subject to federal or state law or Medicare	

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		Conditions of Participation in which inspecting, testing, and maintaining must be in accordance with the manufacturers' recommendations, or otherwise establishes more stringent maintenance requirements - Medical laser devices - Imaging and radiologic equipment (whether used for diagnostic or therapeutic purposes) - New medical equipment with insufficient maintenance history to support the use of alternative maintenance strategies Note: Maintenance history includes any of the following documented evidence: - Records provided by the hospital's contractors - Information made public by nationally recognized sources - Records of the hospital's experience over time **EC.02.04.01, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes: A qualified individual(s) uses written criteria to support the determination whether it is safe to permit medical equipment to be maintained in an alternate manner that includes the following: - How the equipment is used, including the seriousness and prevalence of harm during normal use - Likely consequences of equipment failure or malfunction, including seriousness of and prevalence of harm - Availability of alternative or backup equipment in the event the equipment fails or malfunctions - Incident history of identical or similar equipment - Maintenance requirements of the equipment	

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		(For more information on defining staff qualifications, refer to Standard HR.01.01.01) **EC.02.04.01, EP 7** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital identifies medical equipment on its inventory that is included in an alternative equipment maintenance program. **EC.02.04.01, EP 9** The hospital has written procedures to follow when medical equipment fails, including using emergency clinical interventions and backup equipment. **EC.02.04.01, EP 11** The hospital monitors and reports all incidents in which medical equipment is suspected in or attributed to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Devices Act of 1990. **EC.02.04.03, EP 1** For hospitals that do not use Joint Commission accreditation for deemed status purposes: Before initial use of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. For hospitals that use Joint Commission accreditation for deemed status purposes: Before initial use and after major repairs or upgrades of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks.	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		EC.02.04.03, EP 2 The hospital inspects, tests, and maintains all high-risk equipment. These activities are documented. 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. **EC.02.04.03, EP 3** The hospital inspects, tests, and maintains non-high-risk equipment identified on the medical equipment inventory. These activities are documented. **EC.02.04.03, EP 4** The hospital conducts performance testing of and maintains all sterilizers. These activities are documented. **EC.02.04.03, EP 5** The hospital performs equipment maintenance and chemical and biological testing of water used in hemodialysis. These activities are documented. **EC.02.04.03, EP 8** Equipment listed for use in oxygen-enriched atmospheres is clearly and permanently labeled (withstands cleaning/disinfecting) as follows: - Oxygen-metering equipment, pressure-reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier.	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Oxygen-metering equipment and pressure reducing regulators are labeled "OXYGEN–USE NO OIL." - Labels on flowmeters, pressure-reducing regulators, and oxygen-dispensing apparatuses designate the gases for which they are intended. - Cylinders and containers are labeled in accordance with Compressed Gas Association (CGA) C-7. (For full text, refer to NFPA 99-2012: 11.5.3.1) Note: Color coding is not utilized as the primary method of determining cylinder or container contents. **EC.02.04.03, EP 10** All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99-2012: Chapter 14. **EC.02.04.03, EP 27** The hospital meets NFPA 99-2012: Health Care Facilities Code requirements related to electrical equipment in the patient care vicinity. (For full text, refer to NFPA 99-2012: Chapter 10) Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the applicable provisions of the Health Care Facilities Code Tentative Interim Amendment (TIA) 12-5. **EC.02.05.01, EP 3** For hospitals that do not use Joint Commission accreditation for deemed status purposes: The hospital maintains a written inventory of all operating components of utility systems or maintains a written inventory of selected operating components of utility	

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		systems based on risks for infection, occupant needs, and systems critical to patient care (including all life-support systems). The hospital evaluates new types of utility components before initial use to determine whether they should be included in the inventory. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital maintains a written inventory of all operating components of utility systems. **EC.02.05.01, EP 4** The hospital identifies high-risk operating components of utility systems on the inventory for which there is a risk of serious harm or death to a patient or staff member should the component fail. Note: High-risk utility system components include life-support equipment. **EC.02.05.01, EP 5** The hospital identifies the activities and associated frequencies, in writing, for inspecting, testing, and maintaining all operating components of utility systems on the inventory. Note: For guidance on maintenance and testing activities for Essential Electric Systems (Type I), see NFPA 99-2012: 6.4.4. **EC.02.05.01, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's activities and frequencies for inspecting, testing, and maintaining the following items must be in accordance with	

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		manufacturers' recommendations: - Equipment subject to federal or state law or Medicare Conditions of Participation in which inspecting, testing, and maintaining be in accordance with the manufacturers' recommendations, or otherwise establishes more stringent maintenance requirements - New operating components with insufficient maintenance history to support the use of alternative maintenance strategies Note: Maintenance history includes any of the following documented evidence: - Records provided by the hospital's contractors - Information made public by nationally recognized sources - Records of the hospital's experience over time **EC.02.05.01, EP 7** For hospitals that use Joint Commission accreditation for deemed status purposes: A qualified individual(s) uses written criteria to support the determination of whether it is safe to permit operating components of utility systems to be maintained in an alternate manner that includes the following: - How the equipment is used, including the seriousness and prevalence of harm during normal use - Likely consequences of equipment failure or malfunction, including seriousness of and prevalence of harm - Availability of alternative or backup equipment in the event the equipment fails or malfunctions - Incident history of identical or similar equipment - Maintenance requirements of the equipment (For more information on defining staff qualifications,	

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		refer to Standard HR.01.01.01) **EC.02.05.01, EP 8** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital identifies operating components of utility systems on its inventory that are included in an alternative equipment maintenance program. **EC.02.05.01, EP 11** The hospital's procedures address shutting off the malfunctioning system and notifying staff in affected areas. **EC.02.05.01, EP 15** 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. For new and existing health care facilities, or altered, renovated, or modernized portions of existing systems or individual components (constructed or plans approved on or after July 5, 2016), heating, cooling, and ventilation are in accordance with NFPA 99-2012, which includes 2008 ASHRAE 170, or state design requirements if more stringent. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: Existing facilities may elect to implement a Centers for Medicare & Medicaid Services (CMS) categorical waiver to reduce their relative humidity to 20% in operating rooms and other anesthetizing locations. Should the facility	

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		elect the waiver, it must be included in its Basic Building Information (BBI), and the facility's equipment and supplies must be compatible with the humidity reduction. For further information on waiver and equivalency requests, see https://www.jointcommission.org/resources/patient-safety-topics/the-physical-environment/life-safety-code-information-and-resources/. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: Existing facilities may comply with the 2012 NFPA 99 ventilation requirements or the ventilation requirements in the edition of the NFPA code previously adopted by CMS at the time of installation (for example, 1999 NFPA 99). **EC.02.05.01, EP 20** Operating rooms are considered wet procedure locations, unless otherwise determined by a risk assessment authorized 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. (For full text, refer to NFPA 99-2012: 6.3.2.2.8.4; 6.3.2.2.8.7; 6.4.4.2) **EC.02.05.01, EP 21** Electrical distribution in the hospital is based on the following categories: - Category 1: Critical care rooms served by a Type 1 essential electrical system (EES) in which electrical system failure is likely to cause major injury or death to patients, including all rooms where electric life support equipment is required.	

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		- Category 2: General care rooms served by a Type 1 or Type 2 EES in which electrical system failure is likely to cause minor injury to patients. - Category 3: Basic care rooms in which electrical system failure is not likely to cause injury to patients. Patient care rooms are required to have a Type 3 EES where the life safety branch has an alternate source of power that will be effective for 1 1/2 hours. (For full text, refer to NFPA 99-2012: 3.3.138; 6.3.2.2.10; 6.6.2.2.2; 6.6.3.1.1) **EC.02.05.01, EP 22** Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered are tested after initial installation, replacement, or servicing. In pediatric locations, receptacles in patient rooms (other than nurseries), bathrooms, play rooms, and activity rooms are listed tamper-resistant or have a listed tamper-resistant cover. Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. (For full text, refer to NFPA 99-2012: 6.3.2; 6.3.3; 6.3.4; 6.4.2.2.6; 6.5.2.2.4.2; 6.6.2.2.3.2) **EC.02.05.01, EP 23** Power strips in a patient care vicinity are only used for components of movable electrical equipment assemblies used for patient care. These power strips meet UL 1363A or UL 60601-1. Power strips used outside of a patient care vicinity, but within the patient care room, meet UL 1363. In non–patient care rooms, power strips meet other UL standards. (For full text, refer to NFPA 99-2012: 10.2.3.6; 10.2.4; NFPA 70-2011:	

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		400-8; 590.3(D); Tentative Interim Amendment [TIA] 12-5) Note 1: The mounting of power strips to medical equipment assemblies or the reconfiguration of equipment powered by power strips in a medical equipment assembly must be performed by personnel who are qualified to make certain that this is done in accordance with NFPA 99-2012: 10.2.3.6. Note 2: Per NFPA 99-2012: 3.3.138, patient care room is defined as any room of a health care facility wherein patients are intended to be examined or treated. Per NFPA 99-2012: 3.3.139, patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 1.8 meters (6 feet) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment and extending vertically to 2.3 meters (7 feet, 6 inches) above the floor. Note 3: In new facilities, the number of receptacles shall be in accordance with NFPA 99-2012: 6.3.2.2.6.2. If patient bed locations in existing health care facilities undergo renovation or a change in occupancy, the number of receptacles must be increased to meet the requirements of NFPA 99-2012: 6.3.2.2.6.2 to eliminate the need for power strips. **EC.02.05.01, EP 24** Extension cords are not used as a substitute for fixed wiring in a building. Extension cords used temporarily are removed immediately upon completion of the intended purpose. (For full text, refer to NFPA 99-2012: 10.2.3.6; 10.2.4; NFPA 70-2011: 400-8; 590.3(D); Tentative Interim Amendment [TIA] 12-5)	

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		EC.02.05.01, EP 25 Areas designated for administration of general anesthesia (specifically, inhaled anesthetics) using medical gases or vacuum are in accordance with NFPA 101-2012: 8.7 and NFPA 99-2012 as follows: - Zone valves are located immediately outside each anesthetizing location 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 installed to monitor all medical gas, medical-surgical vacuum, and piped waste anesthetic gas disposal (WAGD) systems. Alarm panels include visual and audible sensors and are in locations that provide for surveillance, including medical gas pressure decreases of 20% and vacuum decreases of 12-inch gauge HgV (mercury vacuum). - 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 valve box assemblies. (For full text, refer to NFPA 101-2012: 18/19.3.2.3; NFPA 99-2012: 5.1.4.8.7; 5.1.9.3) **EC.02.05.01, EP 26** Areas designated for administration of general anesthesia (specifically, inhaled anesthetics) using medical gases or vacuum are in accordance with NFPA 101-2012: 8.7 and NFPA 99-2012 as follows: The essential electrical system's (EES) critical branch supplies power for task illumination, fixed equipment, select receptacles, and select power circuits. The EES	

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		equipment system supplies power to the ventilation system. (For full text, refer to NFPA 101-2012: 18/19.3.2.3; NFPA 99-2012: 6.4.2.2.4.2) **EC.02.05.01, EP 27** Newly engineered smoke control systems are designed, installed, maintained, and tested per NFPA 92-2012. Existing smoke control systems are tested and maintained to established engineering principles unless specifically exempted by the authority having jurisdiction. Systems not meeting the performance requirements of the testing specified in NFPA 101-2012: 19.7.7.1 can be continued in operation only with the specific approval of the authority having jurisdiction. (For full text, refer to NFPA 101-2012: 18/19: 7.7; NFPA 92-2012) Note: The smoke plume created by the thermal destruction of tissue by cauterizing equipment and lasers is addressed at Standard EC.02.02.01, EP 9. **EC.02.05.02, 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. **EC.02.05.02, 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	

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		Note: An example would be a flow chart with symbols showing sinks, showers, water fountains, ice machines, and so forth. - A water risk management plan based on the diagram that includes an evaluation of the physical and chemical conditions of each step of the water flow diagram to identify any areas where potentially hazardous conditions may occur (these conditions are most likely to occur in areas with slow or stagnant water) Note: Refer to the Centers for Disease Control and Prevention's "Water Infection Control Risk Assessment (WICRA) for Healthcare Settings" tool as an example for conducting a water-related risk assessment. - A plan for addressing the use of water in areas of buildings where water may have been stagnant for a period of time (for example, unoccupied or temporarily closed areas) - An evaluation of the patient populations served to identify patients who are immunocompromised - Monitoring protocols and acceptable ranges for control measures Note: 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. **EC.02.05.02, EP 3** The individual or team responsible for the water management program manages the following:	

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		- 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 EC.04.01.01, EP 1 for the process of monitoring, reporting, and investigating utility system issues. **EC.02.05.02, 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 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 additional guidance on creating a water management plan. For additional guidance, consult	

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		ANSI/ASHRAE Guideline 12-2020 "Managing the Risk of Legionellosis Associated with Building Water Systems." **EC.02.05.05, EP 2** For hospitals that do not use Joint Commission accreditation for deemed status purposes: The hospital tests utility system components on the inventory before initial use. The completion dates and test results are documented. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital tests utility system components on the inventory before initial use and after major repairs or upgrades. The completion date and the results of the tests are documented. **EC.02.05.05, EP 4** The hospital inspects, tests, and maintains the following: High-risk utility system components on the inventory. The completion date and the results of the activities are 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. **EC.02.05.05, EP 5** The hospital inspects, tests, and maintains the following: Infection control utility system components on the inventory. The completion date and the results of the activities are documented.	

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		Note: Required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components must have a 100% completion rate. **EC.02.05.05, EP 6** The hospital inspects, tests, and maintains the following: Non-high-risk utility system components on the inventory. The completion date and the results of the activities are documented. **EC.02.05.05, EP 7** Line isolation monitors (LIM), if installed, are tested at least monthly by actuating the LIM test switch per NFPA 99-2012: 6.3.2.6.3.6, which activates both visual and audible alarms. For LIM circuits with automated self-testing, a manual test is performed at least annually. LIM circuits are tested per NFPA 99-2012: 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. (For full text, refer to NFPA 99-2012: 6.3.2; 6.3.3; 6.3.4) FOR FULL EP MAPPING VIEW HAP CROSSWALK	
§482.41(d)(3)	(3) The extent and complexity of facilities must be determined by the services offered.	**LD.04.01.11, EP 3** The interior and exterior space provided for care, treatment, and services meets the needs of patients. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The extent and complexity of facilities must be determined by the services offered.	**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.
§482.41(d)(4)	(4) There must be proper ventilation, light, and temperature controls in pharmaceutical,	**EC.02.02.01, EP 9** The hospital minimizes risks associated with selecting,	**PE.04.01.01, EP 3** The hospital has proper ventilation, lighting, and temperature

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	food preparation, and other appropriate areas.	handling, storing, transporting, using, and disposing of hazardous gases and vapors. Note: 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) **EC.02.05.01, EP 16** In non–critical care areas, the ventilation system provides required pressure relationships, temperature, and humidity. Note: Examples of non–critical care areas are general care nursing units; clean and soiled utility rooms in acute care areas; laboratories, pharmacies, diagnostic and treatment areas, food preparation areas, and other support departments. **EC.02.06.01, EP 11** Lighting is suitable for care, treatment, and services.	control in all pharmaceutical, patient care, and food preparation areas.
§482.41(e)	(e) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C.552(a) and 1 CFR part 51. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to:	**EC.02.06.05, EP 1** When planning for new, altered, or renovated space, the hospital uses one of the following design criteria: - State rules and regulations - The most current edition of the Guidelines for Design and Construction of Hospitals published by the Facility Guidelines Institute When the above rules, regulations, and guidelines do not meet specific design needs, use other reputable standards and guidelines that provide equivalent design criteria. Note: For hospitals that use Joint Commission	

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	http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.	accreditation for deemed status purposes: The hospital complies with National Fire Protection Association requirements, including emergency generator location requirements as follows: - Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6) - Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4) - NFPA 110-2010 when a new structure is built or when an existing structure or building is renovated	
§482.41(e)(1)	(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.		
§482.41(e)(1)(i)	(i) NFPA 99, Standards for Health Care Facilities Code of the National Fire Protection Association 99, 2012 edition, issued August 11, 2011.	**EC.01.01.01, EP 12** The hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	**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(e)(1)(ii)	(ii) TIA 12–2 to NFPA 99, issued August 11, 2011.	**EC.01.01.01, EP 12** The hospital complies with the 2012 edition of NFPA 99:	**PE.04.01.01, EP 1** The hospital meets the applicable provisions and proceeds in

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		Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	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(e)(1)(iii)	(iii) TIA 12–3 to NFPA 99, issued August 9, 2012.	**EC.01.01.01, EP 12** The hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	**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.

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§482.41(e)(1)(iv)	(iv) TIA 12–4 to NFPA 99, issued March 7, 2013.	**EC.01.01.01, EP 12** The hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	**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(e)(1)(v)	(v) TIA 12–5 to NFPA 99, issued August 1, 2013.	**EC.01.01.01, EP 12** The hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	**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

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			person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§482.41(e)(1)(vi)	(vi) TIA 12–6 to NFPA 99, issued March 3, 2014.	**EC.01.01.01, EP 12** The hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	**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(e)(1)(vii)	(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011;	**LS.01.01.01, EP 8** The hospital complies with the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	**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

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			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.
§482.41(e)(1)(viii)	(viii) TIA 12–1 to NFPA 101, issued August 11, 2011.	**LS.01.01.01, EP 8** The hospital complies with the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	**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 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

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			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(e)(1)(ix)	(ix) TIA 12–2 to NFPA 101, issued October 30, 2012.	**LS.01.01.01, EP 8** The hospital complies with the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	**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 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.
§482.41(e)(1)(x)	(x) TIA 12–3 to NFPA 101, issued October 22, 2013.	**LS.01.01.01, EP 8** The hospital complies with the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	**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

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			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 standard(s) referenced for the activity; and results of the activity.
§482.41(e)(1)(xi)	(xi) TIA 12–4 to NFPA 101, issued October 22, 2013.	**LS.01.01.01, EP 8** The hospital complies with the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	**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

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			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.
§482.42	§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.	**EC.02.05.01, EP 15** 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. For new and existing health care facilities, or altered, renovated, or modernized portions of existing systems or individual components (constructed or plans approved on or after July 5, 2016), heating, cooling, and ventilation are in accordance with NFPA 99-2012, which includes 2008 ASHRAE 170, or state design requirements if more stringent. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: Existing facilities may elect to implement a Centers for Medicare & Medicaid Services (CMS) categorical waiver to reduce their relative humidity to 20% in operating rooms and other anesthetizing locations. Should the facility elect the waiver, it must be included in its Basic Building Information (BBI), and the facility's equipment and	**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

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		supplies must be compatible with the humidity reduction. For further information on waiver and equivalency requests, see https://www.jointcommission.org/resources/patient-safety-topics/the-physical-environment/life-safety-code-information-and-resources/. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: Existing facilities may comply with the 2012 NFPA 99 ventilation requirements or the ventilation requirements in the edition of the NFPA code previously adopted by CMS at the time of installation (for example, 1999 NFPA 99). **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 staff 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	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 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

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		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.01.06.01 EPs 1, 3, 5, 6). **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	Protection Standard 29 CFR 1910.134; health care worker vaccination laws; state and local public health authorities' requirements for reporting of communicable diseases and outbreaks; and state and local regulatory requirements for biohazardous or regulated medical waste generators. Note 2: For full details on the CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, refer to https://www.cdc.gov/infection-control/hcp/disinfection-sterilization/introduction-methods-definition-of-terms.html. Note 3: The hospital determines which evidence-based guidelines, expert recommendations, best practices, or a combination thereof it adopts in its policies and procedures. **IC.04.01.01, EP 5** The infection prevention and control program reflects the scope and complexity of the 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**

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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/infection-control/hcp/disinfection-sterilization/introduction-methods-definition-of-terms.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 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 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). **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 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

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		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 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.09.01.01, EP 10** The hospital allocates financial resources for staffing	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.

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		and information technology to support the antibiotic stewardship program. **MM.09.01.01, EP 12** The leader(s) of the antibiotic stewardship program is responsible for the following: - Developing and implementing a hospitalwide antibiotic stewardship program that is based on nationally recognized guidelines to monitor and improve the use of antibiotics - Documenting antibiotic stewardship activities, including any new or sustained improvements - Communicating and collaborating with the medical staff, nursing leaders, and pharmacy leaders, as well as with the hospital's infection prevention and control and quality assessment and performance improvement programs on antibiotic use issues - Providing competency-based training and education for staff on the practical applications of antibiotic stewardship guidelines, policies, and procedures	
§482.42(a)	(a) Standard: Infection prevention and control program organization and policies. The hospital must demonstrate that:		
§482.42(a)(1)	(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 preventionist(s)/infection control professional(s) responsible for the infection prevention and control program and that the appointment is based on the	**HR.01.01.01, 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 of 1988 (CLIA '88), under Subpart M:	**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 (CLIA), under Subpart M: "Personnel for Nonwaived Testing" §493.1351-§493.1495. A complete description of the requirement is located

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	recommendations of medical staff leadership and nursing leadership;	"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 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital. The provision of care and staff qualifications are in accordance with national acceptable standards of practice and also meet the requirements of 409.17. See Appendix A for 409.17 requirements. 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. Note 5: For hospitals that use Joint Commission accreditation for deemed status purposes: Staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing. **IC.04.01.01, EP 1** The hospital's governing body, based on the	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. 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.

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		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.	
§482.42(a)(2)	(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;	**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 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	**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 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

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		1910.134; health care worker vaccination laws; state and local public health authorities' requirements for reporting of communicable diseases and outbreaks; and state and local regulatory requirements for biohazardous or regulated medical waste generators. Note 2: For full details on the CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, refer to https://www.cdc.gov/infection-control/hcp/disinfection-sterilization/introduction-methods-definition-of-terms.html. Note 3: The 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 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	biohazardous or regulated medical waste generators. Note 2: For full details on the CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, refer to https://www.cdc.gov/infection-control/hcp/disinfection-sterilization/introduction-methods-definition-of-terms.html. Note 3: The 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 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

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		in accordance with FDA-cleared label and device manufacturers' instructions - Required documentation for device reprocessing cycles, including but not limited to sterilizer cycle logs, the frequency of chemical and biological testing, and the results of testing for appropriate concentration for chemicals used in high-level disinfection - Resolution of conflicts or discrepancies between a medical device manufacturer's instructions and manufacturers' instructions for automated high-level disinfection or sterilization equipment - Criteria and process for the use of immediate-use steam sterilization - Actions to take in the event of a reprocessing error or failure identified either prior to the release of the reprocessed item(s) or after the reprocessed item(s) was used or stored for later use Note 1: The Spaulding classification system classifies medical and surgical devices as critical, semicritical, or noncritical based on risk to the patient from contamination on a device and establishes the levels of germicidal activity (sterilization, high-level disinfection, intermediate-level disinfection, and low-level disinfection) to be used for the three classes of devices. Note 2: Depending on the nature of the incident, examples of actions may include quarantine of the sterilizer, recall of item(s), stakeholder notification, patient notification, surveillance, and follow-up.	equipment - Criteria and process for the use of immediate-use steam sterilization - Actions to take in the event of a reprocessing error or failure identified either prior to the release of the reprocessed item(s) or after the reprocessed item(s) was used or stored for later use Note 1: The Spaulding classification system classifies medical and surgical devices as critical, semicritical, or noncritical based on risk to the patient from contamination on a device and establishes the levels of germicidal activity (sterilization, high-level disinfection, intermediate-level disinfection, and low-level disinfection) to be used for the three classes of devices. Note 2: Depending on the nature of the incident, examples of actions may include quarantine of the sterilizer, recall of item(s), stakeholder notification, patient notification, surveillance, and follow-up.
§482.42(a)(3)	(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	**EC.02.05.02, 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	**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

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	addresses any infection control issues identified by public health authorities; and	activities. **EC.02.05.02, EP 2** The individual or team responsible for the water management program develops the following: - A basic diagram that maps all water supply sources, treatment systems, processing steps, control measures, and end-use points Note: An example would be a flow chart with symbols showing sinks, showers, water fountains, ice machines, and so forth. - A water risk management plan based on the diagram that includes an evaluation of the physical and chemical conditions of each step of the water flow diagram to identify any areas where potentially hazardous conditions may occur (these conditions are most likely to occur in areas with slow or stagnant water) Note: Refer to the Centers for Disease Control and Prevention's "Water Infection Control Risk Assessment (WICRA) for Healthcare Settings" tool as an example for conducting a water-related risk assessment. - A plan for addressing the use of water in areas of buildings where water may have been stagnant for a period of time (for example, unoccupied or temporarily closed areas) - An evaluation of the patient populations served to identify patients who are immunocompromised - Monitoring protocols and acceptable ranges for control measures Note: 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,	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 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.

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		protocols should include specificity around the parameters measured, locations where measurements are made, and appropriate corrective actions taken when parameters are out of range. **EC.02.06.05, EP 2** When planning for demolition, construction, renovation, or general maintenance, the hospital conducts a preconstruction risk assessment for air quality requirements, infection control, utility requirements, noise, vibration, and other hazards that affect care, treatment, and services. Note: See LS.01.02.01 for information on fire safety procedures to implement during construction or renovation. **EC.02.06.05, EP 3** The hospital takes action based on its assessment to minimize risks during demolition, construction, renovation, or general maintenance. **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:	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.04.01.05, EP 1** The water management program has an individual or a team responsible for the oversight and implementation of the program, including but not limited to development, management, and maintenance activities. **PE.04.01.05, EP 2** The individual or team responsible for the water management program develops the following: - A basic diagram that maps all water supply sources, treatment systems, processing steps, control measures, and end-use points Note: An example would be a flow chart with symbols showing sinks, showers, water fountains, ice machines, and so forth. - A water risk management plan based on the diagram that includes an evaluation of the physical and chemical conditions of each step of the water flow diagram to identify any areas where potentially hazardous conditions may occur (these conditions are most likely to occur in areas with slow or stagnant water) Note: Refer to the Centers for Disease Control and Prevention's "Water Infection Control Risk Assessment (WICRA) for Healthcare Settings" tool as an example for conducting a water-related risk assessment. - A plan for addressing the use of water in areas of buildings where water may have been stagnant for a period of time (for example, unoccupied or temporarily closed areas)

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		- Implementing infection prevention and control activities when an outbreak is first recognized by internal surveillance or public health authorities - Reporting an outbreak in accordance with state and local public health authorities' requirements - Investigating an outbreak - Communicating information necessary to prevent further transmission of the infection among patients, visitors, and staff, as appropriate **IC.06.01.01, EP 5** The 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	- 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.
§482.42(a)(4)	(4) The infection prevention and control program reflects the scope and complexity of the hospital services provided.	**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.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(b)	(b) Standard: Antibiotic stewardship program organization and policies. The hospital must demonstrate that:		
§482.42(b)(1)	(1) An individual (or individuals), who is qualified through education, training, or experience in infectious diseases and/or	**MM.09.01.01, EP 11** The governing body appoints a physician and/or pharmacist who is qualified through education, training,	**MM.18.01.01, EP 2** The hospital demonstrates that an individual (or individuals), who is qualified through education, training, or experience in infectious

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	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;	or experience in infectious diseases and/or antibiotic stewardship as the leader(s) of the antibiotic stewardship program. Note: The appointment(s) is based on recommendations of medical staff leaders and pharmacy leaders.	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)(2)	(2) The hospital-wide antibiotic stewardship program:		
§482.42(b)(2)(i)	(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;	**MM.09.01.01, EP 14** The 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.	**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 of the hospital. - Documents any improvements, including sustained improvements, in proper antibiotic use.
§482.42(b)(2)(ii)	(ii) Documents the evidence-based use of antibiotics in all departments and services of the hospital; and	**MM.09.01.01, EP 15** The antibiotic stewardship program documents the evidence-based use of antibiotics in all departments and services of the hospital.	**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 of the hospital. - Documents any improvements, including sustained improvements, in proper antibiotic use.
§482.42(b)(2)(iii)	(iii) Documents any improvements, including sustained improvements, in proper antibiotic use;	**MM.09.01.01, EP 12** The leader(s) of the antibiotic stewardship program is responsible for the following:	**MM.18.01.01, EP 5** The hospitalwide antibiotic stewardship program: - Demonstrates coordination among all components of the

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		- Developing and implementing a hospitalwide antibiotic stewardship program that is based on nationally recognized guidelines to monitor and improve the use of antibiotics - Documenting antibiotic stewardship activities, including any new or sustained improvements - Communicating and collaborating with the medical staff, nursing leaders, and pharmacy leaders, as well as with the hospital's infection prevention and control and quality assessment and performance improvement programs on antibiotic use issues - Providing competency-based training and education for staff on the practical applications of antibiotic stewardship guidelines, policies, and procedures **MM.09.01.01, EP 20** The antibiotic stewardship program collects, analyzes, and reports data to hospital leaders and prescribers. Note: Examples of antibiotic stewardship program data include antibiotic resistance patterns, antibiotic prescribing practices, or an evaluation of antibiotic stewardship activities. **MM.09.01.01, EP 21** The hospital takes action on improvement opportunities identified by the antibiotic stewardship program.	hospital responsible for antibiotic use and resistance, including, but not limited to, the infection prevention and control program, the QAPI program, the medical staff, nursing services, and pharmacy services. - Documents the evidence-based use of antibiotics in all departments and services of the hospital. - Documents any improvements, including sustained improvements, in proper antibiotic use.
§482.42(b)(3)	(3) The antibiotic stewardship program adheres to nationally recognized guidelines, as well as best practices, for improving antibiotic use; and	**MM.09.01.01, EP 17** The antibiotic stewardship program implements one or both of the following strategies to optimize antibiotic prescribing: - Preauthorization for specific antibiotics that includes an internal review and approval process prior to use - Prospective review and feedback regarding antibiotic	**MM.18.01.01, EP 6** The antibiotic stewardship program adheres to nationally recognized guidelines, as well as best practices, for improving antibiotic use.

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		prescribing practices, including the treatment of positive blood cultures, by a member of the antibiotic stewardship program **MM.09.01.01, EP 18** The antibiotic stewardship program implements at least two evidence-based guidelines to improve antibiotic use for the most common indications. Note 1: Examples include, but are not limited to, the following: - Community-acquired pneumonia - Urinary tract infections - Skin and soft tissue infections - Clostridioides difficile colitis - Asymptomatic bacteriuria - Plan for parenteral to oral antibiotic conversion - Use of surgical prophylactic antibiotics Note 2: Evidence-based guidelines must be based on national guidelines and also reflect local susceptibilities, formulary options, and the patients served, as needed. **MM.09.01.01, EP 19** The antibiotic stewardship program evaluates adherence (including antibiotic selection and duration of therapy, where applicable) to at least one of the evidence-based guidelines the hospital implements. Note 1: The hospital may measure adherence at the group level (that is, departmental, unit, clinician subgroup) or at the individual prescriber level. Note 2: The hospital may obtain adherence data for a sample of patients from relevant clinical areas by	

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		analyzing electronic health records or by conducting chart reviews.	
§482.42(b)(4)	(4) The antibiotic stewardship program reflects the scope and complexity of the hospital services provided.	**MM.09.01.01, EP 12** The leader(s) of the antibiotic stewardship program is responsible for the following: - Developing and implementing a hospitalwide antibiotic stewardship program that is based on nationally recognized guidelines to monitor and improve the use of antibiotics - Documenting antibiotic stewardship activities, including any new or sustained improvements - Communicating and collaborating with the medical staff, nursing leaders, and pharmacy leaders, as well as with the hospital's infection prevention and control and quality assessment and performance improvement programs on antibiotic use issues - Providing competency-based training and education for staff on the practical applications of antibiotic stewardship guidelines, policies, and procedures **MM.09.01.01, EP 15** The antibiotic stewardship program documents the evidence-based use of antibiotics in all departments and services of the hospital.	**MM.18.01.01, EP 1** The antibiotic stewardship program reflects the scope and complexity of the hospital services provided.
§482.42(c)	(c) Standard: Leadership responsibilities.		
§482.42(c)(1)	(1) The governing body must ensure all of the following:		
§482.42(c)(1)(i)	(i) Systems are in place and operational for the tracking of all infection surveillance, prevention, and control, and antibiotic use activities, in order to demonstrate the implementation, success, and sustainability of such activities.	**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.	**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.

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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.09.01.01, EP 12** The leader(s) of the antibiotic stewardship program is responsible for the following: - Developing and implementing a hospitalwide antibiotic stewardship program that is based on nationally recognized guidelines to monitor and improve the use of antibiotics - Documenting antibiotic stewardship activities, including any new or sustained improvements - Communicating and collaborating with the medical staff, nursing leaders, and pharmacy leaders, as well as with the hospital's infection prevention and control and quality assessment and performance improvement programs on antibiotic use issues - Providing competency-based training and education for staff on the practical applications of antibiotic stewardship guidelines, policies, and procedures **MM.09.01.01, EP 20** The antibiotic stewardship program collects, analyzes, and reports data to hospital leaders and prescribers. Note: Examples of antibiotic stewardship program data include antibiotic resistance patterns, antibiotic prescribing practices, or an evaluation of antibiotic	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.

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		stewardship activities. **MM.09.01.01, EP 21** The hospital takes action on improvement opportunities identified by the antibiotic stewardship program.	
§482.42(c)(1)(ii)	(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.	**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.09.01.01, EP 12** The leader(s) of the antibiotic stewardship program is responsible for the following: - Developing and implementing a hospitalwide antibiotic stewardship program that is based on nationally recognized guidelines to monitor and improve the use of antibiotics - Documenting antibiotic stewardship activities, including any new or sustained improvements - Communicating and collaborating with the medical staff, nursing leaders, and pharmacy leaders, as well as with the hospital's infection prevention and control and quality assessment and performance improvement programs on antibiotic use issues - Providing competency-based training and education for staff on the practical applications of antibiotic stewardship guidelines, policies, and procedures **MM.09.01.01, EP 14** The antibiotic stewardship program demonstrates	**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 ensures all antibiotic use issues identified by the antibiotic stewardship program are addressed in collaboration with the hospital's QAPI leadership.

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		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.	
§482.42(c)(2)	(2) The infection preventionist(s)/infection control professional(s) is responsible for:		
§482.42(c)(2)(i)	(i) The development and implementation of hospital-wide infection surveillance, prevention, and control policies and procedures that adhere to nationally recognized guidelines.	**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 staff 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	**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 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

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		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.01.06.01 EPs 1, 3, 5, 6).	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).
§482.42(c)(2)(ii)	(ii) All documentation, written or electronic, of the infection prevention and control program and its surveillance, prevention, and control activities.	**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 staff 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	**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 address infection prevention and control issues

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		- 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.01.06.01 EPs 1, 3, 5, 6).	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).
§482.42(c)(2)(iii)	(iii) Communication and collaboration with the hospital's QAPI program on infection prevention and control issues.	**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 staff 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	**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

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		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.01.06.01 EPs 1, 3, 5, 6).	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).
§482.42(c)(2)(iv)	(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.	**HR.01.05.03, 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.01.06.01, EP 1** The hospital defines the competencies it requires of its staff who provide patient care, treatment, or services. **HR.01.06.01, EP 3** An individual with the educational background, experience, or knowledge related to the skills being reviewed assesses competence. Note: When a suitable individual cannot be found to assess staff competence, the hospital can utilize an outside individual for this task. If a suitable individual inside or outside the hospital cannot be found, the hospital may consult the competency guidelines from	**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, 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

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		an appropriate professional organization to make its assessment. **HR.01.06.01, EP 5** Staff competence is initially assessed and documented as part of orientation. **HR.01.06.01, EP 6** Staff competence is assessed and documented 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, 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 staff 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	- 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 high-level disinfection. (For more information on competency requirements, refer to HR.11.04.01 EP 1).

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		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.01.06.01 EPs 1, 3, 5, 6).	
§482.42(c)(2)(v)	(v) The prevention and control of HAIs, including auditing of adherence to infection prevention and control policies and procedures by hospital personnel.	**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 staff 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	**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,

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		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.01.06.01 EPs 1, 3, 5, 6).	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).
§482.42(c)(2)(vi)	(vi) Communication and collaboration with the antibiotic stewardship program.	**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 staff 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	**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

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		- 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.01.06.01 EPs 1, 3, 5, 6).	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).
§482.42(c)(3)	(3) The leader(s) of the antibiotic stewardship program is responsible for:		
§482.42(c)(3)(i)	(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.	**MM.09.01.01, EP 12** The leader(s) of the antibiotic stewardship program is responsible for the following: - Developing and implementing a hospitalwide antibiotic stewardship program that is based on nationally recognized guidelines to monitor and improve the use of antibiotics - Documenting antibiotic stewardship activities, including any new or sustained improvements - Communicating and collaborating with the medical staff, nursing leaders, and pharmacy leaders, as well as with the hospital's infection prevention and control and quality assessment and performance improvement	**MM.18.01.01, EP 3** The leader(s) of the antibiotic stewardship program is responsible for the following: - Development and implementation 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

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		programs on antibiotic use issues - Providing competency-based training and education for staff on the practical applications of antibiotic stewardship guidelines, policies, and procedures	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.
§482.42(c)(3)(ii)	(ii) All documentation, written or electronic, of antibiotic stewardship program activities.	**MM.09.01.01, EP 12** The leader(s) of the antibiotic stewardship program is responsible for the following: - Developing and implementing a hospitalwide antibiotic stewardship program that is based on nationally recognized guidelines to monitor and improve the use of antibiotics - Documenting antibiotic stewardship activities, including any new or sustained improvements - Communicating and collaborating with the medical staff, nursing leaders, and pharmacy leaders, as well as with the hospital's infection prevention and control and quality assessment and performance improvement programs on antibiotic use issues - Providing competency-based training and education for staff on the practical applications of antibiotic stewardship guidelines, policies, and procedures	**MM.18.01.01, EP 3** The leader(s) of the antibiotic stewardship program is responsible for the following: - Development and implementation 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.
§482.42(c)(3)(iii)	(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.	**MM.09.01.01, EP 12** The leader(s) of the antibiotic stewardship program is responsible for the following: - Developing and implementing a hospitalwide antibiotic stewardship program that is based on nationally recognized guidelines to monitor and improve the use of antibiotics - Documenting antibiotic stewardship activities, including any new or sustained improvements - Communicating and collaborating with the medical staff, nursing leaders, and pharmacy leaders, as well as with the hospital's infection prevention and control and	**MM.18.01.01, EP 3** The leader(s) of the antibiotic stewardship program is responsible for the following: - Development and implementation 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.

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		quality assessment and performance improvement programs on antibiotic use issues - Providing competency-based training and education for staff on the practical applications of antibiotic stewardship guidelines, policies, and procedures	- 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.
§482.42(c)(3)(iv)	(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.	**MM.09.01.01, EP 12** The leader(s) of the antibiotic stewardship program is responsible for the following: - Developing and implementing a hospitalwide antibiotic stewardship program that is based on nationally recognized guidelines to monitor and improve the use of antibiotics - Documenting antibiotic stewardship activities, including any new or sustained improvements - Communicating and collaborating with the medical staff, nursing leaders, and pharmacy leaders, as well as with the hospital's infection prevention and control and quality assessment and performance improvement programs on antibiotic use issues - Providing competency-based training and education for staff on the practical applications of antibiotic stewardship guidelines, policies, and procedures	**MM.18.01.01, EP 3** The leader(s) of the antibiotic stewardship program is responsible for the following: - Development and implementation 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.
§482.42(d)	(d) Standard: Unified and integrated infection prevention and control and antibiotic stewardship programs for multi-hospital systems. If a hospital is 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	**LD.01.03.01, EP 27** 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	**LD.11.01.01, EP 10** 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. Each separately certified hospital subject to the system governing

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	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:	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	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 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).

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§482.42(d)(1)	(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;	**LD.01.03.01, EP 27** 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	**LD.11.01.01, EP 10** 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. 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 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

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		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	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).
§482.42(d)(2)	(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;	**LD.01.03.01, EP 27** 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	**LD.11.01.01, EP 10** 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. 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

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		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	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 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).
§482.42(d)(3)	(3) The unified and integrated infection prevention and control and antibiotic stewardship programs have mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed; and	**LD.01.03.01, EP 27** 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	**LD.11.01.01, EP 10** 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. Each separately certified hospital subject to the system governing

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		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	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 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).

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§482.42(d)(4)	(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.	**LD.01.03.01, EP 27** 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	**LD.11.01.01, EP 10** 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. 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 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

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		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	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).
§482.43	§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 postdischarge 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.	**PC.04.01.03, EP 7** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has an effective discharge planning process that focuses on the patient's goals and treatment preferences and includes the patient and the patient's caregiver or support person(s) as active partners in the discharge planning for post-discharge care. The discharge planning process is consistent with the patient's goals for care and their treatment preferences, makes certain that there is an effective transition of the patient from the hospital to post-discharge care, and reduces the factors leading to preventable hospital readmissions.	**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 postdischarge 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 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).

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			Note 2: For hospitals that use Joint 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.
§482.43(a)	§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.	**PC.04.01.03, EP 1** The hospital begins the discharge planning process early in the patient's episode of care, treatment, and services. **PC.04.01.03, EP 2** The hospital identifies any needs the patient may have for psychosocial or physical care, treatment, and services after discharge or transfer. For hospitals that use Joint Commission accreditation for deemed status purposes: The identification of needs also includes hospice care, post-hospital extended care, home health, and non–health care services, as well as the need for community-based care providers. The hospital determines the availability of the post-hospital services as well as the patient's access to those services.	**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 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)	(1) Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital	**PC.04.01.03, EP 1** 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

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	care will be made before discharge and to avoid unnecessary delays in discharge.	**PC.04.01.03, EP 2** The hospital identifies any needs the patient may have for psychosocial or physical care, treatment, and services after discharge or transfer. For hospitals that use Joint Commission accreditation for deemed status purposes: The identification of needs also includes hospice care, post-hospital extended care, home health, and non–health care services, as well as the need for community-based care providers. The hospital determines the availability of the post-hospital services as well as the patient's access to those services. **PC.04.01.03, EP 4** Prior to discharge, the hospital arranges or assists in arranging the services required by the patient after discharge in order to meet the patient's ongoing needs for care and services.	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)(2)	(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, 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.	**PC.04.01.03, EP 2** The hospital identifies any needs the patient may have for psychosocial or physical care, treatment, and services after discharge or transfer. For hospitals that use Joint Commission accreditation for deemed status purposes: The identification of needs also includes hospice care, post-hospital extended care, home health, and non–health care services, as well as the need for community-based care providers. The hospital determines the availability of the post-hospital services as well as the patient's access to those services.	**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 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.

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		PC.04.01.03, EP 4 Prior to discharge, the hospital arranges or assists in arranging the services required by the patient after discharge in order to meet the patient's ongoing needs for care and services.	
§482.43(a)(3)	(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).	**PC.04.01.03, EP 3** The patient, the patient's family, physicians, other licensed practitioners, clinical psychologists, and staff involved in the patient's care, treatment, and services participate in planning the patient's discharge or transfer. 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 psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Social service staff responsibilities include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the hospital. Note 3: For hospitals that use Joint 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 in writing. 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. Note 4: For hospitals that use Joint Commission	**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 - 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

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		accreditation for deemed status purposes: Discharge planning is performed by, or under the supervision of, a registered nurse, social worker, or other qualified person. **RC.02.01.01, EP 2** The medical record contains the following clinical information: - The reason(s) for admission for care, treatment, and services - The patient's initial diagnosis, diagnostic impression(s), or condition(s) - Any findings of assessments and reassessments - Any allergies to food - Any allergies to medications - Any conclusions or impressions drawn from the patient's medical history and physical examination - Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric hospitals using Joint Commission accreditation for deemed status purposes: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival	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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		- Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration Note 1: 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. Note 2: For the definition and a further explanation of block charting, refer to the Glossary. - Any access site for medication, administration devices used, and rate of administration - Any adverse drug reactions - Treatment goals, plan of care, and revisions to the plan of care - Results of diagnostic and therapeutic tests and procedures - Any medications dispensed or prescribed on discharge - Discharge diagnosis - Discharge plan and discharge planning evaluation	
§482.43(a)(4)	(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.	**PC.04.01.03, EP 1** The hospital begins the discharge planning process early in the patient's episode of care, treatment, and services. **PC.04.01.03, EP 2** The hospital identifies any needs the patient may have for psychosocial or physical care, treatment, and services after discharge or transfer. For hospitals that use Joint Commission accreditation for deemed status purposes: The identification of needs also includes hospice care, post-hospital extended	**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

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		care, home health, and non–health care services, as well as the need for community-based care providers. The hospital determines the availability of the post-hospital services as well as the patient's access to those services. **PC.04.01.03, EP 3** The patient, the patient's family, physicians, other licensed practitioners, clinical psychologists, and staff involved in the patient's care, treatment, and services participate in planning the patient's discharge or transfer. 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 psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Social service staff responsibilities include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the hospital. Note 3: For hospitals that use Joint 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 in writing. 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.	subsequent discharge plan is created by, or under the supervision of, a registered nurse, social worker, or other qualified person.

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		Note 4: For hospitals that use Joint Commission accreditation for deemed status purposes: Discharge planning is performed by, or under the supervision of, a registered nurse, social worker, or other qualified person. **PC.04.01.03, EP 4** Prior to discharge, the hospital arranges or assists in arranging the services required by the patient after discharge in order to meet the patient's ongoing needs for care and services.	
§482.43(a)(5)	(5) Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of, a registered nurse, social worker, or other appropriately qualified personnel.	**HR.01.01.01, 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 of 1988 (CLIA '88), 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 484.4) provide physical therapy, occupational therapy, speech-	**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.

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		language pathology, or audiology services, if these services are provided by the hospital. The provision of care and staff qualifications are in accordance with national acceptable standards of practice and also meet the requirements of 409.17. See Appendix A for 409.17 requirements. 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. Note 5: For hospitals that use Joint Commission accreditation for deemed status purposes: 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.02.01.05, EP 1** Care, treatment, and services are provided to the patient in an interdisciplinary, collaborative manner. **PC.02.02.01, EP 3** The hospital coordinates the patient's care, treatment, and services within a time frame that meets the patient's needs. Note: Coordination involves resolving scheduling conflicts and duplication of care, treatment, and services. **PC.04.01.03, EP 3** The patient, the patient's family, physicians, other	

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		licensed practitioners, clinical psychologists, and staff involved in the patient's care, treatment, and services participate in planning the patient's discharge or transfer. 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 psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Social service staff responsibilities include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the hospital. Note 3: For hospitals that use Joint 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 in writing. 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. Note 4: For hospitals that use Joint Commission accreditation for deemed status purposes: Discharge planning is performed by, or under the supervision of, a registered nurse, social worker, or other qualified person.	
§482.43(a)(6)	(6) The hospital's discharge planning process must require regular re-evaluation of the patient's condition to identify changes	**PC.01.02.03, EP 3** Each patient is reassessed as necessary based on their plan for care or changes in their condition.	**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

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	that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.	Note: Reassessments may also be based on the patient's diagnosis; desire for care, treatment, and services; response to previous care, treatment, and services; discharge planning needs; and/or their setting requirements. **PC.01.03.01, EP 22** Based on the goals established in the patient's plan of care, staff evaluate the patient's progress. **PC.01.03.01, EP 23** The hospital revises plans and goals for care, treatment, and services based on the patient's needs.	treatment preferences; makes certain there is an effective transition of the patient from the hospital to postdischarge 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)(7)	(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 within 30 days of a previous admission, to ensure that the plans are responsive to patient post-discharge needs.	**PC.04.01.03, EP 10** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital assesses its discharge planning process within its established time frames. The assessment includes ongoing, periodic review of a representative sample of discharge plans, including those patients who were readmitted within 30 days of a previous admission, to make certain that the plans are responsive to patient post-discharge needs.	**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 plans for patients who were readmitted within 30 days of a previous admission, to make certain that the plans are responsive to patient postdischarge needs.
§482.43(a)(8)	(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.	**PC.04.01.01, EP 31** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital assists 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, 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	**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.

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		relevant and applicable to the patient's goals of care and treatment preferences.	
§482.43(b)	§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 course of illness and treatment, postdischarge goals of care, and treatment preferences, at the time of discharge, to the appropriate post-acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners responsible for the patient's follow-up or ancillary care.	**IM.02.01.01, EP 4** The hospital discloses health information only as authorized by the patient or as otherwise consistent with law and regulation. **PC.02.02.01, EP 1** The hospital follows a process to receive or share patient information when the patient is referred to other internal or external providers of care, treatment, and services. **PC.04.02.01, EP 1** At the time of the patient's discharge or transfer, the hospital informs other service providers who will provide care, treatment, and services to the patient about the following: - The reason for the patient's discharge or transfer - The patient's physical and psychosocial status - A summary of care, treatment, and services it provided to the patient - The patient's progress toward goals - A list of community resources or referrals made or provided to the patient Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital also informs other service providers of the patient's treatment preferences. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The information sent to the receiving	**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 a minimum, the following: - Current course of illness and treatment - Postdischarge goals of care - Treatment preferences at the time of discharge

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		provider also includes the following: - Contact information of the physician or other licensed practitioner responsible for the care of the resident - Resident representative information, including contact information - Advance directive information - All special instructions or precautions for ongoing care, when appropriate - Comprehensive care plan goals	
§482.43(c)	§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:		
§482.43(c)(1)	(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.	**PC.04.01.01, EP 32** 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.	**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.

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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, post-hospital extended care services, skilled nursing, inpatient rehabilitation, or long-term care hospital services are identified as needed.	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)(i)	(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.	**PC.04.01.01, EP 32** 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, post-hospital extended care services, skilled nursing, inpatient rehabilitation, or long-term care hospital services are identified as needed.	**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)(ii)	(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	**PC.04.01.01, EP 33** 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	**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

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	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.	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.	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)(iii)	(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.	**PC.04.01.01, EP 32** 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, post-hospital extended care services, skilled nursing, inpatient rehabilitation, or long-term care hospital services are identified as needed.	**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)(2)	(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	**PC.04.01.01, EP 22** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital informs the patient or the patient's representative of the patient's freedom to choose among participating Medicare providers and suppliers of post-discharge services and, when possible, respects the patient's or patient representative's goals of care and treatment	**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

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	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.	preferences, as well as other preferences when they are expressed. The hospital does not limit the qualified providers who are available to the patient.	the qualified providers or suppliers that are available to the patient.
§482.43(c)(3)	(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 accordance with the provisions of part 420, subpart C, of this chapter.	**PC.04.01.01, EP 25** 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 determined in accordance with the provisions in 42 CFR 420, subpart C and section 1861 of the Social Security Act.	**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 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).
§482.45	§482.45 Condition of Participation: Organ, Tissue and Eye Procurement		
§482.45(a)	§482.45(a) Standard: Organ Procurement Responsibilities The hospital must have and implement written protocols that:		
§482.45(a)(1)	(1) Incorporate an agreement with an OPO designated under part 486 of this chapter, under which it must notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the 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	**TS.01.01.01, EP 1** The hospital has a written agreement with an organ procurement organization (OPO) and follows its rules and regulations. **TS.01.01.01, EP 9** The hospital notifies the organ procurement organization (OPO) of patients who have died and of mechanically ventilated patients whose death is imminent, according to the following: - Clinical triggers defined jointly with its medical staff and the designated OPO - Within the time frames (ideally, within one hour of	**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 requires the hospital to notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the 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

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	consultation with the tissue and eye banks identified by the hospital for this purpose;	death for patients who have expired) jointly agreed on by the hospital and the designated OPO - For mechanically ventilated patients, prior to the withdrawal of life-sustaining therapies including medical or pharmacological support Note: For additional information about criteria for the determination of brain death, please see the American Academy of Neurology guidelines available at https://n.neurology.org/content/early/2023/09/13/WNL.0000000000207740 and 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.01.01.01, EP 11** The organ procurement organization determines medical suitability of organs for organ donation and, in the absence of alternative arrangements by the hospital, it determines the medical suitability of tissue and eyes for donation.	extent that the agreement does not interfere with organ procurement - Designation of an individual, who is an organ procurement representative, an organizational representative of a tissue or eye bank, or a designated requestor, to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes. - Procedures for informing the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes, in collaboration with the designated OPO - Education and training of staff in the use of discretion and sensitivity to the circumstances, views, and beliefs of the family when discussing potential organ, tissue, or eye donations Note 1: 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: Note: 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

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			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.
§482.45(a)(2)	(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;	**TS.01.01.01, EP 3** The hospital has 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. Note 1: This process should not interfere with organ procurement. Note 2: It is not necessary for a hospital to have a separate agreement with a tissue bank if it has an agreement with its organ procurement organization (OPO) to provide tissue procurement services, nor is it necessary for a hospital to have a separate agreement with an eye bank if its OPO provides eye procurement services. The hospital is not required to use the OPO for tissue or eye procurement, and is free to have an agreement with the tissue bank or eye bank of its choice.	**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 requires the hospital to notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the hospital, and that includes the OPO's responsibility to determine medical suitability for organ donation - A written agreement with at least one tissue bank and at least one eye bank to cooperate in retrieving, processing, preserving, storing, and distributing tissues and eyes to make certain that all usable tissues and eyes are obtained from potential donors, to the extent that the agreement does not interfere with organ procurement - Designation of an individual, who is an organ procurement representative, an organizational representative of a tissue or eye bank, or a designated requestor, to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes. - Procedures for informing the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes, in collaboration with the designated OPO - Education and training of staff in the use of discretion and sensitivity to the circumstances, views, and beliefs of the family when discussing potential organ, tissue, or eye donations Note 1: 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.

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			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: Note: 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.
§482.45(a)(3)	(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	**TS.01.01.01, EP 6** The hospital develops, in collaboration with the designated organ procurement organization, written procedures for notifying the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes.	**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 requires the hospital to notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the 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

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	by the OPO and designed in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ or tissue donation;		eye bank to cooperate in retrieving, processing, preserving, storing, and distributing tissues and eyes to make certain that all usable tissues and eyes are obtained from potential donors, to the extent that the agreement does not interfere with organ procurement - Designation of an individual, who is an organ procurement representative, an organizational representative of a tissue or eye bank, or a designated requestor, to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes. - Procedures for informing the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes, in collaboration with the designated OPO - Education and training of staff in the use of discretion and sensitivity to the circumstances, views, and beliefs of the family when discussing potential organ, tissue, or eye donations Note 1: 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: Note: For additional information about criteria for the determination of brain death, see the American Academy of

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			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.
§482.45(a)(3) continued	Element Deleted	**TS.01.01.01, EP 7** The individual designated by the hospital to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes is an organ procurement representative, an organizational representative of a tissue or eye bank, or a designated requestor. Note: 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.	
§482.45(a)(4)	(4) Encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of the families of potential donors;	**TS.01.01.01, EP 5** Staff who have been designated to discuss potential organ, tissue, or eye donations with families are educated and trained in the use of discretion and sensitivity to the circumstances, beliefs, and desires of the families.	**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 requires the hospital to notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the 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

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			extent that the agreement does not interfere with organ procurement - Designation of an individual, who is an organ procurement representative, an organizational representative of a tissue or eye bank, or a designated requestor, to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes. - Procedures for informing the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes, in collaboration with the designated OPO - Education and training of staff in the use of discretion and sensitivity to the circumstances, views, and beliefs of the family when discussing potential organ, tissue, or eye donations Note 1: 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: Note: 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

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			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.
§482.45(a)(5)	(5) Ensure that the hospital works cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes take place.	**TS.01.01.01, EP 4** The hospital works 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. - Develop a written donation policy that addresses opportunities for asystolic recovery that is mutually agreed upon by the hospital, its medical staff, and the designated OPO. When the hospital and its medical staff agree not to provide for asystolic recovery and cannot achieve agreement with the designated OPO, the hospital documents its efforts to reach an agreement with its OPO, and the donation policy addresses the hospital's justification for not providing for asystolic recovery. **TS.01.01.01, EP 5** Staff who have been designated to discuss potential organ, tissue, or eye donations with families are educated and trained in the use of discretion and sensitivity to the circumstances, beliefs, and desires of the families.	**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

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§482.45(a)(5) continued	Element Deleted	**TS.01.01.01, EP 4** The hospital works 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. - Develop a written donation policy that addresses opportunities for asystolic recovery that is mutually agreed upon by the hospital, its medical staff, and the designated OPO. When the hospital and its medical staff agree not to provide for asystolic recovery and cannot achieve agreement with the designated OPO, the hospital documents its efforts to reach an agreement with its OPO, and the donation policy addresses the hospital's justification for not providing for asystolic recovery.	
§482.45(b)	§482.45(b) Standard: Organ Transplantation Responsibilities		
§482.45(b)(1)	(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	**TS.02.01.01, 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. Footnote *: 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	**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

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	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 he or she approves the decision to exclude the hospital from the OPTN and has notified the hospital in writing.	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.	1138(a)(1)(B) of the Act, or with the requirements of this element of performance, 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.
§482.45(b)(2)	(2) For purposes of these standards, the term "organ" means a human kidney, liver, heart, lung, or pancreas.		**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 requires the hospital to notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the hospital, and that includes the OPO's responsibility to determine medical suitability for organ donation - A written agreement with at least one tissue bank and at least one eye bank to cooperate in retrieving, processing, preserving, storing, and distributing tissues and eyes to make certain that all usable tissues and eyes are obtained from potential donors, to the extent that the agreement does not interfere with organ procurement - Designation of an individual, who is an organ procurement representative, an organizational representative of a tissue or eye bank, or a designated requestor, to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes. - Procedures for informing the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes, in collaboration with the designated OPO - Education and training of staff in the use of discretion and sensitivity to the circumstances, views, and beliefs of the family

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			when discussing 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: Note: 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.
§482.45(b)(3)	(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	**TS.02.01.01, EP 2** If requested, the hospital provides all data related to organ transplant to the Organ Procurement and Transplantation Network (OPTN), the Scientific Registry, or the hospital's designated organ procurement organization (OPO), and when requested by the Office of	**TS.12.01.01, EP 2** If requested, the hospital provides all data related to organ transplant to the Organ Procurement and Transplantation Network (OPTN), the Scientific Registry of Transplant Recipients (SRTR), the hospital's designated organ procurement organization (OPO), and,

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	to the Department when requested by the Secretary.	the Secretary, directly to the US Department of Health & Human Services.	when requested by the Office of the Secretary, directly to the US Department of Health & Human Services.
§482.51	§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.	**HR.01.05.03, 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.01.06.01, EP 1** The hospital defines the competencies it requires of its staff who provide patient care, treatment, or services. **HR.01.06.01, EP 3** An individual with the educational background, experience, or knowledge related to the skills being reviewed assesses competence. Note: When a suitable individual cannot be found to assess staff competence, the hospital can utilize an outside individual for this task. If a suitable individual inside or outside the hospital cannot be found, the hospital may consult the competency guidelines from an appropriate professional organization to make its assessment. **HR.01.06.01, EP 5** Staff competence is initially assessed and documented as part of orientation. **HR.01.06.01, EP 6** Staff competence is assessed and documented once every three years, or more frequently as required by hospital policy or in accordance with law and regulation.	**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.

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		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.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. **LD.03.06.01, EP 3** Those who work in the hospital are competent to complete their assigned responsibilities. **LD.03.10.01, EP 3** When clinical practice guidelines will be used in the design or modification of processes, the following occurs: - The hospital follows criteria to manage guideline	

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		selection and implementation. - The leaders of the hospital and the organized medical staff review, approve, and modify the clinical practice guidelines as needed. - The leaders of the hospital manage and evaluate the implementation of the guidelines. **LD.04.03.01, EP 3** The hospital provides at least one of the following acute care clinical services: - Child, adolescent, or adult psychiatry - Medicine - Obstetrics and gynecology - Pediatrics - Treatment for addictions - Surgery Note: When the hospital provides surgical or obstetric services, anesthesia services are also available. **LD.04.03.07, EP 1** Variances in staff, setting, or payment source do not affect outcomes of care, treatment, and services in a negative way.	
§482.51(a)	§482.51(a) Standard: Organization and Staffing The organization of the surgical services must be appropriate to the scope of the services offered.	**LD.01.03.01, EP 3** The governing body approves the hospital's written scope of services. **LD.03.10.01, EP 3** When clinical practice guidelines will be used in the design or modification of processes, the following occurs: - The hospital follows criteria to manage guideline selection and implementation.	**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

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		- The leaders of the hospital and the organized medical staff review, approve, and modify the clinical practice guidelines as needed. - The leaders of the hospital manage and evaluate the implementation of the guidelines. **LD.04.03.01, EP 3** The hospital provides at least one of the following acute care clinical services: - Child, adolescent, or adult psychiatry - Medicine - Obstetrics and gynecology - Pediatrics - Treatment for addictions - Surgery Note: When the hospital provides surgical or obstetric services, anesthesia services are also available.	- Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic **LD.13.03.01, EP 11** The surgical services are consistent with the resources available.
§482.51(a)(1)	(1) The operating rooms must be supervised by an experienced registered nurse or a doctor of medicine or osteopathy.	**HR.01.01.01, 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 of 1988 (CLIA '88), 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	**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.

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		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 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital. The provision of care and staff qualifications are in accordance with national acceptable standards of practice and also meet the requirements of 409.17. See Appendix A for 409.17 requirements. 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. Note 5: For hospitals that use Joint Commission accreditation for deemed status purposes: Staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing. **HR.01.01.01, EP 3** The hospital verifies and documents that the applicant has the education and experience required by the job responsibilities. **LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and	

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		services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.03.06.01, EP 3** Those who work in the hospital are competent to complete their assigned responsibilities. **LD.04.01.05, EP 2** Programs, services, sites, or departments providing patient care are directed by one or more qualified professionals or by a qualified licensed practitioner with clinical privileges. **PC.03.01.01, EP 5** A registered nurse supervises perioperative nursing care. Note: Qualified registered nurses may perform circulating duties in the operating room. In accordance with state law and regulation and hospital policy, licensed practical nurses and surgical technologists may assist the circulating registered nurse in performing circulatory duties as long as the registered nurse supervises these staff and is immediately available to respond to emergencies.	
§482.51(a)(2)	(2) Licensed practical nurses (LPNs) and surgical technologists (operating room technicians) may serve as “scrub nurses” under the supervision of a registered nurse.	**HR.01.01.01, 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	**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

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		described in the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88), 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 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital. The provision of care and staff qualifications are in accordance with national acceptable standards of practice and also meet the requirements of 409.17. See Appendix A for 409.17 requirements. 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. Note 5: For hospitals that use Joint Commission accreditation for deemed status purposes: Staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing.	- 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.

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		HR.01.02.07, EP 2 Staff who provide patient care, treatment, and services practice within the scope of their license, certification, or registration and as required by law and regulation. **PC.03.01.01, EP 5** A registered nurse supervises perioperative nursing care. Note: Qualified registered nurses may perform circulating duties in the operating room. In accordance with state law and regulation and hospital policy, licensed practical nurses and surgical technologists may assist the circulating registered nurse in performing circulatory duties as long as the registered nurse supervises these staff and is immediately available to respond to emergencies.	
§482.51(a)(3)	(3) Qualified registered nurses may perform circulating duties in the operating room. 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.	**HR.01.01.01, 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 of 1988 (CLIA '88), 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	**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.

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		physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists (as defined in 42 CFR 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital. The provision of care and staff qualifications are in accordance with national acceptable standards of practice and also meet the requirements of 409.17. See Appendix A for 409.17 requirements. 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. Note 5: For hospitals that use Joint Commission accreditation for deemed status purposes: Staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing. **HR.01.02.07, EP 2** Staff who provide patient care, treatment, and services practice within the scope of their license, certification, or registration and as required by law and regulation. **LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services.	

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		Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.03.06.01, EP 3** Those who work in the hospital are competent to complete their assigned responsibilities. **LD.04.01.07, EP 1** Leaders review, approve, and manage the implementation of policies and procedures that guide and support patient care, treatment, and services. **PC.03.01.01, EP 5** A registered nurse supervises perioperative nursing care. Note: Qualified registered nurses may perform circulating duties in the operating room. In accordance with state law and regulation and hospital policy, licensed practical nurses and surgical technologists may assist the circulating registered nurse in performing circulatory duties as long as the registered nurse supervises these staff and is immediately available to respond to emergencies.	
§482.51(a)(4)	(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.	**MS.03.01.01, EP 2** Physicians and other licensed practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff. **MS.06.01.03, EP 4** The credentialing process is outlined in the medical staff bylaws.	**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

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		MS.06.01.05, EP 15 For hospitals that use Joint Commission accreditation for deemed status purposes: The surgical service maintains a current roster listing each practitioner's surgical privileges. Note: The roster may be in paper or electronic format. **MS.06.01.07, EP 1** The information review and analysis process is clearly defined. **MS.06.01.07, EP 2** The hospital, based on recommendations by the organized medical staff and approval by the governing body, develops criteria that will be considered in the decision to grant, limit, or deny a requested privilege. Note: Medical staff membership and professional privileges are not dependent solely upon certification, fellowship, or membership in a specialty body or society. **MS.06.01.07, EP 5** The hospital's privilege granting/denial criteria are consistently applied for each requesting physician or other licensed practitioner. **MS.06.01.09, EP 3** The decision to grant, deny, revise, or revoke privilege(s) is disseminated and made available to all appropriate internal and external persons or entities, as defined by the hospital and applicable law.	**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(b)	§482.51(b) Standard: Delivery of Service Surgical services must be consistent with	**EC.02.03.01, EP 11** Periodic evaluations, as determined by the hospital, are	**LD.13.01.09, EP 6** The hospital develops and implements surgical care policies and

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	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.	made of potential fire hazards that could be encountered during surgical procedures. Written fire prevention and response procedures, including safety precautions related to the use of flammable germicides or antiseptics, are established. **EC.02.03.01, EP 12** When flammable germicides or antiseptics are used during surgeries utilizing electrosurgery, cautery, or lasers, the following are required: - Nonflammable packaging - Unit-dose applicators - Preoperative "time-out" prior to the initiation of any surgical procedure to verify the following: - 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 operating room prior to draping and use of surgical devices (For full text, refer to NFPA 99-2012: 15.13) **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.	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 **LD.13.03.01, EP 11** The surgical services are consistent with the resources available.

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		c. Nationally recognized evidence-based guidelines and standards of practice, including the Centers for Disease Control and Prevention's (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings or, in the absence of such guidelines, expert consensus or best practices. The guidelines are documented within the policies and procedures. Note 1: Relevant federal, state, and local law and regulations include but are not limited to the Centers for Medicare & Medicaid Services' Conditions of Participation, Food and Drug Administration's regulations for reprocessing single-use medical devices; Occupational Safety and Health Administration’s Bloodborne Pathogens Standard 29 CFR 1910.1030, Personal Protective Equipment Standard 29 CFR 1910.132, and Respiratory Protection Standard 29 CFR 1910.134; health care worker vaccination laws; state and local public health authorities’ requirements for reporting of communicable diseases and outbreaks; and state and local regulatory requirements for biohazardous or regulated medical waste generators. Note 2: For full details on the CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, refer to https://www.cdc.gov/infection-control/hcp/disinfection-sterilization/introduction-methods-definition-of-terms.html. Note 3: The hospital determines which evidence-based guidelines, expert recommendations, best practices, or a combination thereof it adopts in its policies and procedures.	

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		IC.04.01.01, EP 4 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 - Use of disinfectants registered by the Environmental Protection Agency for noncritical devices and equipment according to the directions on the product labeling, including but not limited to indication, specified use dilution, contact time, and method of application - Use of FDA-approved liquid chemical sterilants for the processing of critical devices and high-level disinfectants for the processing of semicritical devices in accordance with FDA-cleared label and device manufacturers' instructions - Required documentation for device reprocessing cycles, including but not limited to sterilizer cycle logs, the frequency of chemical and biological testing, and the results of testing for appropriate concentration for chemicals used in high-level disinfection - Resolution of conflicts or discrepancies between a medical device manufacturer's instructions and manufacturers' instructions for automated high-level disinfection or sterilization equipment - Criteria and process for the use of immediate-use steam sterilization - Actions to take in the event of a reprocessing error or failure identified either prior to the release of the reprocessed item(s) or after the reprocessed item(s)	

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		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. **LD.04.01.07, EP 1** Leaders review, approve, and manage the implementation of policies and procedures that guide and support patient care, treatment, and services. **LD.04.01.11, EP 5** The leaders provide for equipment, information systems, supplies, and other resources. **LD.04.03.01, EP 1** The needs of the population(s) served guide decisions about which services will be provided directly or through referral, consultation, contractual arrangements, or other agreements. Note: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: 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 make sure that the services are	

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		immediately available or an agreement needs to be established for transferring patients to a general hospital that participates in the Medicare program.	
§482.51(b)(1)	(1) Prior to surgery or a procedure requiring anesthesia services and except in the case of emergencies:		
§482.51(b)(1)(i)	(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.	**PC.01.02.03, EP 4** The patient receives a medical history and physical examination 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 any specific outpatient surgical or procedural services for which an assessment is performed instead. Note 2: For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text. **RC.01.03.01, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital records the patient's medical history and physical examination, including updates, in the medical record within 24 hours after registration or inpatient admission but prior to surgery or a procedure requiring anesthesia 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 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/.
§482.51(b)(1)(ii)	(ii) An updated examination of the patient, including any changes in the patient's condition, must be completed and	**PC.01.02.03, EP 5** For a medical history and physical examination that was completed within 30 days prior to registration or	**PC.11.02.01, EP 3** For a medical history and physical examination that was completed within 30 days prior to registration or inpatient

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	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.	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 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 any specific outpatient surgical or procedural services for which an assessment is performed instead. Note 2: For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text. **RC.01.03.01, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital records the patient's medical history and physical examination, including updates, in the medical record within 24 hours after registration or inpatient admission but prior to surgery or a procedure requiring anesthesia services.	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 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/.
§482.51(b)(1)(iii)	(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 §	**PC.01.02.03, EP 7** For hospitals that use Joint Commission accreditation for deemed status purposes: When the medical staff has chosen to allow an assessment (in lieu of a comprehensive medical history and physical examination) for patients receiving specific outpatient surgical or procedural services, the assessment of the patient is completed and documented after registration but prior to surgery or a procedure requiring anesthesia	**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)

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	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.	services when the patient is receiving specific outpatient surgical or procedural services. (For more information, refer to Standard MS.03.01.01) Note: For further regulatory guidance, refer to 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 "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text.	and (B), 482.51(b)(1)(i) and (ii), and 482.22(c)(5)(v), refer to https://www.ecfr.gov/.
§482.51(b)(2)	(2) A properly executed informed consent form for the operation must be in the patient's chart before surgery, except in emergencies.	**RC.02.01.01, EP 4** As needed to provide care, treatment, and services, the medical record contains the following additional information: - Any advance directives - Any informed consent, when required by hospital policy 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. - Any records of communication with the patient, such as telephone calls or e-mail - Any patient-generated information **RI.01.03.01, EP 1** The hospital follows a written policy on informed consent that describes the following: - The specific care, treatment, and services that require informed consent - Circumstances that would allow for exceptions to	**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.

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		obtaining informed consent - The process used to obtain informed consent - The physician or other licensed practitioner permitted to conduct the informed consent discussion in accordance with law and regulation - How informed consent is documented in the patient record Note: Documentation may be recorded in a form, in progress notes, or elsewhere in the record. - When a surrogate decision-maker may give informed consent	
§482.51(b)(3)	(3) The following equipment must be available to the operating room suites: call-in system, cardiac monitor, resuscitator, defibrillator, aspirator, and tracheotomy set.	**PC.02.01.11, EP 5** 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 secretions) - Tracheotomy set	**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 secretions) - Tracheotomy set
§482.51(b)(4)	(4) There must be adequate provisions for immediate post-operative care.	**LD.04.01.11, EP 5** The leaders provide for equipment, information systems, supplies, and other resources. **PC.03.01.07, EP 1** The hospital assesses the patient's physiological status immediately after the operative or other high-risk procedure and/or as the patient recovers from moderate	**PC.13.01.03, EP 5** The hospital has adequate provisions for immediate postoperative care.

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		or deep sedation or anesthesia. **PC.03.01.07, EP 2** The hospital monitors the patient's physiological status, mental status, and pain level at a frequency and intensity consistent with the potential effect of the operative or other high-risk procedure and/or the sedation or anesthesia administered.	
§482.51(b)(5)	(5) The operating room register must be complete and up-to-date.	**RC.02.01.03, EP 15** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a complete and up-to-date operating room register 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 personnel - Type of anesthesia used and name of person administering it - Operation performed - Pre- and postoperative diagnosis - Age of patient Note: A postoperative summary may be considered equivalent if all items listed in this element of performance are included.	**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)(6)	(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.	**RC.01.02.01, EP 4** Entries in the medical record are authenticated by the author. Information introduced into the medical record through transcription or dictation is authenticated by the author. Note 1: Authentication can be verified through	**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

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		electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key. Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or hospital policy. For electronic records, electronic signatures will be date-stamped. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: All orders, including verbal orders, are dated and authenticated by the ordering physician or other licensed practitioner who is responsible for the care of the patient, and who, in accordance with hospital policy; law and regulation; and medical staff bylaws, rules, and regulations, is authorized to write orders. **RC.02.01.03, EP 2** A physician or other licensed practitioner involved in the patient's care documents the provisional diagnosis in the medical record before an operative or other high-risk procedure is performed. **RC.02.01.03, EP 5** An operative or other high-risk procedure report is written or dictated upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care. 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. Note 2: If the physician or other licensed practitioner	- 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. 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.

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		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. **RC.02.01.03, EP 6** The operative or other high-risk procedure report includes the following information: - The name(s) of the physician or other licensed practitioner(s) who performed the procedure and their assistant(s) - The name of the procedure performed - A description of the procedure - Findings of the procedure - Any estimated blood loss - Any specimen(s) removed - The postoperative diagnosis **RC.02.01.03, EP 7** When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon(s) and their assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis. **RC.02.01.03, EP 8** The medical record contains the following postoperative information:	

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		- The patient's vital signs and level of consciousness - Any medications, including intravenous fluids and any administered blood, blood products, and blood components - Any unanticipated events or complications (including blood transfusion reactions) and the management of those events **RC.02.01.03, EP 11** The postoperative documentation contains the name of the physician or other licensed practitioner responsible for discharge.	
§482.52	§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.	**LD.01.03.01, EP 3** The governing body approves the hospital's written scope of services. **LD.04.01.05, EP 7** For hospitals that use Joint Commission accreditation for deemed status purposes: A qualified doctor of medicine or osteopathy directs the following services: - Anesthesia - Nuclear medicine - Respiratory care **LD.04.01.05, EP 9** For hospitals that use Joint Commission accreditation for deemed status purposes: The anesthesia service is responsible for all anesthesia administered in the hospital.	**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

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			- Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic
§482.52(a)	§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 --	**LD.01.03.01, EP 3** The governing body approves the hospital's written scope of services. **LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.04.01.11, EP 5** The leaders provide for equipment, information systems, supplies, and other resources.	**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(a)(1)	(1) A qualified anesthesiologist;	**MS.03.01.01, EP 2** Physicians and other licensed practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff. **PC.03.01.01, EP 10** For hospitals that use Joint Commission accreditation	**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

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		for deemed status purposes: In accordance with the hospital's policy and state scope-of-practice laws, anesthesia is administered only by the following individuals: - An anesthesiologist - A doctor of medicine or osteopathy other than an anesthesiologist - A doctor of dental surgery or dental medicine - A doctor of podiatric medicine - A certified registered nurse anesthetist (CRNA) 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 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: "Anesthesiologist assistant" is defined in 42 CFR 410.69(b). Footnote *: 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	- A doctor of dental surgery or dental medicine, who is qualified to administer anesthesia under state law - A doctor of podiatric medicine, who is qualified to administer anesthesia under state law - A certified registered nurse anesthetist (CRNA), as defined in 42 CFR 410.69(b), 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 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

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		& 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.	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.
§482.52(a)(2)	(2) A doctor of medicine or osteopathy (other than an anesthesiologist);	**MS.03.01.01, EP 2** Physicians and other licensed practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff. **PC.03.01.01, EP 10** For hospitals that use Joint Commission accreditation for deemed status purposes: In accordance with the hospital's policy and state scope-of-practice laws, anesthesia is administered only by the following individuals: - An anesthesiologist - A doctor of medicine or osteopathy other than an anesthesiologist - A doctor of dental surgery or dental medicine - A doctor of podiatric medicine - A certified registered nurse anesthetist (CRNA)	**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 - 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

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		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 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: "Anesthesiologist assistant" is defined in 42 CFR 410.69(b). Footnote *: 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 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	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 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.

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		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.	
§482.52(a)(3)	(3) A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law;	**MS.03.01.01, EP 2** Physicians and other licensed practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff. **PC.03.01.01, EP 10** For hospitals that use Joint Commission accreditation for deemed status purposes: In accordance with the hospital's policy and state scope-of-practice laws, anesthesia is administered only by the following individuals: - An anesthesiologist - A doctor of medicine or osteopathy other than an anesthesiologist - A doctor of dental surgery or dental medicine - A doctor of podiatric medicine - A certified registered nurse anesthetist (CRNA) 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 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	**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 - 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.

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		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: "Anesthesiologist assistant" is defined in 42 CFR 410.69(b). Footnote *: 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 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.	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 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.
§482.52(a)(4)	(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	**MS.03.01.01, EP 2** Physicians and other licensed practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.	**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:

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	operating practitioner or of an anesthesiologist who is immediately available if needed; or	**PC.03.01.01, EP 10** For hospitals that use Joint Commission accreditation for deemed status purposes: In accordance with the hospital's policy and state scope-of-practice laws, anesthesia is administered only by the following individuals: - An anesthesiologist - A doctor of medicine or osteopathy other than an anesthesiologist - A doctor of dental surgery or dental medicine - A doctor of podiatric medicine - A certified registered nurse anesthetist (CRNA) 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 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: "Anesthesiologist assistant" is defined in 42 CFR 410.69(b). Footnote *: The CoP at 42 CFR 482.52(c) for state exemption states: A hospital may be exempt from the	- 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 - 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 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

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		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 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.	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.
§482.52(a)(5)	(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.	**HR.01.02.07, EP 2** Staff who provide patient care, treatment, and services practice within the scope of their license, certification, or registration and as required by law and regulation. **MS.03.01.01, EP 2** Physicians and other licensed practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff. **PC.03.01.01, EP 10** For hospitals that use Joint Commission accreditation for deemed status purposes: In accordance with the hospital's policy and state scope-of-practice laws,	**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 - 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

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		anesthesia is administered only by the following individuals: - An anesthesiologist - A doctor of medicine or osteopathy other than an anesthesiologist - A doctor of dental surgery or dental medicine - A doctor of podiatric medicine - A certified registered nurse anesthetist (CRNA) 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 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: "Anesthesiologist assistant" is defined in 42 CFR 410.69(b). Footnote *: 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	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 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.

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		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.	
§482.52(b)	§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:	**EC.02.04.03, EP 26** The hospital performs equipment maintenance on anesthesia apparatus. The 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 flow and an oxygen analyzer is used to verify oxygen concentration. Areas designated for servicing of oxygen equipment are clean and free of oil, grease, or other flammables. (For full text, refer to NFPA 99-2012: 11.4.1.3; 11.5.1.3; 11.6.2.5; 11.6.2.6) **LD.01.03.01, EP 3** The governing body approves the hospital's written scope of services. **LD.01.03.01, EP 5** The governing body provides for the resources needed to maintain safe, quality care, treatment, and services.	**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.13.01.03, EP 2** For hospitals that use Joint Commission accreditation for deemed

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		LD.04.01.07, EP 1 Leaders review, approve, and manage the implementation of policies and procedures that guide and support patient care, treatment, and services. **PC.03.01.01, EP 6** For operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia, the following is available: - Equipment to monitor the patient's physiological status - Equipment to administer intravenous fluids and medications and, if needed, blood and blood components **PC.03.01.03, EP 1** Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered: The hospital conducts a presedation or preanesthesia patient assessment. **PC.03.01.03, EP 8** The hospital reevaluates the patient immediately before administering moderate or deep sedation or anesthesia. **PC.03.01.07, EP 1** The hospital assesses the patient's physiological status immediately after the operative or other high-risk procedure and/or as the patient recovers from moderate or deep sedation or anesthesia. **PC.03.01.07, EP 2** The hospital monitors the patient's physiological status,	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 reflect current standards of anesthesia care.

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		mental status, and pain level at a frequency and intensity consistent with the potential effect of the operative or other high-risk procedure and/or the sedation or anesthesia administered. **PC.03.01.07, EP 4** A qualified physician or other licensed practitioner discharges the patient from the recovery area or from the hospital. In the absence of a qualified individual, patients are discharged according to criteria approved by clinical leaders.	
§482.52(b)(1)	(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.	**PC.03.01.03, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes: A preanesthesia evaluation is completed and documented by an individual qualified to administer anesthesia within 48 hours prior to surgery or a procedure requiring anesthesia services.	**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 reflect current standards of anesthesia care.
§482.52(b)(2)	(2) An intraoperative anesthesia record.	**PC.03.01.05, EP 1** During operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia, the patient's oxygenation,	**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

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		ventilation, and circulation are monitored continuously. **RC.02.01.03, EP 1** The hospital documents in the patient's medical record any operative or other high-risk procedure and/or the administration of moderate or deep sedation or anesthesia.	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 reflect current standards of anesthesia care.
§482.52(b)(3)	(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 by the medical staff and that reflect current standards of anesthesia care.	**PC.03.01.07, EP 7** For hospitals that use Joint Commission accreditation for deemed status purposes: A postanesthesia evaluation is completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services. **PC.03.01.07, EP 8** For hospitals that use Joint Commission accreditation for deemed status purposes: The postanesthesia evaluation for anesthesia recovery is completed in accordance with law and regulation and policies and procedures that have been approved by the medical staff.	**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 reflect current standards of anesthesia care.
§482.52(c)	§482.52(c) Standard: State Exemption		

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§482.52(c)(1)	(1) A hospital may be exempted from the requirement for physician 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 physician 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 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 physician supervision requirement, and that the opt-out is consistent with State law.	**MS.03.01.01, EP 2** Physicians and other licensed practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff. **PC.03.01.01, EP 10** For hospitals that use Joint Commission accreditation for deemed status purposes: In accordance with the hospital's policy and state scope-of-practice laws, anesthesia is administered only by the following individuals: - An anesthesiologist - A doctor of medicine or osteopathy other than an anesthesiologist - A doctor of dental surgery or dental medicine - A doctor of podiatric medicine - A certified registered nurse anesthetist (CRNA) 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 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	**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 - 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

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		Accrediting Commission. Note 2: "Anesthesiologist assistant" is defined in 42 CFR 410.69(b). Footnote *: 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 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.	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 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.
§482.52(c)(2)	(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.	**PC.03.01.01, EP 10** For hospitals that use Joint Commission accreditation for deemed status purposes: In accordance with the hospital's policy and state scope-of-practice laws, anesthesia is administered only by the following individuals: - An anesthesiologist - A doctor of medicine or osteopathy other than an anesthesiologist - A doctor of dental surgery or dental medicine	**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

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		- A doctor of podiatric medicine - A certified registered nurse anesthetist (CRNA) 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 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: "Anesthesiologist assistant" is defined in 42 CFR 410.69(b). Footnote *: 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 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	- 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 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-

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		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.	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.
§482.53	§482.53 Condition of Participation: Nuclear Medicine Services If the hospital provides nuclear medicine services, those services must meet the needs of the patients in accordance with acceptable standards of practice.	**LD.01.03.01, EP 3** The governing body approves the hospital's written scope of services. **LD.01.03.01, EP 5** The governing body provides for the resources needed to maintain safe, quality care, treatment, and services. **LD.03.10.01, EP 3** When clinical practice guidelines will be used in the design or modification of processes, the following occurs: - The hospital follows criteria to manage guideline selection and implementation. - The leaders of the hospital and the organized medical staff review, approve, and modify the clinical practice guidelines as needed. - The leaders of the hospital manage and evaluate the implementation of the guidelines. **LD.04.03.01, EP 2** The hospital provides essential services, including the following: - Diagnostic radiology - Dietary - Emergency	**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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Medical records - Nuclear medicine - Nursing care - Pathology and clinical laboratory - Pharmaceutical - Physical rehabilitation - Respiratory care - Social work Note 1: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The diagnostic radiology services provided by the hospital, as well as staff qualifications, meet professionally approved standards.	
§482.53	Element Deleted	**LD.01.03.01, EP 3** The governing body approves the hospital's written scope of services. **LD.01.03.01, EP 5** The governing body provides for the resources needed to maintain safe, quality care, treatment, and services. **LD.03.10.01, EP 3** When clinical practice guidelines will be used in the	

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		design or modification of processes, the following occurs: - The hospital follows criteria to manage guideline selection and implementation. - The leaders of the hospital and the organized medical staff review, approve, and modify the clinical practice guidelines as needed. - The leaders of the hospital manage and evaluate the implementation of the guidelines. **LD.04.03.01, EP 2** The hospital provides essential services, including the following: - Diagnostic radiology - Dietary - Emergency - Medical records - Nuclear medicine - Nursing care - Pathology and clinical laboratory - Pharmaceutical - Physical rehabilitation - Respiratory care - Social work Note 1: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to “Appendix	

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		A: Medicare Requirements for Hospitals" (AXA). Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The diagnostic radiology services provided by the hospital, as well as staff qualifications, meet professionally approved standards.	
§482.53(a)	§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.	**LD.01.03.01, EP 3** The governing body approves the hospital's written scope of services. **LD.01.03.01, EP 5** The governing body provides for the resources needed to maintain safe, quality care, treatment, and services. **LD.04.01.11, EP 5** The leaders provide for equipment, information systems, supplies, and other resources.	**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(a)(1)	(1) There must be a director who is a doctor of medicine or osteopathy qualified in nuclear medicine.	**LD.04.01.05, EP 7** For hospitals that use Joint Commission accreditation for deemed status purposes: A qualified doctor of medicine or osteopathy directs the following services: - Anesthesia - Nuclear medicine - Respiratory care	**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.

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			Note 2: For respiratory care services, the director may serve on either a full-time or part-time basis.
§482.53(a)(2)	(2) The qualifications, training, functions and responsibilities of the nuclear medicine personnel must be specified by the service director and approved by the medical staff.	**HR.01.01.01, 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 of 1988 (CLIA '88), 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 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital. The provision of care and staff qualifications are in accordance with national acceptable standards of practice and also meet the requirements of 409.17. See Appendix A for 409.17 requirements. Note 4: Qualifications for language interpreters and translators may be met through language proficiency assessment, education, training, and experience. The	**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.

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		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: For hospitals that use Joint Commission accreditation for deemed status purposes: Staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing. **HR.01.06.01, EP 1** The hospital defines the competencies it requires of its staff who provide patient care, treatment, or services. **LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.03.06.01, EP 3** Those who work in the hospital are competent to complete their assigned responsibilities. **MS.03.01.01, EP 17** 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(b)	§482.53(b) Standard: Delivery of Service Radioactive materials must be prepared,	**EC.02.01.01, EP 8** The hospital controls access to and from areas it	**PE.02.01.01, EP 4** The hospital develops and implements policies and procedures to

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	labeled, used, transported, stored, and disposed of in accordance with acceptable standards of practice.	identifies as security sensitive. **EC.02.02.01, EP 3** 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. **EC.02.02.01, EP 4** The hospital implements its procedures in response to hazardous material and waste spills or exposures. **EC.02.02.01, EP 6** The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of radioactive materials. **EC.02.02.01, EP 7** The hospital minimizes risks associated with selecting and using hazardous energy sources. 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: This includes the use of proper shielding during fluoroscopic procedures. **EC.02.02.01, EP 8** The hospital minimizes risks associated with disposing of hazardous medications. **EC.02.02.01, EP 11**	protect patients and staff from exposure to hazardous materials. The policies and procedures address the following: - Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors - Disposal of hazardous medications - Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding - Periodic inspection of radiology equipment and prompt correction of hazards found during inspection - Precautions to follow and personal protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers and MRIs). Note 2: Hazardous gases and vapors include but are not limited to ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9)

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		For managing hazardous materials and waste, the hospital has the permits, licenses, manifests, and safety data sheets required by law and regulation. **EC.02.02.01, EP 12** The hospital labels hazardous materials and waste. Labels identify the contents and hazard warnings. * Footnote *: The Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens and Hazard Communications Standards and the National Fire Protection Association (NFPA) provide details on labeling requirements. **MM.01.01.03, EP 1** The hospital identifies, in writing, its high-alert and hazardous medications. * Note: This element of performance is also applicable to sample medications. Footnote *: For a list of high-alert medications, see https://www.ismp.org/recommendations. For a list of hazardous drugs, see https://www.cdc.gov/niosh/docs/2016-161/pdfs/2016-161.pdf. **MM.01.01.03, EP 2** The hospital follows a process for managing high-alert and hazardous medications. Note: This element of performance is also applicable to sample medications.	
§482.53(b)(1)	(1) In-house preparation of radiopharmaceuticals is by, or under the supervision of, an appropriately trained		**MM.15.01.01, EP 7** For hospitals that use Joint Commission accreditation for deemed status purposes: An appropriately trained registered pharmacist or

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	registered pharmacist or a doctor of medicine or osteopathy.		doctor of medicine or osteopathy performs or supervises in-house preparation of radiopharmaceuticals.
§482.53(b)(2)	(2) There is proper storage and disposal of radioactive material.	**EC.02.02.01, EP 6** The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of radioactive materials. **EC.02.02.01, EP 8** The hospital minimizes risks associated with disposing of hazardous medications. **EC.02.02.01, EP 11** For managing hazardous materials and waste, the hospital has the permits, licenses, manifests, and safety data sheets required by law and regulation. **EC.02.02.01, EP 12** The hospital labels hazardous materials and waste. Labels identify the contents and hazard warnings. * Footnote *: The Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens and Hazard Communications Standards and the National Fire Protection Association (NFPA) provide details on labeling requirements.	**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 personal protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers and MRIs). Note 2: Hazardous gases and vapors include but are not limited to ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9)
§482.53(b)(3)	(3) If laboratory tests are performed in the nuclear medicine service, the service must meet the applicable requirement for laboratory services specified in §482.27.	**LD.04.01.01, EP 1** The hospital is licensed, is certified, or has a permit, in accordance with law and regulation, to provide the care, treatment, or services for which the hospital is seeking accreditation from The Joint Commission. Note 1: Each service location that performs laboratory testing (waived or nonwaived) must have a Clinical Laboratory Improvement Amendments of 1988 (CLIA	**LD.13.03.01, EP 9** For hospitals that use Joint Commission accreditation 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.

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		'88) certificate as specified by the federal CLIA regulations (42 CFR 493.55 and 493.3) and applicable state law. Laboratory services meet the applicable requirements at 42 CFR 482.27. Note 2: For more information on how to obtain a CLIA certificate, see http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_Certificate_International_Laboratories.html.	
§482.53(c)	§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--	**EC.02.04.03, EP 2** The hospital inspects, tests, and maintains all high-risk equipment. These activities are documented. 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. **EC.02.04.03, EP 3** The hospital inspects, tests, and maintains non-high-risk equipment identified on the medical equipment inventory. These activities are documented. **LD.01.03.01, EP 5** The governing body provides for the resources needed to maintain safe, quality care, treatment, and services. **LD.04.01.11, EP 5** The leaders provide for equipment, information systems, supplies, and other resources.	**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.
§482.53(c)(1)	(1) Maintained in safe operating condition; and	**EC.02.04.01, EP 4** The hospital identifies the activities and associated	**PE.04.01.01, EP 4** The hospital maintains equipment and supplies appropriate for the

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		frequencies, in writing, for maintaining, inspecting, and testing all medical equipment on the inventory. Note: Activities and associated frequencies for maintaining, inspecting, and testing of medical equipment must have a 100% completion rate. **EC.02.04.03, EP 1** For hospitals that do not use Joint Commission accreditation for deemed status purposes: Before initial use of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. For hospitals that use Joint Commission accreditation for deemed status purposes: Before initial use and after major repairs or upgrades of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. **EC.02.04.03, EP 3** The hospital inspects, tests, and maintains non-high-risk equipment identified on the medical equipment inventory. These activities are documented.	types of nuclear medicine services offered. The equipment is maintained for safe operation and efficient performance.
§482.53(c)(2)	(2) Inspected, tested and calibrated at least annually by qualified personnel.	**EC.02.04.03, EP 16** For hospitals that use Joint Commission accreditation for deemed status purposes: Qualified hospital staff inspect, test, and calibrate nuclear medicine equipment annually. The results and completion dates are documented.	**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

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			- High-contrast resolution/system spatial resolution - Sensitivity - 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)
§482.53(d)	§482.53(d) Standard: Records The hospital must maintain signed and dated reports of nuclear medicine interpretations, consultations, and procedures.	**RC.01.01.01, EP 7** All entries in the medical record are dated. **RC.01.02.01, EP 3** The author of each medical record entry is identified in the medical record. **RC.01.02.01, EP 4** Entries in the medical record are authenticated by the author. Information introduced into the medical record through transcription or dictation is authenticated by the author. Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key. Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or hospital policy. For electronic records, electronic signatures will be date-stamped.	**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 promptly completed, properly filed and retained, and readily accessible. **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

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		Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: All orders, including verbal orders, are dated and authenticated by the ordering physician or other licensed practitioner who is responsible for the care of the patient, and who, in accordance with hospital policy; law and regulation; and medical staff bylaws, rules, and regulations, is authorized to write orders. **RC.01.02.01, EP 5** The individual identified by the signature stamp or method of electronic authentication is the only individual who uses it. **RC.02.01.01, EP 2** The medical record contains the following clinical information: - The reason(s) for admission for care, treatment, and services - The patient's initial diagnosis, diagnostic impression(s), or condition(s) - Any findings of assessments and reassessments - Any allergies to food - Any allergies to medications - Any conclusions or impressions drawn from the patient's medical history and physical examination - Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric hospitals using Joint Commission accreditation for deemed status purposes: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for	- 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, 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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		example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival - Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration Note 1: 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. Note 2: For the definition and a further explanation of block charting, refer to the Glossary. - Any access site for medication, administration devices used, and rate of administration - Any adverse drug reactions - Treatment goals, plan of care, and revisions to the plan of care - Results of diagnostic and therapeutic tests and procedures - Any medications dispensed or prescribed on discharge - Discharge diagnosis - Discharge plan and discharge planning evaluation	
§482.53(d)(1)	(1) The hospital must maintain copies of nuclear medicine reports for at least 5 years.	**RC.01.05.01, EP 1** The retention time of the original or legally reproduced medical record is determined by its use and hospital	**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

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		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, scans; and other applicable image records.	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.
§482.53(d)(2)	(2) The practitioner approved by the medical staff to interpret diagnostic procedures must sign and date the interpretation of these tests.	**MS.03.01.01, EP 2** Physicians and other licensed practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff. **RC.01.01.01, EP 7** All entries in the medical record are dated. **RC.01.02.01, EP 3** The author of each medical record entry is identified in the medical record. **RC.01.02.01, EP 4** Entries in the medical record are authenticated by the author. Information introduced into the medical record through transcription or dictation is authenticated by the author. Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key. Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or hospital policy. For electronic records,	**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 promptly completed, properly filed and retained, and readily accessible.

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		electronic signatures will be date-stamped. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: All orders, including verbal orders, are dated and authenticated by the ordering physician or other licensed practitioner who is responsible for the care of the patient, and who, in accordance with hospital policy; law and regulation; and medical staff bylaws, rules, and regulations, is authorized to write orders. **RC.01.02.01, EP 5** The individual identified by the signature stamp or method of electronic authentication is the only individual who uses it.	
§482.53(d)(3)	(3) The hospital must maintain records of the receipt and distribution of radio pharmaceuticals.	**MM.03.01.01, EP 4** The hospital follows a written policy addressing the control of medication between receipt by a staff member and administration of the medication, including safe storage, handling, wasting, security, disposition, and return to storage. Note: This element of performance is also applicable to sample medications. **MM.03.01.01, EP 8** The hospital removes all expired, damaged, and/or contaminated medications and stores them separately from medications available for administration. Note: This element of performance is also applicable to sample medications. **MM.03.01.01, EP 24** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital maintains	**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.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		records of the receipt and disposition of radiopharmaceuticals.	
§482.53(d)(4)	(4) Nuclear medicine services must be ordered only by practitioners whose scope of Federal or State licensure and whose defined staff privileges allow such referrals.	**MS.03.01.01, EP 2** Physicians and other licensed practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.	**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 dietetic 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.
§482.54	§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.	**LD.01.03.01, EP 3** The governing body approves the hospital's written scope of services. **LD.01.03.01, EP 5** The governing body provides for the resources needed to maintain safe, quality care, treatment, and services. **LD.03.10.01, EP 3** When clinical practice guidelines will be used in the design or modification of processes, the following occurs: - The hospital follows criteria to manage guideline selection and implementation. - The leaders of the hospital and the organized medical	**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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		staff review, approve, and modify the clinical practice guidelines as needed. - The leaders of the hospital manage and evaluate the implementation of the guidelines. **LD.04.01.11, EP 5** The leaders provide for equipment, information systems, supplies, and other resources. **LD.04.03.01, EP 1** The needs of the population(s) served guide decisions about which services will be provided directly or through referral, consultation, contractual arrangements, or other agreements. Note: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: 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 make sure that the services are immediately available or an agreement needs to be established for transferring patients to a general hospital that participates in the Medicare program.	- Respiratory - Dietetic
§482.54	Element Deleted	**LD.01.03.01, EP 3** The governing body approves the hospital's written scope of services. **LD.01.03.01, EP 5** The governing body provides for the resources needed to maintain safe, quality care, treatment, and services. **LD.03.10.01, EP 3** When clinical practice guidelines will be used in the	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		design or modification of processes, the following occurs: - The hospital follows criteria to manage guideline selection and implementation. - The leaders of the hospital and the organized medical staff review, approve, and modify the clinical practice guidelines as needed. - The leaders of the hospital manage and evaluate the implementation of the guidelines. **LD.04.01.11, EP 5** The leaders provide for equipment, information systems, supplies, and other resources. **LD.04.03.01, EP 1** The needs of the population(s) served guide decisions about which services will be provided directly or through referral, consultation, contractual arrangements, or other agreements. Note: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: 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 make sure that the services are immediately available or an agreement needs to be established for transferring patients to a general hospital that participates in the Medicare program.	
§482.54(a)	§482.54(a) Standard: Organization Outpatient services must be appropriately organized and integrated with inpatient services.	**LD.04.01.05, EP 5** Leaders provide for the coordination of care, treatment, and services among the hospital's different programs, services, sites, or departments.	**LD.13.03.01, EP 5** If the hospital provides outpatient services, the services are integrated with inpatient services.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		PC.02.02.01, EP 1 The hospital follows a process to receive or share patient information when the patient is referred to other internal or external providers of care, treatment, and services. **PC.02.02.01, EP 3** The hospital coordinates the patient's care, treatment, and services within a time frame that meets the patient's needs. Note: Coordination involves resolving scheduling conflicts and duplication of care, treatment, and services.	
§482.54(b)	§482.54(b) Standard: Personnel The hospital must -		
§482.54(b)(1)	(1) Assign one or more individuals to be responsible for outpatient services.	**LD.04.01.05, EP 8** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital assigns one or more individuals who are responsible for outpatient services.	**LD.13.01.07, EP 2** The hospital assigns one or more individuals who are responsible for outpatient services.
§482.54(b)(2)	(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.	**HR.01.01.01, 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 of 1988 (CLIA '88), 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-	**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

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		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 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital. The provision of care and staff qualifications are in accordance with national acceptable standards of practice and also meet the requirements of 409.17. See Appendix A for 409.17 requirements. 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. Note 5: For hospitals that use Joint Commission accreditation for deemed status purposes: Staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing. **HR.01.01.01, EP 3** The hospital verifies and documents that the applicant has the education and experience required by the job responsibilities.	- Diagnostic and therapeutic radiology services Note 2: Emergency services staff are qualified in emergency care.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		HR.01.06.01, EP 1 The hospital defines the competencies it requires of its staff who provide patient care, treatment, or services. **LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered.	
§482.54(c)	(c) Standard: Orders for outpatient services. Outpatient services must be ordered by a practitioner who meets the following conditions:		
§482.54(c)(1)	(1) Is responsible for the care of the patient.	**PC.02.01.03, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: 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: Outpatient services may be ordered by a physician or other licensed practitioner not appointed to the medical staff as long as the practitioner meets the following: - Responsible for the care of the patient - Licensed to practice in the state where the practitioner provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements - Acting within the practitioner's scope of practice under	**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.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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 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.	
§482.54(c)(2)	(2) Is licensed in the State where he or she provides care to the patient.	**PC.02.01.03, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: 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: Outpatient services may be ordered by a physician or other licensed practitioner not appointed to the medical staff as long as the practitioner meets the following: - Responsible for the care of the patient - Licensed to practice in the state where the practitioner provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements - Acting within the practitioner's scope of practice under state law	**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.

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		- 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 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.	
§482.54(c)(3)	(3) Is acting within his or her scope of practice under State law.	**PC.02.01.03, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: 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: Outpatient services may be ordered by a physician or other licensed practitioner not appointed to the medical staff as long as the practitioner meets the following: - Responsible for the care of the patient - Licensed to practice in the state where the practitioner provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements - Acting within the practitioner's scope of practice under state law - Authorized in accordance with state law and policies	**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.

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		adopted by the medical staff and approved by the governing body to order the applicable outpatient services 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.	
§482.54(c)(4)	(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:	**PC.02.01.03, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: 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: Outpatient services may be ordered by a physician or other licensed practitioner not appointed to the medical staff as long as the practitioner meets the following: - Responsible for the care of the patient - Licensed to practice in the state where the practitioner provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements - Acting within the practitioner's scope of practice under state law - Authorized in accordance with state law and policies adopted by the medical staff and approved by the	**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.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		governing body to order the applicable outpatient services 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.	
§482.54(c)(4)(i)	(i) All practitioners who are appointed to the hospital's medical staff and who have been granted privileges to order the applicable outpatient services.	**MS.06.01.05, EP 2** The hospital, based on recommendations by the organized medical staff and approval by the governing body, establishes criteria that determine a physician's or other licensed practitioner's ability to provide patient care, treatment, and services within the scope of the privilege(s) requested. Evaluation of all of the following are included in the criteria: - Current licensure and/or certification, as appropriate, verified with the primary source - The applicant's specific relevant training, verified with the primary source - Evidence of physical ability to perform the requested privilege - Data from professional practice review by an organization(s) that currently privileges the applicant (if available) - Peer and/or faculty recommendation - When renewing privileges, review of the physician's or other licensed practitioner's performance within the hospital **MS.06.01.05, EP 3**	**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.

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		All of the criteria used are consistently evaluated for all physicians and other licensed practitioners holding that privilege. **PC.02.01.03, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: 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: Outpatient services may be ordered by a physician or other licensed practitioner not appointed to the medical staff as long as the practitioner meets the following: - Responsible for the care of the patient - Licensed to practice in the state where the practitioner provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements - Acting within the practitioner's 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 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	

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		nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals.	
§482.54(c)(4)(ii)	(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.	**PC.02.01.03, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: 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: Outpatient services may be ordered by a physician or other licensed practitioner not appointed to the medical staff as long as the practitioner meets the following: - Responsible for the care of the patient - Licensed to practice in the state where the practitioner provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements - Acting within the practitioner's 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 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	**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.

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		staff and acting in accordance with state law governing dietitians and nutrition professionals.	
§482.55	§482.55 Condition of Participation: Emergency Services The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice.	**LD.01.03.01, EP 3** The governing body approves the hospital's written scope of services. **LD.01.03.01, EP 5** The governing body provides for the resources needed to maintain safe, quality care, treatment, and services. **LD.04.03.01, EP 2** The hospital provides essential services, including the following: - Diagnostic radiology - Dietary - Emergency - Medical records - Nuclear medicine - Nursing care - Pathology and clinical laboratory - Pharmaceutical - Physical rehabilitation - Respiratory care - Social work Note 1: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to “Appendix	**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 are organized under the direction of a qualified member of the medical staff, and are integrated with other departments of the hospital.

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		A: Medicare Requirements for Hospitals" (AXA). Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The diagnostic radiology services provided by the hospital, as well as staff qualifications, meet professionally approved standards.	
§482.55(a)	§482.55(a) Standard: Organization and Direction. If emergency services are provided at the hospital --		
§482.55(a)(1)	(1) The services must be organized under the direction of a qualified member of the medical staff;	**LD.04.01.05, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's emergency services are directed and supervised by a qualified member of the medical staff.	**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 are organized under the direction of a qualified member of the medical staff, and are integrated with other departments of the hospital.
§482.55(a)(2)	(2) The services must be integrated with other departments of the hospital;	**LD.04.01.05, EP 5** Leaders provide for the coordination of care, treatment,	**LD.13.03.01, EP 1** The hospital provides services directly or through referral,

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		and services among the hospital's different programs, services, sites, or departments. **LD.04.03.11, EP 1** The hospital has processes that support the flow of patients throughout the hospital that address the following: - Plans for the care of admitted patients who are in overflow locations or temporary bed locations, such as the postanesthesia care unit or the emergency department - Criteria to guide decisions to initiate ambulance diversion **MS.03.01.03, EP 6** There is coordination of the care, treatment, and services among the staff involved in a patient's care, treatment, and services. **PC.02.01.05, EP 1** Care, treatment, and services are provided to the patient in an interdisciplinary, collaborative manner. **PC.02.02.01, EP 3** The hospital coordinates the patient's care, treatment, and services within a time frame that meets the patient's needs. Note: Coordination involves resolving scheduling conflicts and duplication of care, treatment, and services.	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 are organized under the direction of a qualified member of the medical staff, and are integrated with other departments of the hospital.
§482.55(a)(3)	(3) The policies and procedures governing medical care provided in the emergency service or department are established by and	**LD.04.01.07, EP 1** Leaders review, approve, and manage the implementation of policies and procedures that guide	**MS.16.01.01, EP 9** If the hospital provides emergency services, the medical staff

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	are a continuing responsibility of the medical staff.	and support patient care, treatment, and services. **MS.01.01.01, EP 36** The medical staff bylaws include the following requirements: If departments of the medical staff exist, the qualifications and roles and responsibilities of the department chair, which are defined by the organized medical staff, include the following: Qualifications: - Certification by an appropriate specialty board or comparable competence affirmatively established through the credentialing process Roles and responsibilities: - Clinically related activities of the department - Administratively related activities of the department, unless otherwise provided by the hospital - Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges - Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department - Recommending clinical privileges for each member of the department - Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization - Integration of the department or service into the primary functions of the organization - Coordination and integration of interdepartmental and	establishes and is continually responsible for the policies and procedures governing emergency medical care.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		intradepartmental services - Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services - Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services - Determination of the qualifications and competence of department or service staff who provide patient care, treatment, and services but are not licensed to practice independently - Continuous assessment and improvement of the quality of care, treatment, and services - Maintenance of quality control programs, as appropriate - Orientation and continuing education of all persons in the department or service - Recommending space and other resources needed by the department or service Note: For hospitals that use Joint Commission accreditation for deemed status purposes: When departments of the medical staff do not exist, the medical staff is responsible for the development of policies and procedures that minimize medication errors. The medical staff may delegate this responsibility to the organized pharmaceutical service.	
§482.55(b)	§482.55(b) Standard: Personnel		
§482.55(b)(1)	(1) The emergency services must be supervised by a qualified member of the medical staff.	**LD.04.01.05, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's emergency services are directed and supervised by a qualified member of the medical staff.	**LD.13.01.07, EP 1** The hospital's emergency services are supervised by a qualified member of the medical staff.

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§482.55(b)(2)	(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.	**HR.01.01.01, 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 of 1988 (CLIA '88), 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 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital. The provision of care and staff qualifications are in accordance with national acceptable standards of practice and also meet the requirements of 409.17. See Appendix A for 409.17 requirements. 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	**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.

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		the Rehabilitation Act of 1973, and Title VI of the Civil Rights Act of 1964. Note 5: For hospitals that use Joint Commission accreditation for deemed status purposes: Staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing. **HR.01.01.01, EP 3** The hospital verifies and documents that the applicant has the education and experience required by the job responsibilities. **HR.01.06.01, EP 1** The hospital defines the competencies it requires of its staff who provide patient care, treatment, or services. **LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.03.06.01, EP 3** Those who work in the hospital are competent to complete their assigned responsibilities.	
§482.56	§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	**LD.01.03.01, EP 3** The governing body approves the hospital's written scope of services. **LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of	**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

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	organized and staffed to ensure the health and safety of patients.	individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.04.01.11, EP 5** The leaders provide for equipment, information systems, supplies, and other resources. **LD.04.03.01, EP 1** The needs of the population(s) served guide decisions about which services will be provided directly or through referral, consultation, contractual arrangements, or other agreements. Note: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: 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 make sure that the services are immediately available or an agreement needs to be established for transferring patients to a general hospital that participates in the Medicare program. **LD.04.03.01, EP 2** The hospital provides essential services, including the following: - Diagnostic radiology - Dietary - Emergency - Medical records - Nuclear medicine - Nursing care	deemed status purposes: The provision of rehabilitation services is in accordance with 42 CFR 409.17.

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		- Pathology and clinical laboratory - Pharmaceutical - Physical rehabilitation - Respiratory care - Social work Note 1: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to "Appendix A: Medicare Requirements for Hospitals" (AXA). Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The diagnostic radiology services provided by the hospital, as well as staff qualifications, meet professionally approved standards.	
§482.56(a)	§482.56(a) Standard: Organization and Staffing The organization of the service must be appropriate to the scope of the services offered.	**LD.01.03.01, EP 3** The governing body approves the hospital's written scope of services. **LD.01.03.01, EP 5** The governing body provides for the resources needed to maintain safe, quality care, treatment, and services. **LD.04.01.11, EP 5** The leaders provide for equipment, information systems, supplies, and other resources.	**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(a)(1)	(1) The director of the services must have the necessary knowledge, experience, and	**HR.01.01.01, EP 3** The hospital verifies and documents that the applicant	**HR.11.02.01, EP 3** The director of rehabilitation services has the knowledge,

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	capabilities to properly supervise and administer the services.	has the education and experience required by the job responsibilities. **HR.01.06.01, EP 1** The hospital defines the competencies it requires of its staff who provide patient care, treatment, or services. **LD.04.01.05, EP 2** Programs, services, sites, or departments providing patient care are directed by one or more qualified professionals or by a qualified licensed practitioner with clinical privileges. **LD.04.01.05, EP 3** The hospital defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: This includes the full-time employee who directs and manages dietary services.	experience, and capabilities to supervise and administer the services.
§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.	**HR.01.01.01, 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 of 1988 (CLIA '88), under Subpart M: "Personnel for Nonwaived Testing" §493.1351-§493.1495. A complete description of the requirement is	**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 (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&

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		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 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital. The provision of care and staff qualifications are in accordance with national acceptable standards of practice and also meet the requirements of 409.17. See Appendix A for 409.17 requirements. 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. Note 5: For hospitals that use Joint Commission accreditation for deemed status purposes: Staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing. **HR.01.01.01, EP 3** The hospital verifies and documents that the applicant has the education and experience required by the job responsibilities.	amp;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. 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.

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		HR.01.06.01, EP 1 The hospital defines the competencies it requires of its staff who provide patient care, treatment, or services. **LD.03.06.01, EP 3** Those who work in the hospital are competent to complete their assigned responsibilities.	
§482.56(b)	§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.	**PC.02.01.03, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: 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: Outpatient services may be ordered by a physician or other licensed practitioner not appointed to the medical staff as long as the practitioner meets the following: - Responsible for the care of the patient - Licensed to practice in the state where the practitioner provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements - Acting within the practitioner's 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 2: For hospitals that use Joint Commission	**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 dietetic 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.

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		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. **PC.02.01.03, EP 7** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital provides care, treatment, and services using the most recent patient order(s).	
§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.	**RC.02.01.01, EP 2** The medical record contains the following clinical information: - The reason(s) for admission for care, treatment, and services - The patient's initial diagnosis, diagnostic impression(s), or condition(s) - Any findings of assessments and reassessments - Any allergies to food - Any allergies to medications - Any conclusions or impressions drawn from the patient's medical history and physical examination - Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric hospitals using Joint Commission accreditation for deemed status purposes: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an	**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

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		intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival - Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration Note 1: 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. Note 2: For the definition and a further explanation of block charting, refer to the Glossary. - Any access site for medication, administration devices used, and rate of administration - Any adverse drug reactions - Treatment goals, plan of care, and revisions to the plan of care - Results of diagnostic and therapeutic tests and procedures - Any medications dispensed or prescribed on discharge - Discharge diagnosis - Discharge plan and discharge planning evaluation	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.
§482.56(b)(2)	(2)The provision of care and the personnel qualifications must be in accordance with national acceptable standards of practice	**HR.01.01.01, EP 1** The hospital defines staff qualifications specific to their job responsibilities. Note 1: Qualifications for infection control may be met	**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

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	and must also meet the requirements of §409.17 of this chapter.	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 of 1988 (CLIA '88), 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 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital. The provision of care and staff qualifications are in accordance with national acceptable standards of practice and also meet the requirements of 409.17. See Appendix A for 409.17 requirements. 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. Note 5: For hospitals that use Joint Commission accreditation for deemed status purposes: Staff	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.

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		qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing. **HR.01.01.01, EP 3** The hospital verifies and documents that the applicant has the education and experience required by the job responsibilities. **HR.01.02.07, EP 2** Staff who provide patient care, treatment, and services practice within the scope of their license, certification, or registration and as required by law and regulation. **HR.01.06.01, EP 1** The hospital defines the competencies it requires of its staff who provide patient care, treatment, or services. **LD.03.06.01, EP 3** Those who work in the hospital are competent to complete their assigned responsibilities. **LD.03.10.01, EP 3** When clinical practice guidelines will be used in the design or modification of processes, the following occurs: - The hospital follows criteria to manage guideline selection and implementation. - The leaders of the hospital and the organized medical staff review, approve, and modify the clinical practice guidelines as needed. - The leaders of the hospital manage and evaluate the implementation of the guidelines.	

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		LD.04.01.01, EP 2 The hospital provides care, treatment, and services in accordance with licensure requirements, laws, and 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). (See Appendix A [AXA] for the language of this CMS requirement.)	
§482.57	§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.	**LD.03.10.01, EP 3** When clinical practice guidelines will be used in the design or modification of processes, the following occurs: - The hospital follows criteria to manage guideline selection and implementation. - The leaders of the hospital and the organized medical staff review, approve, and modify the clinical practice guidelines as needed. - The leaders of the hospital manage and evaluate the implementation of the guidelines. **LD.04.03.01, EP 1** The needs of the population(s) served guide decisions about which services will be provided directly or through referral, consultation, contractual arrangements, or other agreements. Note: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: If medical and surgical diagnostic and treatment services are not available within the hospital, the hospital has an agreement with an outside source for	**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

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		these services to make sure that the services are immediately available or an agreement needs to be established for transferring patients to a general hospital that participates in the Medicare program. **LD.04.03.01, EP 2** The hospital provides essential services, including the following: - Diagnostic radiology - Dietary - Emergency - Medical records - Nuclear medicine - Nursing care - Pathology and clinical laboratory - Pharmaceutical - Physical rehabilitation - Respiratory care - Social work Note 1: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The diagnostic radiology services provided by the hospital,	

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		as well as staff qualifications, meet professionally approved standards.	
§482.57(a)	§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.	**LD.01.03.01, EP 3** The governing body approves the hospital's written scope of services. **LD.01.03.01, EP 5** The governing body provides for the resources needed to maintain safe, quality care, treatment, and services. **LD.03.06.01, EP 3** Those who work in the hospital are competent to complete their assigned responsibilities. **LD.04.01.11, EP 5** The leaders provide for equipment, information systems, supplies, and other resources.	**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(a)(1)	(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.	**LD.04.01.05, EP 7** For hospitals that use Joint Commission accreditation for deemed status purposes: A qualified doctor of medicine or osteopathy directs the following services: - Anesthesia - Nuclear medicine - Respiratory care	**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.
§482.57(a)(2)	(2) There must be adequate numbers of respiratory therapists, respiratory therapy technicians, and other personnel who meet	**HR.01.01.01, EP 1** The hospital defines staff qualifications specific to their job responsibilities.	**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.

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	the qualifications specified by the medical staff, consistent with State law.	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 of 1988 (CLIA '88), 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 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital. The provision of care and staff qualifications are in accordance with national acceptable standards of practice and also meet the requirements of 409.17. See Appendix A for 409.17 requirements. 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. Note 5: For hospitals that use Joint Commission	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.

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		accreditation for deemed status purposes: Staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing. **HR.01.01.01, EP 3** The hospital verifies and documents that the applicant has the education and experience required by the job responsibilities. **HR.01.06.01, EP 1** The hospital defines the competencies it requires of its staff who provide patient care, treatment, or services. **LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered.	
§482.57(b)	§482.57(b) Standard: Delivery of Services Services must be delivered in accordance with medical staff directives.	**LD.04.01.07, EP 1** Leaders review, approve, and manage the implementation of policies and procedures that guide and support patient care, treatment, and services. **MS.01.01.01, EP 36** The medical staff bylaws include the following requirements: If departments of the medical staff exist, the qualifications and roles and responsibilities of the department chair, which are defined by the organized medical staff, include the following: Qualifications:	**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.

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		- Certification by an appropriate specialty board or comparable competence affirmatively established through the credentialing process Roles and responsibilities: - Clinically related activities of the department - Administratively related activities of the department, unless otherwise provided by the hospital - Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges - Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department - Recommending clinical privileges for each member of the department - Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization - Integration of the department or service into the primary functions of the organization - Coordination and integration of interdepartmental and intradepartmental services - Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services - Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services - Determination of the qualifications and competence of department or service staff who provide patient care, treatment, and services but are not licensed to practice	

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		independently - Continuous assessment and improvement of the quality of care, treatment, and services - Maintenance of quality control programs, as appropriate - Orientation and continuing education of all persons in the department or service - Recommending space and other resources needed by the department or service Note: For hospitals that use Joint Commission accreditation for deemed status purposes: When departments of the medical staff do not exist, the medical staff is responsible for the development of policies and procedures that minimize medication errors. The medical staff may delegate this responsibility to the organized pharmaceutical service.	
§482.57(b)(1)	(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.	**HR.01.01.01, 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 of 1988 (CLIA '88), 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	**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 (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,

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		physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists (as defined in 42 CFR 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital. The provision of care and staff qualifications are in accordance with national acceptable standards of practice and also meet the requirements of 409.17. See Appendix A for 409.17 requirements. 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. Note 5: For hospitals that use Joint Commission accreditation for deemed status purposes: Staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing. **HR.01.06.01, EP 1** The hospital defines the competencies it requires of its staff who provide patient care, treatment, or services. **LD.04.01.07, EP 1** Leaders review, approve, and manage the implementation of policies and procedures that guide and support patient care, treatment, and services.	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. 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.

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§482.57(b)(2)	(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.	**LD.04.01.01, EP 1** The hospital is licensed, is certified, or has a permit, in accordance with law and regulation, to provide the care, treatment, or services for which the hospital is seeking accreditation from The Joint Commission. Note 1: Each service location that performs laboratory testing (waived or nonwaived) must have a Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate as specified by the federal CLIA regulations (42 CFR 493.55 and 493.3) and applicable state law. Laboratory services meet the applicable requirements at 42 CFR 482.27. Note 2: For more information on how to obtain a CLIA certificate, see http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_Certificate_International_Laboratories.html.	**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)(3)	(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.	**PC.02.01.03, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes: 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: Outpatient services may be ordered by a physician or other licensed practitioner not appointed to the medical staff as long as the practitioner meets the following: - Responsible for the care of the patient - Licensed to practice in the state where the practitioner provides care to the patient or in accordance with Veterans Administration and Department of Defense	**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 dietetic 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.

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		licensure requirements - Acting within the practitioner's 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 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. **PC.02.01.03, EP 7** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital provides care, treatment, and services using the most recent patient order(s).	
§482.57(b)(4)	(4) All respiratory care services orders must be documented in the patient's medical record in accordance with the requirements at §482.24.	**RC.02.01.01, EP 2** The medical record contains the following clinical information: - The reason(s) for admission for care, treatment, and services - The patient's initial diagnosis, diagnostic impression(s), or condition(s) - Any findings of assessments and reassessments - Any allergies to food - Any allergies to medications - Any conclusions or impressions drawn from the patient's medical history and physical examination	**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

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		- Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric hospitals using Joint Commission accreditation for deemed status purposes: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival - Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration Note 1: 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. Note 2: For the definition and a further explanation of block charting, refer to the Glossary. - Any access site for medication, administration devices used, and rate of administration - Any adverse drug reactions - Treatment goals, plan of care, and revisions to the plan of care - Results of diagnostic and therapeutic tests and	- 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, 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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		procedures - Any medications dispensed or prescribed on discharge - Discharge diagnosis - Discharge plan and discharge planning evaluation	
§482.58	§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: This CoP is not applicable to psychiatric hospitals since they are not permitted to have swing beds.		
§482.58(a)	(a) Eligibility. A hospital must meet the following eligibility requirements:		
§482.58(a)(1)	(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).		
§482.58(a)(2)	(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.		
§482.58(a)(3)	(3) The hospital does not have in effect a 24-hour nursing waiver granted under §488.54(c) of this chapter.		

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§482.58(a)(4)	(4) The hospital has not had a swing-bed approval terminated within the two years previous to application.		
§482.58(b)	(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)	(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.	**IM.02.01.01, EP 1** The hospital follows a written policy addressing the privacy and confidentiality of health information. **IM.02.01.01, EP 3** The hospital uses health information only for purposes permitted by law and regulation or as further limited by its policy on privacy. **IM.02.01.01, EP 4** The hospital discloses health information only as authorized by the patient or as otherwise consistent with law and regulation. **LD.04.02.03, EP 13** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Each resident who is entitled to Medicaid benefits is informed in writing, either at the time of admission or when the resident becomes eligible for Medicaid, of the following: - The items and services included in the state plan for which the resident may not be charged - Those items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services	**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. **IM.12.01.01, EP 2** The hospital discloses health information only as authorized by the patient with the patient's written consent or as otherwise required by law and regulation. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital allows representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with state law. **LD.13.02.01, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Each Medicaid-eligible resident is informed in writing, either at the time of admission or when the resident becomes eligible for Medicaid, of the following: - Items and services included in the state plan for which the resident may not be charged - Items and services that the hospital offers, those for which the

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		LD.04.02.03, EP 14 For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Residents are informed when changes are made to the services that are specified in LD.04.02.03, EP 13. **LD.04.02.03, EP 16** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Residents are informed 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 not covered under Medicare or by the facility's per diem rate. **MS.06.01.03, EP 6** 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: - The applicant's current licensure at the time of initial granting, renewal, and revision of privileges, and at the time of license expiration - The applicant's relevant training - The applicant's current competence **RI.01.01.01, EP 1** The hospital has written policies on patient rights. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's written policies address procedures regarding patient visitation rights, including any clinically	resident may be charged, and the amount of charges for those services Note: The hospital informs residents when changes are made to the items and services. **LD.13.02.01, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital informs residents before or at the time of admission, and periodically during the resident's stay, of services available in the hospital and of charges for those services not covered under Medicare, Medicaid, or by the hospital's per diem rate. **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. **RI.11.01.01, EP 1** The hospital develops and implements written policies to protect and promote patient rights. **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 purposes and have swing beds: Personal privacy includes accommodations, medical treatment, written and

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		necessary or reasonable restrictions or limitations. **RI.01.01.01, EP 2** The hospital informs the patient of the patient's rights. Note 1: 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. 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. Also included is the right to withdraw or deny such consent at any time. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital informs each patient (or support person, where appropriate) of the patient's rights in advance of furnishing or discontinuing patient care whenever possible. **RI.01.01.01, EP 5** The hospital respects the patient's right to and need for effective communication. **RI.01.01.01, EP 6** The hospital respects the patient's cultural and personal values, beliefs, and preferences. **RI.01.01.01, EP 7** The hospital respects the patient's right to privacy. Note 1: This element of performance (EP) addresses a patient's personal privacy.	telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. **RI.11.01.01, EP 8** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides immediate family and other relatives immediate access to the resident, except when the resident denies or withdraws consent. The hospital provides others who are visiting immediate access to the resident, except when reasonable clinical or safety restrictions apply or when the resident denies or withdraws consent. **RI.11.02.01, EP 1** The hospital provides information, including but not limited to the patient's total health status, in a manner tailored to the patient's age, language, and ability to understand. Note: The hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs. **RI.12.01.01, EP 1** The patient or their representative (as allowed, in accordance with state law) has the right to make informed decisions regarding their care. The patient's rights include 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. **RI.12.01.01, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: If a resident is adjudged

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		Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident's right to privacy includes privacy and confidentiality of their personal records and written communications, including the right to send and receive mail promptly. **RI.01.01.03, EP 1** The hospital provides information in a manner tailored to the patient's age, language, and ability to understand. **RI.01.01.03, EP 3** The hospital provides information to the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient's needs. **RI.01.02.01, EP 1** The hospital involves the patient in making decisions about their care, treatment, and services, including the right to have the patient's family and physician or other licensed practitioner promptly notified of their admission to or discharge or transfer from the hospital. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient is informed, prior to the notification occurring, of any process to automatically notify the patient's established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well as all applicable post–acute care services providers and suppliers. The 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	incompetent under state law by a court of proper jurisdiction, the rights of the resident automatically transfer to and are exercised by a resident representative appointed by the court under state law to act on the resident's behalf. The resident representative exercises the resident's rights to the extent allowed by the court in accordance with state law. Note 1: If a resident representative's decision-making authority is limited by state law or court appointment, the resident retains the right to make those decisions outside the representative's authority. Note 2: The resident's wishes and preferences are considered by the representative when exercising the patient's rights. Note 3: To the extent practicable, the resident is provided with opportunities to participate in the care planning process. **RI.12.01.01, EP 4** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to request, refuse, and/or discontinue treatment; to participate in or refuse to participate in experimental research; and to formulate an advance directive. **RI.12.01.01, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident's right to choose a licensed attending physician. Note: If the physician chosen by the resident refuses to or does not meet the requirements for attending physicians at 42 CFR 483, the hospital may seek alternative physician participation to assure provision of appropriate and adequate care and treatment. The hospital informs the resident if it determines that the physician chosen by the resident is unlicensed or unable to serve as the attending physician. The hospital also discusses alternative

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		department or inpatient unit. Notifications with primary care practitioners and entities are in accordance with all applicable federal and state laws and regulations. Note 2: 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. **RI.01.02.01, EP 2** When a patient is unable to make decisions about their care, treatment, and services, the hospital involves a surrogate decision-maker in making these decisions. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The selection of the surrogate decision-maker is in accordance with state law. **RI.01.02.01, EP 3** The hospital provides the patient or surrogate decision-maker with written information about the right to refuse care, treatment, and services. **RI.01.02.01, EP 4** The hospital respects the right of the patient or surrogate decision-maker to refuse care, treatment, and services in accordance with law and regulation. **RI.01.03.05, EP 3** The hospital informs the patient that refusing to participate in research, investigation, or clinical trials or discontinuing participation at any time will not jeopardize the patient's access to care, treatment, and services unrelated to the research.	physician participation with the resident and honors the resident's preferences, if any, among the options. **RI.13.01.03, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital allows the patient to keep and use personal clothing and possessions, unless this infringes on others' rights or is medically or therapeutically contraindicated, based on the setting or service. **RI.13.01.03, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital allows the resident to share a room with their spouse when married residents are living in the same hospital and when both individuals consent to the arrangement. **RI.13.01.03, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident's right to send and promptly receive unopened mail through the postal service and to receive letters, packages, and other materials delivered to the hospital for the resident through a means other than a postal service. The hospital respects the resident's right to privacy of such communications and allows access to stationery, postage, and writing implements at the resident's expense.

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		RI.01.05.01, EP 1 The hospital follows written policies on advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services that address the following: - Providing patients with written information about advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services. - Providing the patient upon admission with information on the extent to which the hospital is able, unable, or unwilling to honor advance directives. - For outpatient hospital settings: Communicating its policy on advance directives upon request or when warranted by the care, treatment, and services provided. - Whether the hospital will honor advance directives in its outpatient settings. - That the hospital will honor the patient's right to formulate or review and revise the patient's advance directives. - Informing staff who are involved in the patient's care, treatment, and services whether or not the patient has an advance directive. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient's right to formulate advance directives and have staff and licensed practitioners comply with these directives is in accordance with 42 CFR 489.100, 489.102, and 489.104. **RI.01.06.05, EP 4**	

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		For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital allows the patient to keep and use personal clothing and possessions, unless this infringes on others' rights or is medically or therapeutically contraindicated, based on the setting or service. **RI.01.06.05, EP 8** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides accommodations for residents with significant others living in the same facility when both individuals consent to the arrangement. **RI.01.06.05, EP 14** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to have access to stationery, postage, and writing implements at the resident's own expense. **RI.01.06.05, EP 15** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital offers patients telephone and mail service, based on the setting and population. **RI.01.06.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident's right to choose an attending physician, dentist, and other care providers. Note: The hospital informs the resident if it determines	

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		that the physician chosen by the resident is unlicensed or unable to serve as the attending physician. The hospital also discusses alternative physician participation with the resident and honors the resident's preferences, if any, among the options. **RI.01.06.11, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides the resident and the resident's family with the name, specialty, and telephone number of the physician or other licensed practitioner primarily responsible for the resident's care. **RI.01.07.05, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital establishes liberal visiting hours that are limited only by the resident's personal preferences. **RI.01.07.05, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides space for the resident to receive visitors in comfort and privacy. **RI.01.07.05, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident's right to choose with whom the resident communicates. **RI.01.07.05, EP 6**	

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		For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital complies with law and regulation regarding individuals who are exempted from visiting hour restrictions in order to gain immediate access to the resident.	
§482.58(b)(2)	(2) Admission, transfer, and discharge rights (§483.5 definition of transfer and discharge, §483.15(c)(1), (c)(2)(i), (c)(2)(ii), (c)(3), (c)(4), (c)(5), and (c)(7)).	**PC.04.01.03, EP 3** The patient, the patient's family, physicians, other licensed practitioners, clinical psychologists, and staff involved in the patient's care, treatment, and services participate in planning the patient's discharge or transfer. 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 psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Social service staff responsibilities include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the hospital. Note 3: For hospitals that use Joint 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 in writing. 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 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 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. **PC.14.01.01, EP 12** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides the written notice of transfer or discharge at least 30 days before the resident is transferred or discharged.

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		Note 4: For hospitals that use Joint Commission accreditation for deemed status purposes: Discharge planning is performed by, or under the supervision of, a registered nurse, social worker, or other qualified person. **PC.04.01.03, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Except when specified in the CoP from 42 CFR 483.12(a)(5)(ii), the written notice of transfer or discharge required under paragraph 42 CFR 483.12(a)(4) must be made by the hospital at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered; the health of the individuals in the facility would be endangered; the resident's health improves sufficiently to allow a more immediate transfer or discharge, and immediate transfer or discharge is required by the resident's urgent medical needs; or a resident has not resided in the facility for 30 days. **PC.04.01.03, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The written notice before transfer or discharge specified in the CoP from 42 CFR 483.12(a)(4) includes the following: - The reason for transfer or discharge - The effective date of transfer or discharge - The location to which the resident is transferred or	Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered, the health of the individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the facility for 30 days. **PC.14.01.01, EP 13** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The written notice before transfer or discharge specified in 42 CFR 483.15(c)(3) includes the following: - Reason for transfer or discharge - Effective date of transfer or discharge - Location to which the resident is transferred or discharged - Statement of the resident's appeal rights, including the name, address (mailing and e-mail), and telephone number of the entity which receives appeal requests; information on how to obtain an appeal form; where to find assistance in completing the form; and how to submit the appeal hearing request - Name, address (mailing and e-mail), and telephone number of the office of the state's long-term care ombudsman - For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 - For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act

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		discharged - A statement of the resident's appeal rights, including the name, address (mailing and e-mail), and telephone number of the entity which receives such requests; information on how to obtain an appeal form; where to find assistance in completing the form; and how to submit the appeal hearing request - The name, address (mailing and e-mail), and telephone number of the office of the state's long-term care ombudsman - For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 - For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act **PC.04.01.05, EP 1** When the hospital determines the patient's discharge or transfer needs, it promptly shares this information with the patient, and also with the patient's family when it is involved in decision making or ongoing care. **PC.04.01.05, EP 2** Before the patient is discharged, the hospital informs the patient, and also the patient's family when it is involved in decision making or ongoing care, of the kinds	**PC.14.01.03, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital transfers or discharges residents only under at least one of the following conditions: - The resident's health has improved to the point where they no longer need the hospital's services. - The transfer or discharge is necessary for the resident's welfare, and the hospital cannot meet the resident's needs. - The safety of the individuals in the hospital is endangered due to the resident's clinical or behavioral status. - The health of individuals in the hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a hospital, the hospital may charge a resident only the allowable charges under Medicaid. - The hospital ceases operation. Note: The hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the hospital. The hospital documents the danger that failure to transfer or discharge would pose. **RC.12.03.01, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Documentation in the

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		of continuing care, treatment, and services the patient will need. **PC.04.01.07, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital transfers or discharges residents only when at least one of the following conditions is met: - The resident's health has improved to the point where they no longer need the hospital's services. - The transfer or discharge is necessary for the resident's welfare and the hospital cannot meet the resident's needs. - The safety of the individuals in the hospital is endangered due to the clinical or behavioral status of the resident. - The health of individuals in the hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a hospital, the hospital may charge a resident only the allowable charges under Medicaid. - The hospital ceases operation. Note: The hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer	medical record includes discharge information provided to the resident and/or to the receiving organization. A physician documents in the resident's medical record when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered. The resident's physician documents in the medical record when the transfer is due to the resident improving and no longer needing long term care services or when the transfer is due to the resident's welfare and resident's needs cannot be met in the hospital's swing bed. **RC.12.03.01, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident's discharge information includes the following: - Reason for transfer, discharge, or referral - Treatment provided, diet, medication orders, and orders for the resident's immediate care - Referrals provided to the resident, the referring physician's or other licensed practitioner's name, and the name of the physician or other licensed practitioner who has agreed to be responsible for the resident's medical care and treatment, if this person is someone other than the referring physician or other licensed practitioner - Medical findings and diagnoses; a summary of the care, treatment, and services provided; and progress reached toward goals - Information about the resident's behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation - Nursing information that is useful in the resident's care - Any advance directives - Instructions given to the resident before discharge

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		would endanger the health or safety of the resident or other individuals in the hospital. The hospital documents the danger that failure to transfer or discharge would pose. **RC.01.01.01, EP 5** The medical record includes the following: - Information needed to support the patient's diagnosis and condition - Information needed to justify the patient's care, treatment, and services - Information that documents the course and result of the patient's care, treatment, and services - 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.02.04.01, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. There is documentation in the resident's medical record by the resident's physician when the resident is transferred or discharged, either when the transfer is due to the resident improving and no longer needing long term care services or when the resident's needs cannot be met in the hospital's swing bed. There is documentation in the	**RC.12.03.01, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: When the resident is transferred or discharged because the hospital cannot meet their needs, the hospital documents which needs could not be met, the hospital's attempts to meet the resident's needs, and the services available at the receiving organization that will meet the resident's needs. **RC.12.03.01, EP 4** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital records the reasons for the transfer or discharge in the resident's medical record in accordance with 42 CFR 483.15(c)(2).

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		resident's medical record by a physician when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered. **RC.02.04.01, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident's discharge information includes the following: - The reason for transfer, discharge, or referral - Treatment provided, diet, medication orders, and orders for the resident's immediate care - Referrals provided to the resident, the referring physician's or other licensed practitioner's name, and the name of the physician or other licensed practitioner who has agreed to be responsible for the resident's medical care and treatment, if this person is someone other than the referring physician or other licensed practitioner - Medical findings and diagnoses; a summary of the care, treatment, and services provided; and progress reached toward goals - Information about the resident's behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation - Nursing information that is useful in the resident's care - Any advance directives - Instructions given to the resident before discharge **RI.01.01.01, EP 5** The hospital respects the patient's right to and need for effective communication.	

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		RI.01.01.03, EP 1 The hospital provides information in a manner tailored to the patient's age, language, and ability to understand.	
§482.58(b)(3)	(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)).	**HR.01.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The facility does not employ individuals who have been found guilty by a court of law of abusing, neglecting, exploiting, misappropriating property, or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of residents' property. **PC.01.02.09, EP 7** The hospital reports cases of possible abuse and neglect to external agencies, in accordance with law and regulation. **PC.01.02.09, EP 8** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital reports to the state nurse aide registry or licensing authorities any knowledge it has of any actions taken by a court of law against an employee that would indicate unfitness for service as a nurse aide or other facility staff. **PC.03.05.01, EP 1** The hospital uses restraint or seclusion only to protect the immediate physical safety of the patient, staff, or others.	**HR.11.02.01, EP 4** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital does not employ individuals who have been found guilty by a court of law of abusing, neglecting, exploiting, misappropriating property, or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of residents' property. **PC.13.02.01, EP 1** The hospital does not use restraint or seclusion of any form as a means of coercion, discipline, convenience, or staff retaliation. Restraint or seclusion is only used to protect the immediate physical safety of the patient, staff, or others when less restrictive interventions have been ineffective and is discontinued at the earliest possible time, regardless of the length of time specified in the order. **PC.13.02.01, EP 2** The hospital uses the least restrictive form of restraint or seclusion that will be effective to protect the patient, a staff member, or others from harm. **RI.13.01.01, EP 1** The 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

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		PC.03.05.01, EP 2 The hospital does not use restraint or seclusion as a means of corporal punishment, coercion, discipline, convenience, or staff retaliation. **PC.03.05.01, EP 3** The hospital uses restraint or seclusion only when less restrictive interventions are ineffective. **PC.03.05.01, EP 4** The hospital uses the least restrictive form of restraint or seclusion that protects the physical safety of the patient, staff, or others. **PC.03.05.01, EP 5** The hospital discontinues restraint or seclusion at the earliest possible time, regardless of the scheduled expiration of the order. **RI.01.06.01, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital has policies and procedures that support the resident's right to be free from chemical and physical restraint. Note: The hospital's use of restraint is consistent with the requirements in the "Provision of Care, Treatment, and Services" (PC) chapter. **RI.01.06.03, EP 1** The hospital protects the patient from harassment, neglect, exploitation, and abuse that could occur while the patient is receiving care, treatment, and services.	status purposes and have swing beds: The hospital also protects the resident from misappropriation of property. **RI.13.01.01, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital reports to the state nurse aide registry or licensing authorities any knowledge it has of any actions taken by a court of law against an employee that would indicate unfitness for service as a nurse aide or other facility staff. **RI.13.01.01, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital develops and implements written policies and procedures that prohibit and prevent mistreatment, neglect, and abuse of residents and misappropriation of resident property. The policies and procedures also address investigation of allegations related to these issues. **RI.13.01.01, EP 4** The hospital reports allegations, observations, and suspected cases of neglect, exploitation, and abuse to appropriate authorities based on its evaluation of the suspected events or as required by law. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to the administrator of the facility and to other officials (including the state survey agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law and

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital also determines how it will protect residents from corporal punishment and involuntary seclusion. **RI.01.06.03, EP 3** The hospital reports allegations, observations, and suspected cases of neglect, exploitation, and abuse to appropriate authorities based on its evaluation of the suspected events, or as required by law. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to the administrator of the facility and to other officials (including the state survey agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law and established procedures. The alleged violations are reported in the following time frames: - No later than 2 hours after the allegation is made if the allegation involves abuse or serious bodily injury - No later than 24 hours after the allegation is made if the allegation does not involve abuse or serious bodily injury **RI.01.06.03, EP 4** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital develops and implements written policies and	established procedures. The alleged violations are reported in the following time frames: - No later than 2 hours after the allegation is made if the allegation involves abuse or serious bodily injury - No later than 24 hours after the allegation is made if the allegation does not involve abuse or serious bodily injury **RI.13.01.01, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital has evidence that all alleged violations of abuse, neglect, exploitation, or mistreatment are thoroughly investigated and that it prevents further abuse, neglect, exploitation, or mistreatment while the investigation is in progress. The results of all investigations are reported to the administrator or their designated representative and to other officials in accordance with state law, including the state survey agency, within five working days of the incident. If the alleged violation is verified, appropriate corrective action is taken.

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		procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. **RI.01.06.03, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital has evidence that all alleged violations are thoroughly investigated and that it prevents further abuse while the investigation is in progress. The results of all investigations are reported to the administrator or their designated representative and to other officials in accordance with state law, within five working days of the incident. If the alleged violation is verified, appropriate corrective action is taken.	
§482.58(b)(4)	(4) Social services (§483.40(d) of this chapter).	**HR.01.01.01, 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 of 1988 (CLIA '88), 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,	**PC.14.02.01, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides medically related social services to attain or maintain the optimal physical, mental, and psychosocial well-being of each resident.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists (as defined in 42 CFR 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital. The provision of care and staff qualifications are in accordance with national acceptable standards of practice and also meet the requirements of 409.17. See Appendix A for 409.17 requirements. 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. Note 5: For hospitals that use Joint Commission accreditation for deemed status purposes: 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.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.03.06.01, EP 3** Those who work in the hospital are competent to complete their assigned responsibilities.	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		PC.02.02.01, EP 9 For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides services (directly or through referral) to facilitate family support, social work, nursing care, dental care, rehabilitation, primary physician care, or discharge. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital promptly refers residents with lost or damaged dentures to a dentist.	
§482.58(b)(5)	(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)]	**PC.01.02.01, EP 53** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes the following: - Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into the resident's assessment, care planning, and transitions of care - Referring all level II residents and all residents with newly evident or possibly serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment	**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 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

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			that have been made for the resident's follow up care, and any postdischarge medical and nonmedical services
§482.58(b)(6)	(6) Specialized rehabilitative services (§483.65).	**LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.03.06.01, EP 3** Those who work in the hospital are competent to complete their assigned responsibilities. **PC.01.03.01, EP 1** The hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. **PC.02.01.01, EP 1** The hospital provides the patient with care, treatment, and services according to the patient's individualized plan of care. **PC.02.01.05, EP 1** Care, treatment, and services are provided to the patient in an interdisciplinary, collaborative manner. **PC.02.02.01, EP 3** The hospital coordinates the patient's care, treatment, and services within a time frame that meets the patient's needs. Note: Coordination involves resolving scheduling	**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 (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. Note 5: If respiratory care services are provided, staff qualified to perform specific respiratory care procedures and the amount of

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		conflicts and duplication of care, treatment, and services. **PC.02.02.01, EP 9** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides services (directly or through referral) to facilitate family support, social work, nursing care, dental care, rehabilitation, primary physician care, or discharge. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital promptly refers residents with lost or damaged dentures to a dentist. **PC.02.02.01, EP 10** When the hospital uses external resources to meet the patient's needs, it coordinates the patient's care, treatment, and services.	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 dietetic 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. **PC.14.02.01, EP 8** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: If a resident's comprehensive plan of care requires specialized rehabilitative services, including but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for a mental disorder and intellectual disability or services of a lesser intensity, the hospital provides or obtains the required services from a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Social Security Act.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§482.58(b)(7)	(7) Dental services (§483.55(a)(2), (3), (4), and (5) and (b) of this chapter).	**PC.02.02.01, EP 9** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides services (directly or through referral) to facilitate family support, social work, nursing care, dental care, rehabilitation, primary physician care, or discharge. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital promptly refers residents with lost or damaged dentures to a dentist. **PC.02.02.01, EP 10** When the hospital uses external resources to meet the patient's needs, it coordinates the patient's care, treatment, and services. **PC.02.02.01, EP 12** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital assists residents who are eligible and wish to apply for reimbursement of dental services as an incurred medical expense under the state plan. The hospital may charge a Medicare resident an additional amount for routine and emergency dental services. **PC.02.02.01, EP 29** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital follows its policy identifying circumstances when loss of or damage to a resident's dentures is the hospital's responsibility and it may not charge a resident for the loss or damage of dentures.	**PC.14.02.01, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital assists residents who are eligible and wish to apply for reimbursement of dental services as an incurred medical expense under the state plan. The hospital may charge a Medicare resident an additional amount for routine and emergency dental services. **PC.14.02.01, EP 4** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital develops and implements a policy identifying circumstances when loss of or damage to a resident's dentures is the hospital's responsibility, and it may not charge a resident for the loss or damage of dentures. **PC.14.02.01, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: If necessary or requested, the hospital assists residents in making dental appointments and arranging for transportation to and from the dental services location. **PC.14.02.01, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital refers residents with lost or damaged dentures for dental services within three days. If referral does not occur within three days, the hospital documents what was done to make sure that the resident could adequately eat and drink and any extenuating circumstances that led to the delay. **PC.14.02.01, EP 7**

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		PC.02.02.01, EP 30 For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital refers residents with lost or damaged dentures for dental services within three days. If referral does not occur within three days, the hospital documents what was done to make sure that the resident could adequately eat and drink and any extenuating circumstances that led to the delay. **RI.01.06.11, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital helps the resident make and keep appointments with medical, dental, and other care providers. **RI.01.07.13, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital arranges transportation for the resident to and from medical or dental appointments and other activities identified in the resident's care or service plan.	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides or obtains from an outside resource routine (to the extent covered under the state plan) and emergency dental services.
§483.5	§483.5 Definitions. Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.		
§483.10	§483.10 Resident rights.		

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§483.10(b)(7)	(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law	**RI.01.01.01, EP 1** The hospital has written policies on patient rights. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's written policies address procedures regarding patient visitation rights, including any clinically necessary or reasonable restrictions or limitations. **RI.01.02.01, EP 1** The hospital involves the patient in making decisions about their care, treatment, and services, including the right to have the patient's family and physician or other licensed practitioner promptly notified of their admission to or discharge or transfer from the hospital. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient is informed, prior to the notification occurring, of any process to automatically notify the patient's established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well as all applicable post–acute care services providers and suppliers. The 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. Note 2: 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.	**RI.12.01.01, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: If a resident is adjudged incompetent under state law by a court of proper jurisdiction, the rights of the resident automatically transfer to and are exercised by a resident representative appointed by the court under state law to act on the resident's behalf. The resident representative exercises the resident's rights to the extent allowed by the court in accordance with state law. Note 1: If a resident representative's decision-making authority is limited by state law or court appointment, the resident retains the right to make those decisions outside the representative's authority. Note 2: The resident's wishes and preferences are considered by the representative when exercising the patient's rights. Note 3: To the extent practicable, the resident is provided with opportunities to participate in the care planning process.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		RI.01.02.01, EP 2 When a patient is unable to make decisions about their care, treatment, and services, the hospital involves a surrogate decision-maker in making these decisions. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The selection of the surrogate decision-maker is in accordance with state law.	
§483.10(b)(7)(i)	(i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decision outside the representative's authority.	**RI.01.01.01, EP 1** The hospital has written policies on patient rights. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's written policies address procedures regarding patient visitation rights, including any clinically necessary or reasonable restrictions or limitations. **RI.01.02.01, EP 1** The hospital involves the patient in making decisions about their care, treatment, and services, including the right to have the patient's family and physician or other licensed practitioner promptly notified of their admission to or discharge or transfer from the hospital. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient is informed, prior to the notification occurring, of any process to automatically notify the patient's established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well as all applicable post–acute care services providers and suppliers. The 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	**RI.12.01.01, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: If a resident is adjudged incompetent under state law by a court of proper jurisdiction, the rights of the resident automatically transfer to and are exercised by a resident representative appointed by the court under state law to act on the resident's behalf. The resident representative exercises the resident's rights to the extent allowed by the court in accordance with state law. Note 1: If a resident representative's decision-making authority is limited by state law or court appointment, the resident retains the right to make those decisions outside the representative's authority. Note 2: The resident's wishes and preferences are considered by the representative when exercising the patient's rights. Note 3: To the extent practicable, the resident is provided with opportunities to participate in the care planning process.

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		department or inpatient unit. Notifications with primary care practitioners and entities are in accordance with all applicable federal and state laws and regulations. Note 2: 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. **RI.01.02.01, EP 2** When a patient is unable to make decisions about their care, treatment, and services, the hospital involves a surrogate decision-maker in making these decisions. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The selection of the surrogate decision-maker is in accordance with state law.	
§483.10(b)(7)(ii)	(ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative.	**RI.01.01.01, EP 1** The hospital has written policies on patient rights. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's written policies address procedures regarding patient visitation rights, including any clinically necessary or reasonable restrictions or limitations. **RI.01.01.01, EP 6** The hospital respects the patient's cultural and personal values, beliefs, and preferences. **RI.01.02.01, EP 1** The hospital involves the patient in making decisions about their care, treatment, and services, including the right to have the patient's family and physician or other licensed practitioner promptly notified of their	**RI.12.01.01, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: If a resident is adjudged incompetent under state law by a court of proper jurisdiction, the rights of the resident automatically transfer to and are exercised by a resident representative appointed by the court under state law to act on the resident's behalf. The resident representative exercises the resident's rights to the extent allowed by the court in accordance with state law. Note 1: If a resident representative's decision-making authority is limited by state law or court appointment, the resident retains the right to make those decisions outside the representative's authority. Note 2: The resident's wishes and preferences are considered by the representative when exercising the patient's rights. Note 3: To the extent practicable, the resident is provided with opportunities to participate in the care planning process.

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		admission to or discharge or transfer from the hospital. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient is informed, prior to the notification occurring, of any process to automatically notify the patient's established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well as all applicable post–acute care services providers and suppliers. The 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. Note 2: 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. **RI.01.02.01, EP 2** When a patient is unable to make decisions about their care, treatment, and services, the hospital involves a surrogate decision-maker in making these decisions. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The selection of the surrogate decision-maker is in accordance with state law.	
§483.10(b)(7)(iii)	(iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.	**RI.01.02.01, EP 1** The hospital involves the patient in making decisions about their care, treatment, and services, including the right to have the patient's family and physician or other licensed practitioner promptly notified of their	**RI.12.01.01, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: If a resident is adjudged incompetent under state law by a court of proper jurisdiction, the rights of the resident automatically transfer to and are exercised by

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		admission to or discharge or transfer from the hospital. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient is informed, prior to the notification occurring, of any process to automatically notify the patient's established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well as all applicable post–acute care services providers and suppliers. The 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. Note 2: 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.	a resident representative appointed by the court under state law to act on the resident's behalf. The resident representative exercises the resident's rights to the extent allowed by the court in accordance with state law. Note 1: If a resident representative's decision-making authority is limited by state law or court appointment, the resident retains the right to make those decisions outside the representative's authority. Note 2: The resident's wishes and preferences are considered by the representative when exercising the patient's rights. Note 3: To the extent practicable, the resident is provided with opportunities to participate in the care planning process.
§483.10(c)	(c) Planning and implementing care. The resident has the right to be informed of, and participate in, his or her treatment, including:		**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.
§483.10(c)(1)	(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.	**RI.01.01.01, EP 2** The hospital informs the patient of the patient's rights. Note 1: 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. Visitation	**RI.11.02.01, EP 1** The hospital provides information, including but not limited to the patient's total health status, in a manner tailored to the patient's age, language, and ability to understand. Note: The hospital communicates with the patient during the

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		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. Also included is the right to withdraw or deny such consent at any time. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital informs each patient (or support person, where appropriate) of the patient's rights in advance of furnishing or discontinuing patient care whenever possible. **RI.01.01.01, EP 5** The hospital respects the patient's right to and need for effective communication. **RI.01.01.03, EP 1** The hospital provides information in a manner tailored to the patient's age, language, and ability to understand. **RI.01.01.03, EP 3** The hospital provides information to the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient's needs. **RI.01.02.01, EP 1** The hospital involves the patient in making decisions about their care, treatment, and services, including the right to have the patient's family and physician or other licensed practitioner promptly notified of their admission to or discharge or transfer from the hospital. Note 1: For hospitals that use Joint Commission	provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs.

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		accreditation for deemed status purposes: The patient is informed, prior to the notification occurring, of any process to automatically notify the patient's established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well as all applicable post–acute care services providers and suppliers. The 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. Note 2: 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.	
§483.10(c)(2)	(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:		
§483.10(c)(2)(iii)	(iii) The right to be informed, in advance, of changes to the plan of care.	**RI.01.02.01, EP 1** The hospital involves the patient in making decisions about their care, treatment, and services, including the right to have the patient's family and physician or other licensed practitioner promptly notified of their admission to or discharge or transfer from the hospital. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient is informed, prior to the notification occurring, of any process to automatically notify the patient's established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well	**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.

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		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. Note 2: 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.	
§483.10(c)(6)	(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.	**RI.01.02.01, EP 1** The hospital involves the patient in making decisions about their care, treatment, and services, including the right to have the patient's family and physician or other licensed practitioner promptly notified of their admission to or discharge or transfer from the hospital. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient is informed, prior to the notification occurring, of any process to automatically notify the patient's established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well as all applicable post–acute care services providers and suppliers. The 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. Note 2: For hospitals that use Joint Commission	**RI.12.01.01, EP 4** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to request, refuse, and/or discontinue treatment; to participate in or refuse to participate in experimental research; and to formulate an advance directive.

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		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. **RI.01.02.01, EP 3** The hospital provides the patient or surrogate decision-maker with written information about the right to refuse care, treatment, and services. **RI.01.02.01, EP 4** The hospital respects the right of the patient or surrogate decision-maker to refuse care, treatment, and services in accordance with law and regulation. **RI.01.03.05, EP 3** The hospital informs the patient that refusing to participate in research, investigation, or clinical trials or discontinuing participation at any time will not jeopardize the patient's access to care, treatment, and services unrelated to the research. **RI.01.05.01, EP 1** The hospital follows written policies on advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services that address the following: - Providing patients with written information about advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services. - Providing the patient upon admission with information on the extent to which the hospital is able, unable, or unwilling to honor advance directives.	

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		- For outpatient hospital settings: Communicating its policy on advance directives upon request or when warranted by the care, treatment, and services provided. - Whether the hospital will honor advance directives in its outpatient settings. - That the hospital will honor the patient's right to formulate or review and revise the patient's advance directives. - Informing staff who are involved in the patient's care, treatment, and services whether or not the patient has an advance directive. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient's right to formulate advance directives and have staff and licensed practitioners comply with these directives is in accordance with 42 CFR 489.100, 489.102, and 489.104.	
§483.10(d)	(d) Choice of attending physician. The resident has the right to choose his or her attending physician.	**RI.01.06.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident's right to choose an attending physician, dentist, and other care providers. Note: The hospital informs the resident if it determines that the physician chosen by the resident is unlicensed or unable to serve as the attending physician. The hospital also discusses alternative physician participation with the resident and honors the resident's preferences, if any, among the options.	**RI.12.01.01, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident's right to choose a licensed attending physician. Note: If the physician chosen by the resident refuses to or does not meet the requirements for attending physicians at 42 CFR 483, the hospital may seek alternative physician participation to assure provision of appropriate and adequate care and treatment. The hospital informs the resident if it determines that the physician chosen by the resident is unlicensed or unable to serve as the attending physician. The hospital also discusses alternative physician participation with the resident and honors the resident's preferences, if any, among the options.
§483.10(d)(1)	(1) The physician must be licensed to practice, and	**MS.06.01.03, EP 6** The credentialing process requires that the hospital	**RI.12.01.01, EP 6** For hospitals that use Joint Commission accreditation for deemed

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		verifies in writing and from the primary source whenever feasible, or from a credentials verification organization (CVO), the following information: - The applicant's current licensure at the time of initial granting, renewal, and revision of privileges, and at the time of license expiration - The applicant's relevant training - The applicant's current competence	status purposes and have swing beds: The hospital supports the resident's right to choose a licensed attending physician. Note: If the physician chosen by the resident refuses to or does not meet the requirements for attending physicians at 42 CFR 483, the hospital may seek alternative physician participation to assure provision of appropriate and adequate care and treatment. The hospital informs the resident if it determines that the physician chosen by the resident is unlicensed or unable to serve as the attending physician. The hospital also discusses alternative physician participation with the resident and honors the resident's preferences, if any, among the options.
§483.10(d)(2)	(2) If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment.	**RI.01.06.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident's right to choose an attending physician, dentist, and other care providers. Note: The hospital informs the resident if it determines that the physician chosen by the resident is unlicensed or unable to serve as the attending physician. The hospital also discusses alternative physician participation with the resident and honors the resident's preferences, if any, among the options.	**RI.12.01.01, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident's right to choose a licensed attending physician. Note: If the physician chosen by the resident refuses to or does not meet the requirements for attending physicians at 42 CFR 483, the hospital may seek alternative physician participation to assure provision of appropriate and adequate care and treatment. The hospital informs the resident if it determines that the physician chosen by the resident is unlicensed or unable to serve as the attending physician. The hospital also discusses alternative physician participation with the resident and honors the resident's preferences, if any, among the options.
§483.10(d)(3)	(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.	**RI.01.06.11, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides the resident and the resident's family with the name, specialty, and telephone number of the physician or other licensed practitioner primarily responsible for the resident's care.	**RI.12.02.01, EP 1** The hospital informs the patient of the following: - Name of the physician, clinical psychologist, or other licensed practitioner who has primary responsibility for the patient's care, treatment, and services - Name of the physician(s), clinical psychologist(s), or other licensed practitioner(s) who will provide the patient's care, treatment, and services Note 1: The definition of "physician" is the same as that used by

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			the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital also provides the resident and the resident's family with the specialty of the physician or other licensed practitioner primarily responsible for the resident's care and a method to contact them.
§483.10(d)(4)	(4) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options.	**RI.01.06.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident's right to choose an attending physician, dentist, and other care providers. Note: The hospital informs the resident if it determines that the physician chosen by the resident is unlicensed or unable to serve as the attending physician. The hospital also discusses alternative physician participation with the resident and honors the resident's preferences, if any, among the options.	**RI.12.01.01, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident's right to choose a licensed attending physician. Note: If the physician chosen by the resident refuses to or does not meet the requirements for attending physicians at 42 CFR 483, the hospital may seek alternative physician participation to assure provision of appropriate and adequate care and treatment. The hospital informs the resident if it determines that the physician chosen by the resident is unlicensed or unable to serve as the attending physician. The hospital also discusses alternative physician participation with the resident and honors the resident's preferences, if any, among the options.
§483.10(d)(5)	(5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.	**RI.01.06.09, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident's right to choose an attending physician, dentist, and other care providers. Note: The hospital informs the resident if it determines that the physician chosen by the resident is unlicensed or unable to serve as the attending physician. The hospital also discusses alternative physician participation with the resident and honors the resident's preferences, if any, among the options.	**RI.12.01.01, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident's right to choose a licensed attending physician. Note: If the physician chosen by the resident refuses to or does not meet the requirements for attending physicians at 42 CFR 483, the hospital may seek alternative physician participation to assure provision of appropriate and adequate care and treatment. The hospital informs the resident if it determines that the physician chosen by the resident is unlicensed or unable to serve as the attending physician. The hospital also discusses alternative physician participation with the resident and honors the resident's preferences, if any, among the options.

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§483.10(e)	(e) Respect and dignity. The resident has a right to be treated with respect and dignity, including:		
§483.10(e)(2)	(2) The right to retain and use personal possession, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.	**RI.01.06.05, EP 4** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital allows the patient to keep and use personal clothing and possessions, unless this infringes on others' rights or is medically or therapeutically contraindicated, based on the setting or service.	**RI.13.01.03, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital allows the patient to keep and use personal clothing and possessions, unless this infringes on others' rights or is medically or therapeutically contraindicated, based on the setting or service.
§483.10(e)(4)	(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.	**RI.01.06.05, EP 8** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides accommodations for residents with significant others living in the same facility when both individuals consent to the arrangement.	**RI.13.01.03, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital allows the resident to share a room with their spouse when married residents are living in the same hospital and when both individuals consent to the arrangement.
§483.10(f)(4)(ii)	(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;	**RI.01.07.05, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital establishes liberal visiting hours that are limited only by the resident's personal preferences. **RI.01.07.05, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident's right to choose with whom the resident communicates. **RI.01.07.05, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital complies with law and regulation regarding individuals who are exempted from visiting hour	**RI.11.01.01, EP 8** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides immediate family and other relatives immediate access to the resident, except when the resident denies or withdraws consent. The hospital provides others who are visiting immediate access to the resident, except when reasonable clinical or safety restrictions apply or when the resident denies or withdraws consent.

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		restrictions in order to gain immediate access to the resident.	
§483.10(f)(4)(iii)	(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;	**RI.01.07.05, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital establishes liberal visiting hours that are limited only by the resident's personal preferences. **RI.01.07.05, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident's right to choose with whom the resident communicates. **RI.01.07.05, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital complies with law and regulation regarding individuals who are exempted from visiting hour restrictions in order to gain immediate access to the resident.	**RI.11.01.01, EP 8** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides immediate family and other relatives immediate access to the resident, except when the resident denies or withdraws consent. The hospital provides others who are visiting immediate access to the resident, except when reasonable clinical or safety restrictions apply or when the resident denies or withdraws consent.
§483.10(g)(8)	(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:	**RI.01.06.05, EP 15** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital offers patients telephone and mail service, based on the setting and population.	**RI.13.01.03, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident's right to send and promptly receive unopened mail through the postal service and to receive letters, packages, and other materials delivered to the hospital for the resident through a means other than a postal service. The hospital respects the resident's right to privacy of such communications and allows access to stationery, postage, and writing implements at the resident's expense.
§483.10(g)(8)(i)	(i) Privacy of such communications consistent with this section; and	**RI.01.01.01, EP 7** The hospital respects the patient's right to privacy.	**RI.13.01.03, EP 3** For hospitals that use Joint Commission accreditation for deemed

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		Note 1: This element of performance (EP) addresses a patient's personal privacy. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident's right to privacy includes privacy and confidentiality of their personal records and written communications, including the right to send and receive mail promptly.	status purposes and have swing beds: The hospital supports the resident's right to send and promptly receive unopened mail through the postal service and to receive letters, packages, and other materials delivered to the hospital for the resident through a means other than a postal service. The hospital respects the resident's right to privacy of such communications and allows access to stationery, postage, and writing implements at the resident's expense.
§483.10(g)(8)(ii)	(ii) Access to stationery, postage, and writing implements at the resident's own expense.	**RI.01.06.05, EP 14** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to have access to stationery, postage, and writing implements at the resident's own expense.	**RI.13.01.03, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident's right to send and promptly receive unopened mail through the postal service and to receive letters, packages, and other materials delivered to the hospital for the resident through a means other than a postal service. The hospital respects the resident's right to privacy of such communications and allows access to stationery, postage, and writing implements at the resident's expense.
§483.10(g)(17)	(17) The facility must—		
§483.10(g)(17)(i)	(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of—		
§483.10(g)(17)(i)(A)	(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;	**LD.04.02.03, EP 13** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Each resident who is entitled to Medicaid benefits is informed in writing, either at the time of admission or when the resident becomes eligible for Medicaid, of the following: - The items and services included in the state plan for which the resident may not be charged - Those items and services that the facility offers and for	**LD.13.02.01, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Each Medicaid-eligible resident is informed in writing, either at the time of admission or when the resident becomes eligible for Medicaid, of the following: - Items and services included in the state plan for which the resident may not be charged - Items and services that the hospital offers, those for which the resident may be charged, and the amount of charges for those services

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		which the resident may be charged, and the amount of charges for those services	Note: The hospital informs residents when changes are made to the items and services.
§483.10(g)(17)(i)(B)	(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	**LD.04.02.03, EP 13** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Each resident who is entitled to Medicaid benefits is informed in writing, either at the time of admission or when the resident becomes eligible for Medicaid, of the following: - The items and services included in the state plan for which the resident may not be charged - Those items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services	**LD.13.02.01, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Each Medicaid-eligible resident is informed in writing, either at the time of admission or when the resident becomes eligible for Medicaid, of the following: - Items and services included in the state plan for which the resident may not be charged - Items and services that the hospital offers, those for which the resident may be charged, and the amount of charges for those services Note: The hospital informs residents when changes are made to the items and services.
§483.10(g)(17)(ii)	(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.	**LD.04.02.03, EP 14** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Residents are informed when changes are made to the services that are specified in LD.04.02.03, EP 13.	**LD.13.02.01, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Each Medicaid-eligible resident is informed in writing, either at the time of admission or when the resident becomes eligible for Medicaid, of the following: - Items and services included in the state plan for which the resident may not be charged - Items and services that the hospital offers, those for which the resident may be charged, and the amount of charges for those services Note: The hospital informs residents when changes are made to the items and services.
§483.10(g)(18)	(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under	**LD.04.02.03, EP 16** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Residents are informed 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	**LD.13.02.01, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital informs residents before or at the time of admission, and periodically during the resident's stay, of services available in the hospital and of charges for those services not covered under Medicare, Medicaid, or by the hospital's per diem rate.

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	Medicare/ Medicaid or by the facility's per diem rate.	services not covered under Medicare or by the facility's per diem rate.	
§483.10(h)	(h) Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.	**IM.02.01.01, EP 1** The hospital follows a written policy addressing the privacy and confidentiality of health information. **IM.02.01.01, EP 3** The hospital uses health information only for purposes permitted by law and regulation or as further limited by its policy on privacy. **IM.02.01.01, EP 4** The hospital discloses health information only as authorized by the patient or as otherwise consistent with law and regulation. **RI.01.01.01, EP 7** The hospital respects the patient's right to privacy. Note 1: This element of performance (EP) addresses a patient's personal privacy. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident's right to privacy includes privacy and confidentiality of their personal records and written communications, including the right to send and receive mail promptly.	**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.
§483.10(h)(1)	(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	**IM.02.01.01, EP 1** The hospital follows a written policy addressing the privacy and confidentiality of health information. **IM.02.01.01, EP 3** The hospital uses health information only for purposes permitted by law and regulation or as further limited by	**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 purposes and have swing beds: Personal privacy

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		its policy on privacy. **IM.02.01.01, EP 4** The hospital discloses health information only as authorized by the patient or as otherwise consistent with law and regulation. **RI.01.01.01, EP 7** The hospital respects the patient's right to privacy. Note 1: This element of performance (EP) addresses a patient's personal privacy. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident's right to privacy includes privacy and confidentiality of their personal records and written communications, including the right to send and receive mail promptly. **RI.01.07.05, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides space for the resident to receive visitors in comfort and privacy.	includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.
§483.10(h)(2)	(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	**RI.01.01.01, EP 7** The hospital respects the patient's right to privacy. Note 1: This element of performance (EP) addresses a patient's personal privacy. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident's right to privacy includes privacy and confidentiality of their personal records and written communications, including the right to send and receive mail promptly.	**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 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

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		RI.01.06.05, EP 15 For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital offers patients telephone and mail service, based on the setting and population.	provide a private room for each resident. **RI.13.01.03, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident's right to send and promptly receive unopened mail through the postal service and to receive letters, packages, and other materials delivered to the hospital for the resident through a means other than a postal service. The hospital respects the resident's right to privacy of such communications and allows access to stationery, postage, and writing implements at the resident's expense.
§483.10(h)(3)	(3) The resident has a right to secure and confidential personal and medical records.	**IM.02.01.01, EP 1** The hospital follows a written policy addressing the privacy and confidentiality of health information. **IM.02.01.01, EP 3** The hospital uses health information only for purposes permitted by law and regulation or as further limited by its policy on privacy. **RI.01.01.01, EP 1** The hospital has written policies on patient rights. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's written policies address procedures regarding patient visitation rights, including any clinically necessary or reasonable restrictions or limitations.	**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.
§483.10(h)(3)(i)	(i) The resident has the right to refuse the release of personal and medical records except as provided at § 483.70(i)(2) or other applicable federal or state laws.	**IM.02.01.01, EP 4** The hospital discloses health information only as authorized by the patient or as otherwise consistent with law and regulation.	**IM.12.01.01, EP 2** The hospital discloses health information only as authorized by the patient with the patient's written consent or as otherwise required by law and regulation. Note: For hospitals that use Joint Commission accreditation for

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		RI.01.01.01, EP 1 The hospital has written policies on patient rights. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's written policies address procedures regarding patient visitation rights, including any clinically necessary or reasonable restrictions or limitations.	deemed status purposes and have swing beds: The hospital allows representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with state law.
§483.10(h)(3)(ii)	(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.	**IM.02.01.01, EP 4** The hospital discloses health information only as authorized by the patient or as otherwise consistent with law and regulation.	**IM.12.01.01, EP 2** The hospital discloses health information only as authorized by the patient with the patient's written consent or as otherwise required by law and regulation. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital allows representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with state law.
§483.12	§483.12 Freedom from abuse, neglect, and exploitation. The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.		**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.
§483.12(a)	(a) The facility must—		
§483.12(a)(1)	(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	**RI.01.06.03, EP 1** The hospital protects the patient from harassment, neglect, exploitation, and abuse that could occur while the patient is receiving care, treatment, and services. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital also determines how it will	**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

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		protect residents from corporal punishment and involuntary seclusion.	status purposes and have swing beds: The hospital also protects the resident from misappropriation of property.
§483.12(a)(2)	(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.	**PC.03.05.01, EP 1** The hospital uses restraint or seclusion only to protect the immediate physical safety of the patient, staff, or others. **PC.03.05.01, EP 2** The hospital does not use restraint or seclusion as a means of corporal punishment, coercion, discipline, convenience, or staff retaliation. **PC.03.05.01, EP 3** The hospital uses restraint or seclusion only when less restrictive interventions are ineffective. **PC.03.05.01, EP 4** The hospital uses the least restrictive form of restraint or seclusion that protects the physical safety of the patient, staff, or others. **PC.03.05.01, EP 5** The hospital discontinues restraint or seclusion at the earliest possible time, regardless of the scheduled expiration of the order. **RI.01.06.01, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital has policies and procedures that support the resident's right to be free from chemical and physical restraint. Note: The hospital's use of restraint is consistent with	**PC.13.02.01, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital does not use physical or chemical restraints that are imposed for purposes of discipline or convenience and are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the hospital uses the least restrictive alternative for the least amount of time and documents ongoing reevaluation of the need for restraints.

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		the requirements in the "Provision of Care, Treatment, and Services" (PC) chapter.	
§483.12(a)(3)	(3) Not employ or otherwise engage individuals who—		
§483.12(a)(3)(i)	(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;	**HR.01.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The facility does not employ individuals who have been found guilty by a court of law of abusing, neglecting, exploiting, misappropriating property, or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of residents' property.	**HR.11.02.01, EP 4** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital does not employ individuals who have been found guilty by a court of law of abusing, neglecting, exploiting, misappropriating property, or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of residents' property.
§483.12(a)(3)(ii)	(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or	**HR.01.01.01, EP 18** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The facility does not employ individuals who have been found guilty by a court of law of abusing, neglecting, exploiting, misappropriating property, or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of residents' property.	**HR.11.02.01, EP 4** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital does not employ individuals who have been found guilty by a court of law of abusing, neglecting, exploiting, misappropriating property, or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of residents' property.
§483.12(a)(4)	(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.	**PC.01.02.09, EP 8** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital reports to the state nurse aide registry or licensing authorities any knowledge it has of any actions taken by a court of law against an employee that would indicate unfitness for service as a nurse aide or other facility staff.	**RI.13.01.01, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital reports to the state nurse aide registry or licensing authorities any knowledge it has of any actions taken by a court of law against an employee that would indicate unfitness for service as a nurse aide or other facility staff.

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§483.12(b)	(b) The facility must develop and implement written policies and procedures that:		
§483.12(b)(1)	(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	**RI.01.06.03, EP 1** The hospital protects the patient from harassment, neglect, exploitation, and abuse that could occur while the patient is receiving care, treatment, and services. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital also determines how it will protect residents from corporal punishment and involuntary seclusion. **RI.01.06.03, EP 4** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital develops and implements written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	**RI.13.01.01, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital develops and implements written policies and procedures that prohibit and prevent mistreatment, neglect, and abuse of residents and misappropriation of resident property. The policies and procedures also address investigation of allegations related to these issues.
§483.12(b)(2)	(2) Establish policies and procedures to investigate any such allegations, and	**RI.01.06.03, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital has evidence that all alleged violations are thoroughly investigated and that it prevents further abuse while the investigation is in progress. The results of all investigations are reported to the administrator or their designated representative and to other officials in accordance with state law, within five working days of the incident. If the alleged violation is verified, appropriate corrective action is taken.	**RI.13.01.01, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital develops and implements written policies and procedures that prohibit and prevent mistreatment, neglect, and abuse of residents and misappropriation of resident property. The policies and procedures also address investigation of allegations related to these issues.
§483.12(c)	(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:		

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§483.12(c)(1)	(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	**PC.01.02.09, EP 7** The hospital reports cases of possible abuse and neglect to external agencies, in accordance with law and regulation. **PC.01.02.09, EP 8** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital reports to the state nurse aide registry or licensing authorities any knowledge it has of any actions taken by a court of law against an employee that would indicate unfitness for service as a nurse aide or other facility staff. **RI.01.06.03, EP 1** The hospital protects the patient from harassment, neglect, exploitation, and abuse that could occur while the patient is receiving care, treatment, and services. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital also determines how it will protect residents from corporal punishment and involuntary seclusion. **RI.01.06.03, EP 3** The hospital reports allegations, observations, and suspected cases of neglect, exploitation, and abuse to appropriate authorities based on its evaluation of the suspected events, or as required by law. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of	**RI.13.01.01, EP 4** The hospital reports allegations, observations, and suspected cases of neglect, exploitation, and abuse to appropriate authorities based on its evaluation of the suspected events or as required by law. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to the administrator of the facility and to other officials (including the state survey agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law and established procedures. The alleged violations are reported in the following time frames: - No later than 2 hours after the allegation is made if the allegation involves abuse or serious bodily injury - No later than 24 hours after the allegation is made if the allegation does not involve abuse or serious bodily injury

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		unknown source and misappropriation of resident property, are reported to the administrator of the facility and to other officials (including the state survey agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law and established procedures. The alleged violations are reported in the following time frames: - No later than 2 hours after the allegation is made if the allegation involves abuse or serious bodily injury - No later than 24 hours after the allegation is made if the allegation does not involve abuse or serious bodily injury	
§483.12(c)(2)	(2) Have evidence that all alleged violations are thoroughly investigated.	**RI.01.06.03, EP 1** The hospital protects the patient from harassment, neglect, exploitation, and abuse that could occur while the patient is receiving care, treatment, and services. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital also determines how it will protect residents from corporal punishment and involuntary seclusion. **RI.01.06.03, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital has evidence that all alleged violations are thoroughly investigated and that it prevents further abuse while the investigation is in progress. The results of all investigations are reported to the administrator or their designated representative and to other officials in accordance with state law, within five working days of	**RI.13.01.01, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital has evidence that all alleged violations of abuse, neglect, exploitation, or mistreatment are thoroughly investigated and that it prevents further abuse, neglect, exploitation, or mistreatment while the investigation is in progress. The results of all investigations are reported to the administrator or their designated representative and to other officials in accordance with state law, including the state survey agency, within five working days of the incident. If the alleged violation is verified, appropriate corrective action is taken.

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		the incident. If the alleged violation is verified, appropriate corrective action is taken.	
§483.12(c)(3)	(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	**RI.01.06.03, EP 1** The hospital protects the patient from harassment, neglect, exploitation, and abuse that could occur while the patient is receiving care, treatment, and services. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital also determines how it will protect residents from corporal punishment and involuntary seclusion. **RI.01.06.03, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital has evidence that all alleged violations are thoroughly investigated and that it prevents further abuse while the investigation is in progress. The results of all investigations are reported to the administrator or their designated representative and to other officials in accordance with state law, within five working days of the incident. If the alleged violation is verified, appropriate corrective action is taken.	**RI.13.01.01, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital has evidence that all alleged violations of abuse, neglect, exploitation, or mistreatment are thoroughly investigated and that it prevents further abuse, neglect, exploitation, or mistreatment while the investigation is in progress. The results of all investigations are reported to the administrator or their designated representative and to other officials in accordance with state law, including the state survey agency, within five working days of the incident. If the alleged violation is verified, appropriate corrective action is taken.
§483.12(c)(4)	(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.	**RI.01.06.03, EP 1** The hospital protects the patient from harassment, neglect, exploitation, and abuse that could occur while the patient is receiving care, treatment, and services. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital also determines how it will protect residents from corporal punishment and involuntary seclusion.	**RI.13.01.01, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital has evidence that all alleged violations of abuse, neglect, exploitation, or mistreatment are thoroughly investigated and that it prevents further abuse, neglect, exploitation, or mistreatment while the investigation is in progress. The results of all investigations are reported to the administrator or their designated representative and to other officials in accordance with state law, including the

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		RI.01.06.03, EP 5 For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital has evidence that all alleged violations are thoroughly investigated and that it prevents further abuse while the investigation is in progress. The results of all investigations are reported to the administrator or their designated representative and to other officials in accordance with state law, within five working days of the incident. If the alleged violation is verified, appropriate corrective action is taken.	state survey agency, within five working days of the incident. If the alleged violation is verified, appropriate corrective action is taken.
§483.15	§483.15 Admission, transfer, and discharge rights.		
§483.15(c)	(c) Transfer and discharge—		
§483.15(c)(1)	(1) Facility requirements—		
§483.15(c)(1)(i)	(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—	**PC.04.01.07, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital transfers or discharges residents only when at least one of the following conditions is met: - The resident's health has improved to the point where they no longer need the hospital's services. - The transfer or discharge is necessary for the resident's welfare and the hospital cannot meet the resident's needs. - The safety of the individuals in the hospital is endangered due to the clinical or behavioral status of the resident. - The health of individuals in the hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital.	

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		Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a hospital, the hospital may charge a resident only the allowable charges under Medicaid. - The hospital ceases operation. Note: The hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the hospital. The hospital documents the danger that failure to transfer or discharge would pose.	
§483.15(c)(1)(i)(A)	(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;	**PC.04.01.07, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital transfers or discharges residents only when at least one of the following conditions is met: - The resident's health has improved to the point where they no longer need the hospital's services. - The transfer or discharge is necessary for the resident's welfare and the hospital cannot meet the resident's needs. - The safety of the individuals in the hospital is endangered due to the clinical or behavioral status of the resident. - The health of individuals in the hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital.	**PC.14.01.03, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital transfers or discharges residents only under at least one of the following conditions: - The resident's health has improved to the point where they no longer need the hospital's services. - The transfer or discharge is necessary for the resident's welfare, and the hospital cannot meet the resident's needs. - The safety of the individuals in the hospital is endangered due to the resident's clinical or behavioral status. - The health of individuals in the hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the

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		Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a hospital, the hospital may charge a resident only the allowable charges under Medicaid. - The hospital ceases operation. Note: The hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the hospital. The hospital documents the danger that failure to transfer or discharge would pose.	resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a hospital, the hospital may charge a resident only the allowable charges under Medicaid. - The hospital ceases operation. Note: The hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the hospital. The hospital documents the danger that failure to transfer or discharge would pose.
§483.15(c)(1)(i)(B)	(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;	**PC.04.01.07, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital transfers or discharges residents only when at least one of the following conditions is met: - The resident's health has improved to the point where they no longer need the hospital's services. - The transfer or discharge is necessary for the resident's welfare and the hospital cannot meet the resident's needs. - The safety of the individuals in the hospital is endangered due to the clinical or behavioral status of the resident. - The health of individuals in the hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital.	**PC.14.01.03, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital transfers or discharges residents only under at least one of the following conditions: - The resident's health has improved to the point where they no longer need the hospital's services. - The transfer or discharge is necessary for the resident's welfare, and the hospital cannot meet the resident's needs. - The safety of the individuals in the hospital is endangered due to the resident's clinical or behavioral status. - The health of individuals in the hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the

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§483.15(c)(1)(i)(C)	(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;	**PC.04.01.07, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital transfers or discharges residents only when at least one of the following conditions is met: - The resident's health has improved to the point where they no longer need the hospital's services. - The transfer or discharge is necessary for the resident's welfare and the hospital cannot meet the resident's needs. - The safety of the individuals in the hospital is endangered due to the clinical or behavioral status of the resident. - The health of individuals in the hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital.	**PC.14.01.03, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital transfers or discharges residents only under at least one of the following conditions: - The resident's health has improved to the point where they no longer need the hospital's services. - The transfer or discharge is necessary for the resident's welfare, and the hospital cannot meet the resident's needs. - The safety of the individuals in the hospital is endangered due to the resident's clinical or behavioral status. - The health of individuals in the hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the

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		Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a hospital, the hospital may charge a resident only the allowable charges under Medicaid. - The hospital ceases operation. Note: The hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the hospital. The hospital documents the danger that failure to transfer or discharge would pose.	resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a hospital, the hospital may charge a resident only the allowable charges under Medicaid. - The hospital ceases operation. Note: The hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the hospital. The hospital documents the danger that failure to transfer or discharge would pose.
§483.15(c)(1)(i)(D)	(D) The health of individuals in the facility would otherwise be endangered;	**PC.04.01.07, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital transfers or discharges residents only when at least one of the following conditions is met: - The resident's health has improved to the point where they no longer need the hospital's services. - The transfer or discharge is necessary for the resident's welfare and the hospital cannot meet the resident's needs. - The safety of the individuals in the hospital is endangered due to the clinical or behavioral status of the resident. - The health of individuals in the hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital.	**PC.14.01.03, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital transfers or discharges residents only under at least one of the following conditions: - The resident's health has improved to the point where they no longer need the hospital's services. - The transfer or discharge is necessary for the resident's welfare, and the hospital cannot meet the resident's needs. - The safety of the individuals in the hospital is endangered due to the resident's clinical or behavioral status. - The health of individuals in the hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the

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§483.15(c)(1)(i)(E)	(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or	**PC.04.01.07, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital transfers or discharges residents only when at least one of the following conditions is met: - The resident's health has improved to the point where they no longer need the hospital's services. - The transfer or discharge is necessary for the resident's welfare and the hospital cannot meet the resident's needs. - The safety of the individuals in the hospital is endangered due to the clinical or behavioral status of the resident. - The health of individuals in the hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital.	**PC.14.01.03, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital transfers or discharges residents only under at least one of the following conditions: - The resident's health has improved to the point where they no longer need the hospital's services. - The transfer or discharge is necessary for the resident's welfare, and the hospital cannot meet the resident's needs. - The safety of the individuals in the hospital is endangered due to the resident's clinical or behavioral status. - The health of individuals in the hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the

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§483.15(c)(1)(i)(F)	(F) The facility ceases to operate.	**PC.04.01.07, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital transfers or discharges residents only when at least one of the following conditions is met: - The resident's health has improved to the point where they no longer need the hospital's services. - The transfer or discharge is necessary for the resident's welfare and the hospital cannot meet the resident's needs. - The safety of the individuals in the hospital is endangered due to the clinical or behavioral status of the resident. - The health of individuals in the hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital.	**PC.14.01.03, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital transfers or discharges residents only under at least one of the following conditions: - The resident's health has improved to the point where they no longer need the hospital's services. - The transfer or discharge is necessary for the resident's welfare, and the hospital cannot meet the resident's needs. - The safety of the individuals in the hospital is endangered due to the resident's clinical or behavioral status. - The health of individuals in the hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the

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§483.15(c)(1)(ii)	(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.	**PC.04.01.07, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital transfers or discharges residents only when at least one of the following conditions is met: - The resident's health has improved to the point where they no longer need the hospital's services. - The transfer or discharge is necessary for the resident's welfare and the hospital cannot meet the resident's needs. - The safety of the individuals in the hospital is endangered due to the clinical or behavioral status of the resident. - The health of individuals in the hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital.	**PC.14.01.03, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital transfers or discharges residents only under at least one of the following conditions: - The resident's health has improved to the point where they no longer need the hospital's services. - The transfer or discharge is necessary for the resident's welfare, and the hospital cannot meet the resident's needs. - The safety of the individuals in the hospital is endangered due to the resident's clinical or behavioral status. - The health of individuals in the hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the

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§483.15(c)(2)	(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.	**RC.02.04.01, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. There is documentation in the resident's medical record by the resident's physician when the resident is transferred or discharged, either when the transfer is due to the resident improving and no longer needing long term care services or when the resident's needs cannot be met in the hospital's swing bed. There is documentation in the resident's medical record by a physician when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered. **RC.02.04.01, EP 2**	**RC.12.03.01, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. A physician documents in the resident's medical record when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered. The resident's physician documents in the medical record when the transfer is due to the resident improving and no longer needing long term care services or when the transfer is due to the resident's welfare and resident's needs cannot be met in the hospital's swing bed.

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		For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident's discharge information includes the following: - The reason for transfer, discharge, or referral - Treatment provided, diet, medication orders, and orders for the resident's immediate care - Referrals provided to the resident, the referring physician's or other licensed practitioner's name, and the name of the physician or other licensed practitioner who has agreed to be responsible for the resident's medical care and treatment, if this person is someone other than the referring physician or other licensed practitioner - Medical findings and diagnoses; a summary of the care, treatment, and services provided; and progress reached toward goals - Information about the resident's behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation - Nursing information that is useful in the resident's care - Any advance directives - Instructions given to the resident before discharge	
§483.15(c)(2)(i)	(i) Documentation in the resident's medical record must include:		
§483.15(c)(2)(i)(A)	(A) The basis for the transfer per paragraph (c)(1)(i) of this section.	**RC.02.04.01, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident's discharge information includes the following: - The reason for transfer, discharge, or referral - Treatment provided, diet, medication orders, and orders for the resident's immediate care - Referrals provided to the resident, the referring physician's or other licensed practitioner's name, and	**RC.12.03.01, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident's discharge information includes the following: - Reason for transfer, discharge, or referral - Treatment provided, diet, medication orders, and orders for the resident's immediate care - Referrals provided to the resident, the referring physician's or other licensed practitioner's name, and the name of the physician

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		the name of the physician or other licensed practitioner who has agreed to be responsible for the resident's medical care and treatment, if this person is someone other than the referring physician or other licensed practitioner - Medical findings and diagnoses; a summary of the care, treatment, and services provided; and progress reached toward goals - Information about the resident's behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation - Nursing information that is useful in the resident's care - Any advance directives - Instructions given to the resident before discharge	or other licensed practitioner who has agreed to be responsible for the resident's medical care and treatment, if this person is someone other than the referring physician or other licensed practitioner - Medical findings and diagnoses; a summary of the care, treatment, and services provided; and progress reached toward goals - Information about the resident's behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation - Nursing information that is useful in the resident's care - Any advance directives - Instructions given to the resident before discharge
§483.15(c)(2)(i)(B)	(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).	**RC.02.04.01, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident's discharge information includes the following: - The reason for transfer, discharge, or referral - Treatment provided, diet, medication orders, and orders for the resident's immediate care - Referrals provided to the resident, the referring physician's or other licensed practitioner's name, and the name of the physician or other licensed practitioner who has agreed to be responsible for the resident's medical care and treatment, if this person is someone other than the referring physician or other licensed practitioner - Medical findings and diagnoses; a summary of the care, treatment, and services provided; and progress reached toward goals - Information about the resident's behavior, ambulation, nutrition, physical status, psychosocial status, and	**RC.12.03.01, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: When the resident is transferred or discharged because the hospital cannot meet their needs, the hospital documents which needs could not be met, the hospital's attempts to meet the resident's needs, and the services available at the receiving organization that will meet the resident's needs.

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		potential for rehabilitation - Nursing information that is useful in the resident's care - Any advance directives - Instructions given to the resident before discharge	
§483.15(c)(2)(ii)	(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by—		
§483.15(c)(2)(ii)(A)	(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and	**RC.02.04.01, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. There is documentation in the resident's medical record by the resident's physician when the resident is transferred or discharged, either when the transfer is due to the resident improving and no longer needing long term care services or when the resident's needs cannot be met in the hospital's swing bed. There is documentation in the resident's medical record by a physician when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered.	**RC.12.03.01, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. A physician documents in the resident's medical record when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered. The resident's physician documents in the medical record when the transfer is due to the resident improving and no longer needing long term care services or when the transfer is due to the resident's welfare and resident's needs cannot be met in the hospital's swing bed.
§483.15(c)(2)(ii)(B)	(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.	**RC.02.04.01, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. There is documentation in the resident's medical record by the resident's physician when the resident is transferred or discharged, either when the transfer is due to the resident improving and no longer needing long term care	**RC.12.03.01, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. A physician documents in the resident's medical record when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered. The resident's physician documents in the medical record when the transfer is due to the resident improving and no longer needing long term care

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		services or when the resident's needs cannot be met in the hospital's swing bed. There is documentation in the resident's medical record by a physician when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered.	services or when the transfer is due to the resident's welfare and resident's needs cannot be met in the hospital's swing bed.
§483.15(c)(3)	(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must—		
§483.15(c)(3)(i)	(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.	**PC.04.01.03, EP 3** The patient, the patient's family, physicians, other licensed practitioners, clinical psychologists, and staff involved in the patient's care, treatment, and services participate in planning the patient's discharge or transfer. 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 psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Social service staff responsibilities include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the hospital. Note 3: For hospitals that use Joint 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 in writing. The hospital also provides sufficient preparation and orientation to residents to make sure that transfer or discharge from the hospital is safe and	**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 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.

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		orderly. The hospital sends a copy of the notice to a representative of the office of the state's long-term care ombudsman. Note 4: For hospitals that use Joint Commission accreditation for deemed status purposes: Discharge planning is performed by, or under the supervision of, a registered nurse, social worker, or other qualified person. **RI.01.01.01, EP 5** The hospital respects the patient's right to and need for effective communication. **RI.01.01.03, EP 1** The hospital provides information in a manner tailored to the patient's age, language, and ability to understand.	
§483.15(c)(3)(ii)	(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	**RC.01.01.01, EP 5** The medical record includes the following: - Information needed to support the patient's diagnosis and condition - Information needed to justify the patient's care, treatment, and services - Information that documents the course and result of the patient's care, treatment, and services - 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.12.03.01, EP 4** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital records the reasons for the transfer or discharge in the resident's medical record in accordance with 42 CFR 483.15(c)(2).
§483.15(c)(3)(iii)	(iii) Include in the notice the items described in paragraph (c)(5) of this section.	**PC.04.01.03, EP 3** The patient, the patient's family, physicians, other	**PC.14.01.01, EP 4** The patient, the patient's caregiver(s) or support person(s),

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		licensed practitioners, clinical psychologists, and staff involved in the patient's care, treatment, and services participate in planning the patient's discharge or transfer. 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 psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Social service staff responsibilities include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the hospital. Note 3: For hospitals that use Joint 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 in writing. 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. Note 4: For hospitals that use Joint Commission accreditation for deemed status purposes: Discharge planning is performed by, or under the supervision of, a registered nurse, social worker, or other qualified person. **RC.01.01.01, EP 5** The medical record includes the following:	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 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.

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		- Information needed to support the patient's diagnosis and condition - Information needed to justify the patient's care, treatment, and services - Information that documents the course and result of the patient's care, treatment, and services - 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. **RI.01.01.01, EP 5** The hospital respects the patient's right to and need for effective communication. **RI.01.01.03, EP 1** The hospital provides information in a manner tailored to the patient's age, language, and ability to understand.	
§483.15(c)(4)	(4) Timing of the notice.		
§483.15(c)(4)(i)	(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.	**PC.04.01.03, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Except when specified in the CoP from 42 CFR 483.12(a)(5)(ii), the written notice of transfer or discharge required under paragraph 42 CFR 483.12(a)(4) must be made by the hospital at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered; the health of the	**PC.14.01.01, EP 12** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides the written notice of transfer or discharge at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered, the health of the individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, immediate transfer or

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		individuals in the facility would be endangered; the resident's health improves sufficiently to allow a more immediate transfer or discharge, and immediate transfer or discharge is required by the resident's urgent medical needs; or a resident has not resided in the facility for 30 days.	discharge is required by the resident's urgent medical needs, or a resident has not resided in the facility for 30 days.
§483.15(c)(4)(ii)	(ii) Notice must be made as soon as practicable before transfer or discharge when—		
§483.15(c)(4)(ii)(A)	(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;	**PC.04.01.03, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Except when specified in the CoP from 42 CFR 483.12(a)(5)(ii), the written notice of transfer or discharge required under paragraph 42 CFR 483.12(a)(4) must be made by the hospital at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered; the health of the individuals in the facility would be endangered; the resident's health improves sufficiently to allow a more immediate transfer or discharge, and immediate transfer or discharge is required by the resident's urgent medical needs; or a resident has not resided in the facility for 30 days. **PC.04.01.07, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital transfers or discharges residents only when at least one of the following conditions is met: - The resident's health has improved to the point where	**PC.14.01.01, EP 12** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides the written notice of transfer or discharge at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered, the health of the individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the facility for 30 days.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		they no longer need the hospital's services. - The transfer or discharge is necessary for the resident's welfare and the hospital cannot meet the resident's needs. - The safety of the individuals in the hospital is endangered due to the clinical or behavioral status of the resident. - The health of individuals in the hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a hospital, the hospital may charge a resident only the allowable charges under Medicaid. - The hospital ceases operation. Note: The hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the hospital. The hospital documents the danger that failure to transfer or discharge would pose.	
§483.15(c)(4)(ii)(B)	(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	**PC.04.01.03, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Except when specified in the CoP from 42 CFR 483.12(a)(5)(ii), the written notice of transfer or discharge required under paragraph 42 CFR	**PC.14.01.01, EP 12** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides the written notice of transfer or discharge at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		483.12(a)(4) must be made by the hospital at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered; the health of the individuals in the facility would be endangered; the resident's health improves sufficiently to allow a more immediate transfer or discharge, and immediate transfer or discharge is required by the resident's urgent medical needs; or a resident has not resided in the facility for 30 days. **PC.04.01.07, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital transfers or discharges residents only when at least one of the following conditions is met: - The resident's health has improved to the point where they no longer need the hospital's services. - The transfer or discharge is necessary for the resident's welfare and the hospital cannot meet the resident's needs. - The safety of the individuals in the hospital is endangered due to the clinical or behavioral status of the resident. - The health of individuals in the hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the	or discharge when the safety of the individuals in the facility would be endangered, the health of the individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the facility for 30 days.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a hospital, the hospital may charge a resident only the allowable charges under Medicaid. - The hospital ceases operation. Note: The hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the hospital. The hospital documents the danger that failure to transfer or discharge would pose.	
§483.15(c)(4)(ii)(C)	(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;	**PC.04.01.03, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Except when specified in the CoP from 42 CFR 483.12(a)(5)(ii), the written notice of transfer or discharge required under paragraph 42 CFR 483.12(a)(4) must be made by the hospital at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered; the health of the individuals in the facility would be endangered; the resident's health improves sufficiently to allow a more immediate transfer or discharge, and immediate transfer or discharge is required by the resident's urgent medical needs; or a resident has not resided in the facility for 30 days. **PC.04.01.07, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The	**PC.14.01.01, EP 12** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides the written notice of transfer or discharge at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered, the health of the individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the facility for 30 days.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		hospital transfers or discharges residents only when at least one of the following conditions is met: - The resident's health has improved to the point where they no longer need the hospital's services. - The transfer or discharge is necessary for the resident's welfare and the hospital cannot meet the resident's needs. - The safety of the individuals in the hospital is endangered due to the clinical or behavioral status of the resident. - The health of individuals in the hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a hospital, the hospital may charge a resident only the allowable charges under Medicaid. - The hospital ceases operation. Note: The hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the hospital. The hospital documents the danger that failure to transfer or discharge would pose.	
§483.15(c)(4)(ii)(D)	(D) An immediate transfer or discharge is required by the resident's urgent medical	**PC.04.01.03, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds:	**PC.14.01.01, EP 12** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides the

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	needs, under paragraph (c)(1)(i)(A) of this section; or	Except when specified in the CoP from 42 CFR 483.12(a)(5)(ii), the written notice of transfer or discharge required under paragraph 42 CFR 483.12(a)(4) must be made by the hospital at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered; the health of the individuals in the facility would be endangered; the resident's health improves sufficiently to allow a more immediate transfer or discharge, and immediate transfer or discharge is required by the resident's urgent medical needs; or a resident has not resided in the facility for 30 days. **PC.04.01.07, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital transfers or discharges residents only when at least one of the following conditions is met: - The resident's health has improved to the point where they no longer need the hospital's services. - The transfer or discharge is necessary for the resident's welfare and the hospital cannot meet the resident's needs. - The safety of the individuals in the hospital is endangered due to the clinical or behavioral status of the resident. - The health of individuals in the hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital.	written notice of transfer or discharge at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered, the health of the individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the facility for 30 days.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a hospital, the hospital may charge a resident only the allowable charges under Medicaid. - The hospital ceases operation. Note: The hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the hospital. The hospital documents the danger that failure to transfer or discharge would pose.	
§483.15(c)(4)(ii)(E)	(E) A resident has not resided in the facility for 30 days.	**PC.04.01.03, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Except when specified in the CoP from 42 CFR 483.12(a)(5)(ii), the written notice of transfer or discharge required under paragraph 42 CFR 483.12(a)(4) must be made by the hospital at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered; the health of the individuals in the facility would be endangered; the resident's health improves sufficiently to allow a more immediate transfer or discharge, and immediate transfer or discharge is required by the resident's urgent medical needs; or a resident has not resided in the facility for 30 days.	**PC.14.01.01, EP 12** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides the written notice of transfer or discharge at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered, the health of the individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the facility for 30 days.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		PC.04.01.07, EP 1 For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital transfers or discharges residents only when at least one of the following conditions is met: - The resident's health has improved to the point where they no longer need the hospital's services. - The transfer or discharge is necessary for the resident's welfare and the hospital cannot meet the resident's needs. - The safety of the individuals in the hospital is endangered due to the clinical or behavioral status of the resident. - The health of individuals in the hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a hospital, the hospital may charge a resident only the allowable charges under Medicaid. - The hospital ceases operation. Note: The hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the hospital. The hospital documents the danger that failure to transfer or discharge would pose.	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§483.15(c)(5)	(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:		
§483.15(c)(5)(i)	(i) The reason for transfer or discharge;	**PC.04.01.03, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The written notice before transfer or discharge specified in the CoP from 42 CFR 483.12(a)(4) includes the following: - The reason for transfer or discharge - The effective date of transfer or discharge - The location to which the resident is transferred or discharged - A statement of the resident's appeal rights, including the name, address (mailing and e-mail), and telephone number of the entity which receives such requests; information on how to obtain an appeal form; where to find assistance in completing the form; and how to submit the appeal hearing request - The name, address (mailing and e-mail), and telephone number of the office of the state's long-term care ombudsman - For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 - For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals,	**PC.14.01.01, EP 13** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The written notice before transfer or discharge specified in 42 CFR 483.15(c)(3) includes the following: - Reason for transfer or discharge - Effective date of transfer or discharge - Location to which the resident is transferred or discharged - Statement of the resident's appeal rights, including the name, address (mailing and e-mail), and telephone number of the entity which receives appeal requests; information on how to obtain an appeal form; where to find assistance in completing the form; and how to submit the appeal hearing request - Name, address (mailing and e-mail), and telephone number of the office of the state's long-term care ombudsman - For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 - For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		established under the Protection and Advocacy for Mentally Ill Individuals Act	
§483.15(c)(5)(ii)	(ii) The effective date of transfer or discharge;	**PC.04.01.03, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The written notice before transfer or discharge specified in the CoP from 42 CFR 483.12(a)(4) includes the following: - The reason for transfer or discharge - The effective date of transfer or discharge - The location to which the resident is transferred or discharged - A statement of the resident's appeal rights, including the name, address (mailing and e-mail), and telephone number of the entity which receives such requests; information on how to obtain an appeal form; where to find assistance in completing the form; and how to submit the appeal hearing request - The name, address (mailing and e-mail), and telephone number of the office of the state's long-term care ombudsman - For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 - For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act	**PC.14.01.01, EP 13** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The written notice before transfer or discharge specified in 42 CFR 483.15(c)(3) includes the following: - Reason for transfer or discharge - Effective date of transfer or discharge - Location to which the resident is transferred or discharged - Statement of the resident's appeal rights, including the name, address (mailing and e-mail), and telephone number of the entity which receives appeal requests; information on how to obtain an appeal form; where to find assistance in completing the form; and how to submit the appeal hearing request - Name, address (mailing and e-mail), and telephone number of the office of the state's long-term care ombudsman - For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 - For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§483.15(c)(5)(iii)	(iii) The location to which the resident is transferred or discharged;	**PC.04.01.03, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The written notice before transfer or discharge specified in the CoP from 42 CFR 483.12(a)(4) includes the following: - The reason for transfer or discharge - The effective date of transfer or discharge - The location to which the resident is transferred or discharged - A statement of the resident's appeal rights, including the name, address (mailing and e-mail), and telephone number of the entity which receives such requests; information on how to obtain an appeal form; where to find assistance in completing the form; and how to submit the appeal hearing request - The name, address (mailing and e-mail), and telephone number of the office of the state's long-term care ombudsman - For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 - For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act	**PC.14.01.01, EP 13** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The written notice before transfer or discharge specified in 42 CFR 483.15(c)(3) includes the following: - Reason for transfer or discharge - Effective date of transfer or discharge - Location to which the resident is transferred or discharged - Statement of the resident's appeal rights, including the name, address (mailing and e-mail), and telephone number of the entity which receives appeal requests; information on how to obtain an appeal form; where to find assistance in completing the form; and how to submit the appeal hearing request - Name, address (mailing and e-mail), and telephone number of the office of the state's long-term care ombudsman - For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 - For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act
§483.15(c)(5)(iv)	(iv) A statement of the resident's appeal rights, including the name, address (mailing	**PC.04.01.03, EP 6** For hospitals that use Joint Commission accreditation	**PC.14.01.01, EP 13** For hospitals that use Joint Commission accreditation for deemed

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;	for deemed status purposes and have swing beds: The written notice before transfer or discharge specified in the CoP from 42 CFR 483.12(a)(4) includes the following: - The reason for transfer or discharge - The effective date of transfer or discharge - The location to which the resident is transferred or discharged - A statement of the resident's appeal rights, including the name, address (mailing and e-mail), and telephone number of the entity which receives such requests; information on how to obtain an appeal form; where to find assistance in completing the form; and how to submit the appeal hearing request - The name, address (mailing and e-mail), and telephone number of the office of the state's long-term care ombudsman - For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 - For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act	status purposes and have swing beds: The written notice before transfer or discharge specified in 42 CFR 483.15(c)(3) includes the following: - Reason for transfer or discharge - Effective date of transfer or discharge - Location to which the resident is transferred or discharged - Statement of the resident's appeal rights, including the name, address (mailing and e-mail), and telephone number of the entity which receives appeal requests; information on how to obtain an appeal form; where to find assistance in completing the form; and how to submit the appeal hearing request - Name, address (mailing and e-mail), and telephone number of the office of the state's long-term care ombudsman - For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 - For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act
§483.15(c)(5)(v)	(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;	**PC.04.01.03, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The written notice before transfer or discharge specified in	**PC.14.01.01, EP 13** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The written notice before transfer or discharge specified in 42 CFR 483.15(c)(3) includes the

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		the CoP from 42 CFR 483.12(a)(4) includes the following: - The reason for transfer or discharge - The effective date of transfer or discharge - The location to which the resident is transferred or discharged - A statement of the resident's appeal rights, including the name, address (mailing and e-mail), and telephone number of the entity which receives such requests; information on how to obtain an appeal form; where to find assistance in completing the form; and how to submit the appeal hearing request - The name, address (mailing and e-mail), and telephone number of the office of the state's long-term care ombudsman - For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 - For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act	following: - Reason for transfer or discharge - Effective date of transfer or discharge - Location to which the resident is transferred or discharged - Statement of the resident's appeal rights, including the name, address (mailing and e-mail), and telephone number of the entity which receives appeal requests; information on how to obtain an appeal form; where to find assistance in completing the form; and how to submit the appeal hearing request - Name, address (mailing and e-mail), and telephone number of the office of the state's long-term care ombudsman - For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 - For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act
§483.15(c)(5)(vi)	(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	**PC.04.01.03, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The written notice before transfer or discharge specified in the CoP from 42 CFR 483.12(a)(4) includes the following:	**PC.14.01.01, EP 13** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The written notice before transfer or discharge specified in 42 CFR 483.15(c)(3) includes the following: - Reason for transfer or discharge

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	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	- The reason for transfer or discharge - The effective date of transfer or discharge - The location to which the resident is transferred or discharged - A statement of the resident's appeal rights, including the name, address (mailing and e-mail), and telephone number of the entity which receives such requests; information on how to obtain an appeal form; where to find assistance in completing the form; and how to submit the appeal hearing request - The name, address (mailing and e-mail), and telephone number of the office of the state's long-term care ombudsman - For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 - For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act	- Effective date of transfer or discharge - Location to which the resident is transferred or discharged - Statement of the resident's appeal rights, including the name, address (mailing and e-mail), and telephone number of the entity which receives appeal requests; information on how to obtain an appeal form; where to find assistance in completing the form; and how to submit the appeal hearing request - Name, address (mailing and e-mail), and telephone number of the office of the state's long-term care ombudsman - For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 - For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act
§483.15(c)(5)(vii)	(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.	**PC.04.01.03, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The written notice before transfer or discharge specified in the CoP from 42 CFR 483.12(a)(4) includes the following: - The reason for transfer or discharge - The effective date of transfer or discharge	**PC.14.01.01, EP 13** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The written notice before transfer or discharge specified in 42 CFR 483.15(c)(3) includes the following: - Reason for transfer or discharge - Effective date of transfer or discharge - Location to which the resident is transferred or discharged

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- The location to which the resident is transferred or discharged - A statement of the resident's appeal rights, including the name, address (mailing and e-mail), and telephone number of the entity which receives such requests; information on how to obtain an appeal form; where to find assistance in completing the form; and how to submit the appeal hearing request - The name, address (mailing and e-mail), and telephone number of the office of the state's long-term care ombudsman - For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 - For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act	- Statement of the resident's appeal rights, including the name, address (mailing and e-mail), and telephone number of the entity which receives appeal requests; information on how to obtain an appeal form; where to find assistance in completing the form; and how to submit the appeal hearing request - Name, address (mailing and e-mail), and telephone number of the office of the state's long-term care ombudsman - For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 - For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act
§483.15(c)(7)	(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.	**PC.04.01.03, EP 3** The patient, the patient's family, physicians, other licensed practitioners, clinical psychologists, and staff involved in the patient's care, treatment, and services participate in planning the patient's discharge or transfer. 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 psychiatric hospitals that use Joint	**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).

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Commission accreditation for deemed status purposes: Social service staff responsibilities include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the hospital. Note 3: For hospitals that use Joint 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 in writing. 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. Note 4: For hospitals that use Joint Commission accreditation for deemed status purposes: Discharge planning is performed by, or under the supervision of, a registered nurse, social worker, or other qualified person. **PC.04.01.05, EP 1** When the hospital determines the patient's discharge or transfer needs, it promptly shares this information with the patient, and also with the patient's family when it is involved in decision making or ongoing care. **PC.04.01.05, EP 2** Before the patient is discharged, the hospital informs the patient, and also the patient's family when it is involved in decision making or ongoing care, of the kinds	Note 2: For hospitals that use Joint 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.

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		of continuing care, treatment, and services the patient will need.	
§483.21	§483.21 Comprehensive person-centered care planning.		
§483.21(c)	(c) Discharge planning—		
§483.21(c)(2)	(2) Discharge summary. When the facility anticipates discharge a resident must have a discharge summary that includes, but is not limited to, the following:		
§483.21(c)(2)(i)	(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.	**RC.02.04.01, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. There is documentation in the resident's medical record by the resident's physician when the resident is transferred or discharged, either when the transfer is due to the resident improving and no longer needing long term care services or when the resident's needs cannot be met in the hospital's swing bed. There is documentation in the resident's medical record by a physician when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered. **RC.02.04.01, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident's discharge information includes the following: - The reason for transfer, discharge, or referral - Treatment provided, diet, medication orders, and orders for the resident's immediate care	**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 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

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		- Referrals provided to the resident, the referring physician's or other licensed practitioner's name, and the name of the physician or other licensed practitioner who has agreed to be responsible for the resident's medical care and treatment, if this person is someone other than the referring physician or other licensed practitioner - Medical findings and diagnoses; a summary of the care, treatment, and services provided; and progress reached toward goals - Information about the resident's behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation - Nursing information that is useful in the resident's care - Any advance directives - Instructions given to the resident before discharge **RC.02.04.01, EP 3** In order to provide information to other caregivers and facilitate the patient's continuity of care, the medical record contains a concise discharge summary that includes the following: - The reason for hospitalization - The procedures performed - The care, treatment, and services provided - The patient's condition and disposition at discharge - Information provided to the patient and family - Provisions for follow-up care Note 1: A discharge summary is not required when a patient is seen for minor problems or interventions, as defined by the medical staff. In this instance, a final progress note may be substituted for the discharge summary provided the note contains the outcome of	

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		hospitalization, disposition of the case, and provisions for follow-up care. Note 2: When a patient is transferred to a different level of care within the hospital, and caregivers change, a transfer summary may be substituted for the discharge summary. If the caregivers do not change, a progress note may be used. Note 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The record of each patient discharged needs to include a discharge summary with the above information. The exceptions in Notes 1 and 2 are not applicable. All patients discharged need to have a discharge summary.	
§483.21(c)(2)(ii)	(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.	**RC.02.04.01, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. There is documentation in the resident's medical record by the resident's physician when the resident is transferred or discharged, either when the transfer is due to the resident improving and no longer needing long term care services or when the resident's needs cannot be met in the hospital's swing bed. There is documentation in the resident's medical record by a physician when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered. **RC.02.04.01, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The	**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 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

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		resident's discharge information includes the following: - The reason for transfer, discharge, or referral - Treatment provided, diet, medication orders, and orders for the resident's immediate care - Referrals provided to the resident, the referring physician's or other licensed practitioner's name, and the name of the physician or other licensed practitioner who has agreed to be responsible for the resident's medical care and treatment, if this person is someone other than the referring physician or other licensed practitioner - Medical findings and diagnoses; a summary of the care, treatment, and services provided; and progress reached toward goals - Information about the resident's behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation - Nursing information that is useful in the resident's care - Any advance directives - Instructions given to the resident before discharge **RC.02.04.01, EP 3** In order to provide information to other caregivers and facilitate the patient's continuity of care, the medical record contains a concise discharge summary that includes the following: - The reason for hospitalization - The procedures performed - The care, treatment, and services provided - The patient's condition and disposition at discharge - Information provided to the patient and family - Provisions for follow-up care Note 1: A discharge summary is not required when a	that have been made for the resident's follow up care, and any postdischarge medical and nonmedical services

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		patient is seen for minor problems or interventions, as defined by the medical staff. In this instance, a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care. Note 2: When a patient is transferred to a different level of care within the hospital, and caregivers change, a transfer summary may be substituted for the discharge summary. If the caregivers do not change, a progress note may be used. Note 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The record of each patient discharged needs to include a discharge summary with the above information. The exceptions in Notes 1 and 2 are not applicable. All patients discharged need to have a discharge summary.	
§483.21(c)(2)(iii)	(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).	**RC.02.04.01, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. There is documentation in the resident's medical record by the resident's physician when the resident is transferred or discharged, either when the transfer is due to the resident improving and no longer needing long term care services or when the resident's needs cannot be met in the hospital's swing bed. There is documentation in the resident's medical record by a physician when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered.	**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 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

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		RC.02.04.01, EP 2 For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident's discharge information includes the following: - The reason for transfer, discharge, or referral - Treatment provided, diet, medication orders, and orders for the resident's immediate care - Referrals provided to the resident, the referring physician's or other licensed practitioner's name, and the name of the physician or other licensed practitioner who has agreed to be responsible for the resident's medical care and treatment, if this person is someone other than the referring physician or other licensed practitioner - Medical findings and diagnoses; a summary of the care, treatment, and services provided; and progress reached toward goals - Information about the resident's behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation - Nursing information that is useful in the resident's care - Any advance directives - Instructions given to the resident before discharge **RC.02.04.01, EP 3** In order to provide information to other caregivers and facilitate the patient's continuity of care, the medical record contains a concise discharge summary that includes the following: - The reason for hospitalization - The procedures performed - The care, treatment, and services provided	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

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		- The patient's condition and disposition at discharge - Information provided to the patient and family - Provisions for follow-up care Note 1: A discharge summary is not required when a patient is seen for minor problems or interventions, as defined by the medical staff. In this instance, a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care. Note 2: When a patient is transferred to a different level of care within the hospital, and caregivers change, a transfer summary may be substituted for the discharge summary. If the caregivers do not change, a progress note may be used. Note 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The record of each patient discharged needs to include a discharge summary with the above information. The exceptions in Notes 1 and 2 are not applicable. All patients discharged need to have a discharge summary.	
§483.21(c)(2)(iv)	(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.	**RC.02.04.01, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. There is documentation in the resident's medical record by the resident's physician when the resident is transferred or discharged, either when the transfer is due to the resident improving and no longer needing long term care services or when the resident's needs cannot be met in the hospital's swing bed. There is documentation in the	**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 discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.

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		resident's medical record by a physician when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered. **RC.02.04.01, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident's discharge information includes the following: - The reason for transfer, discharge, or referral - Treatment provided, diet, medication orders, and orders for the resident's immediate care - Referrals provided to the resident, the referring physician's or other licensed practitioner's name, and the name of the physician or other licensed practitioner who has agreed to be responsible for the resident's medical care and treatment, if this person is someone other than the referring physician or other licensed practitioner - Medical findings and diagnoses; a summary of the care, treatment, and services provided; and progress reached toward goals - Information about the resident's behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation - Nursing information that is useful in the resident's care - Any advance directives - Instructions given to the resident before discharge **RC.02.04.01, EP 3** In order to provide information to other caregivers and facilitate the patient's continuity of care, the medical record contains a concise discharge summary that	- 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

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		includes the following: - The reason for hospitalization - The procedures performed - The care, treatment, and services provided - The patient's condition and disposition at discharge - Information provided to the patient and family - Provisions for follow-up care Note 1: A discharge summary is not required when a patient is seen for minor problems or interventions, as defined by the medical staff. In this instance, a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care. Note 2: When a patient is transferred to a different level of care within the hospital, and caregivers change, a transfer summary may be substituted for the discharge summary. If the caregivers do not change, a progress note may be used. Note 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The record of each patient discharged needs to include a discharge summary with the above information. The exceptions in Notes 1 and 2 are not applicable. All patients discharged need to have a discharge summary.	
§483.40	§483.40 Behavioral Health Services Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a		

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	resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.		
§483.40(d)	(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.	**PC.02.02.01, EP 9** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides services (directly or through referral) to facilitate family support, social work, nursing care, dental care, rehabilitation, primary physician care, or discharge. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital promptly refers residents with lost or damaged dentures to a dentist.	**PC.14.02.01, EP 2** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides medically related social services to attain or maintain the optimal physical, mental, and psychosocial well-being of each resident.
§483.55	§483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care.	**PC.02.02.01, EP 12** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital assists residents who are eligible and wish to apply for reimbursement of dental services as an incurred medical expense under the state plan. The hospital may charge a Medicare resident an additional amount for routine and emergency dental services.	
§483.55(a)	(a) Skilled nursing facilities. A facility		
§483.55(a)(2)	(2) May charge a Medicare resident an additional amount for routine and emergency dental services;	**PC.02.02.01, EP 12** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital assists residents who are eligible and wish to apply for reimbursement of dental services as an incurred medical expense under the state plan. The hospital may charge a Medicare resident an additional amount for routine and emergency dental services.	**PC.14.02.01, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital assists residents who are eligible and wish to apply for reimbursement of dental services as an incurred medical expense under the state plan. The hospital may charge a Medicare resident an additional amount for routine and emergency dental services.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§483.55(a)(3)	(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;	**PC.02.02.01, EP 29** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital follows its policy identifying circumstances when loss of or damage to a resident's dentures is the hospital's responsibility and it may not charge a resident for the loss or damage of dentures.	**PC.14.02.01, EP 4** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital develops and implements a policy identifying circumstances when loss of or damage to a resident's dentures is the hospital's responsibility, and it may not charge a resident for the loss or damage of dentures.
§483.55(a)(4)	(4) Must if necessary or if requested, assist the resident—		
§483.55(a)(4)(i)	(i) In making appointments; and	**PC.02.02.01, EP 9** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides services (directly or through referral) to facilitate family support, social work, nursing care, dental care, rehabilitation, primary physician care, or discharge. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital promptly refers residents with lost or damaged dentures to a dentist. **PC.02.02.01, EP 10** When the hospital uses external resources to meet the patient's needs, it coordinates the patient's care, treatment, and services. **RI.01.06.11, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital helps the resident make and keep appointments with medical, dental, and other care providers.	**PC.14.02.01, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: If necessary or requested, the hospital assists residents in making dental appointments and arranging for transportation to and from the dental services location.

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		RI.01.07.13, EP 1 For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital arranges transportation for the resident to and from medical or dental appointments and other activities identified in the resident's care or service plan.	
§483.55(a)(4)(ii)	(ii) By arranging for transportation to and from the dental services location; and	**PC.02.02.01, EP 9** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides services (directly or through referral) to facilitate family support, social work, nursing care, dental care, rehabilitation, primary physician care, or discharge. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital promptly refers residents with lost or damaged dentures to a dentist. **PC.02.02.01, EP 10** When the hospital uses external resources to meet the patient's needs, it coordinates the patient's care, treatment, and services. **RI.01.06.11, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital helps the resident make and keep appointments with medical, dental, and other care providers. **RI.01.07.13, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The	**PC.14.02.01, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: If necessary or requested, the hospital assists residents in making dental appointments and arranging for transportation to and from the dental services location.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		hospital arranges transportation for the resident to and from medical or dental appointments and other activities identified in the resident's care or service plan.	
§483.55(a)(5)	(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.	**PC.02.02.01, EP 30** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital refers residents with lost or damaged dentures for dental services within three days. If referral does not occur within three days, the hospital documents what was done to make sure that the resident could adequately eat and drink and any extenuating circumstances that led to the delay.	**PC.14.02.01, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital refers residents with lost or damaged dentures for dental services within three days. If referral does not occur within three days, the hospital documents what was done to make sure that the resident could adequately eat and drink and any extenuating circumstances that led to the delay.
§483.55(b)	(b) Nursing facilities. The facility		
§483.55(b)(1)	(1) Must provide or obtain from an outside resource, in accordance with § 483.70(g) of this part, the following dental services to meet the needs of each resident:		
§483.55(b)(1)(i)	(i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services;	**PC.02.02.01, EP 9** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides services (directly or through referral) to facilitate family support, social work, nursing care, dental care, rehabilitation, primary physician care, or discharge. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital promptly refers residents with lost or damaged dentures to a dentist. **PC.02.02.01, EP 12** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital assists residents who are eligible and wish to	**PC.14.02.01, EP 7** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides or obtains from an outside resource routine (to the extent covered under the state plan) and emergency dental services.

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		apply for reimbursement of dental services as an incurred medical expense under the state plan. The hospital may charge a Medicare resident an additional amount for routine and emergency dental services.	
§483.55(b)(2)	(2) Must, if necessary or if requested, assist the resident—		
§483.55(b)(2)(i)	(i) In making appointments; and	**PC.02.02.01, EP 9** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides services (directly or through referral) to facilitate family support, social work, nursing care, dental care, rehabilitation, primary physician care, or discharge. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital promptly refers residents with lost or damaged dentures to a dentist. **PC.02.02.01, EP 10** When the hospital uses external resources to meet the patient's needs, it coordinates the patient's care, treatment, and services. **RI.01.06.11, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital helps the resident make and keep appointments with medical, dental, and other care providers. **RI.01.07.13, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The	**PC.14.02.01, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: If necessary or requested, the hospital assists residents in making dental appointments and arranging for transportation to and from the dental services location.

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		hospital arranges transportation for the resident to and from medical or dental appointments and other activities identified in the resident's care or service plan.	
§483.55(b)(2)(ii)	(ii) By arranging for transportation to and from the dental services locations;	**PC.02.02.01, EP 9** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides services (directly or through referral) to facilitate family support, social work, nursing care, dental care, rehabilitation, primary physician care, or discharge. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital promptly refers residents with lost or damaged dentures to a dentist. **PC.02.02.01, EP 10** When the hospital uses external resources to meet the patient's needs, it coordinates the patient's care, treatment, and services. **RI.01.06.11, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital helps the resident make and keep appointments with medical, dental, and other care providers. **RI.01.07.13, EP 1** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital arranges transportation for the resident to and from medical or dental appointments and other activities identified in the resident's care or service plan.	**PC.14.02.01, EP 5** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: If necessary or requested, the hospital assists residents in making dental appointments and arranging for transportation to and from the dental services location.

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§483.55(b)(3)	(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;	**PC.02.02.01, EP 30** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital refers residents with lost or damaged dentures for dental services within three days. If referral does not occur within three days, the hospital documents what was done to make sure that the resident could adequately eat and drink and any extenuating circumstances that led to the delay.	**PC.14.02.01, EP 6** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital refers residents with lost or damaged dentures for dental services within three days. If referral does not occur within three days, the hospital documents what was done to make sure that the resident could adequately eat and drink and any extenuating circumstances that led to the delay.
§483.55(b)(4)	(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	**PC.02.02.01, EP 29** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital follows its policy identifying circumstances when loss of or damage to a resident's dentures is the hospital's responsibility and it may not charge a resident for the loss or damage of dentures.	**PC.14.02.01, EP 4** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital develops and implements a policy identifying circumstances when loss of or damage to a resident's dentures is the hospital's responsibility, and it may not charge a resident for the loss or damage of dentures.
§483.55(b)(5)	(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.	**PC.02.02.01, EP 12** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital assists residents who are eligible and wish to apply for reimbursement of dental services as an incurred medical expense under the state plan. The hospital may charge a Medicare resident an additional amount for routine and emergency dental services.	**PC.14.02.01, EP 3** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital assists residents who are eligible and wish to apply for reimbursement of dental services as an incurred medical expense under the state plan. The hospital may charge a Medicare resident an additional amount for routine and emergency dental services.
§483.65	§483.65 Specialized rehabilitative services.		
§483.65(a)	(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for a mental disorder and intellectual disability or services of a lesser intensity as set forth at § 483.120(c), are required in the resident's		

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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	comprehensive plan of care, the facility must—		
§483.65(a)(1)	(1) Provide the required services; or	**PC.02.01.01, EP 1** The hospital provides the patient with care, treatment, and services according to the patient's individualized plan of care. **PC.02.02.01, EP 3** The hospital coordinates the patient's care, treatment, and services within a time frame that meets the patient's needs. Note: Coordination involves resolving scheduling conflicts and duplication of care, treatment, and services. **PC.02.02.01, EP 10** When the hospital uses external resources to meet the patient's needs, it coordinates the patient's care, treatment, and services.	**PC.14.02.01, EP 8** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: If a resident's comprehensive plan of care requires specialized rehabilitative services, including but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for a mental disorder and intellectual disability or services of a lesser intensity, the hospital provides or obtains the required services from a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Social Security Act.
§483.65(a)(2)	(2) In accordance with § 483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act.	**PC.02.01.01, EP 1** The hospital provides the patient with care, treatment, and services according to the patient's individualized plan of care. **PC.02.02.01, EP 3** The hospital coordinates the patient's care, treatment, and services within a time frame that meets the patient's needs. Note: Coordination involves resolving scheduling conflicts and duplication of care, treatment, and services. **PC.02.02.01, EP 10**	**PC.14.02.01, EP 8** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: If a resident's comprehensive plan of care requires specialized rehabilitative services, including but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for a mental disorder and intellectual disability or services of a lesser intensity, the hospital provides or obtains the required services from a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Social Security Act.

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		When the hospital uses external resources to meet the patient's needs, it coordinates the patient's care, treatment, and services.	
§483.65(b)	(b) Qualifications. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.	**LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.03.06.01, EP 3** Those who work in the hospital are competent to complete their assigned responsibilities. **PC.01.03.01, EP 1** The hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. **PC.02.01.01, EP 1** The hospital provides the patient with care, treatment, and services according to the patient's individualized plan of care. **PC.02.01.05, EP 1** Care, treatment, and services are provided to the patient in an interdisciplinary, collaborative manner. **PC.02.02.01, EP 9** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides services (directly or through referral)	**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 (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. Note 5: If respiratory care services are provided, staff qualified to

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		to facilitate family support, social work, nursing care, dental care, rehabilitation, primary physician care, or discharge. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital promptly refers residents with lost or damaged dentures to a dentist.	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 dietetic 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.

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