Critical Access Hospital Distinct Part Unit Crosswalk

Medicare Hospital Requirements to 2026 Joint Commission Critical Access Hospital Distinct Part Unit Standards & EPs

CFR Number §482.1	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.1	**TAG: A-0008**		
§482.1 Basis and scope.			
§482.1(a)	**TAG: A-0008**		
(a) Statutory basis.			
§482.1(a)(1)	**TAG: A-0008**		
(1) Section 1861(e) of the [Social Security] Act provides that—			
§482.1(a)(1)(i)	**TAG: A-0008**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
(i) Hospitals participating in Medicare must meet certain specified requirements; and		**EP 1**	The critical access hospital provides care, treatment, and services in accordance with licensure requirements and federal, state, and local laws, rules, and regulations.
§482.1(a)(1)(ii)	**TAG: A-0008**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
(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.		**EP 1**	The critical access hospital provides care, treatment, and services in accordance with licensure requirements and federal, state, and local laws, rules, and regulations.
§482.1(b)	**TAG: A-0008**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
(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.		**EP 1**	The critical access hospital provides care, treatment, and services in accordance with licensure requirements and federal, state, and local laws, rules, and regulations.
§482.11	**TAG: A-0020**		
§482.11 Condition of Participation: Compliance with Federal, State and Local Laws			
§482.11(a)	**TAG: A-0021**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
(a) The hospital must be in compliance with applicable Federal laws related to the health and safety of patients.		**EP 1**	The critical access hospital provides care, treatment, and services in accordance with licensure requirements and federal, state, and local laws, rules, and regulations.
§482.11(b)	**TAG: A-0022**		
(b) The hospital must be--			
§482.11(b)(1)	**TAG: A-0022**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
(1) Licensed; or		**EP 2**	The critical access hospital is licensed in accordance with law and regulation to provide the care, treatment, or services for which the critical access hospital is seeking accreditation from Joint Commission. Note: For rehabilitation or psychiatric distinct part units in critical access hospitals: The critical access hospital is licensed or approved as meeting the standards for licensing established by the state or responsible locality.

CFR Number §482.11(b)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.11(b)(2)	**TAG: A-0022**	**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
(2) Approved as meeting standards for licensing established by the agency of the State or locality responsible for licensing hospitals.		**EP 2**	The critical access hospital is licensed in accordance with law and regulation to provide the care, treatment, or services for which the critical access hospital is seeking accreditation from Joint Commission. Note: For rehabilitation or psychiatric distinct part units in critical access hospitals: The critical access hospital is licensed or approved as meeting the standards for licensing established by the state or responsible locality.
§482.11(c)	**TAG: A-0023**	**HR.11.01.03**	**The critical access hospital determines how staff function within the organization.**
(c) The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws.		**EP 1**	All staff who provide patient care, treatment, and services are qualified and possess a current license, certification, or registration, in accordance with law and regulation.
		MS.17.01.03	**The critical access hospital collects information regarding each physician's or other licensed practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.**
		EP 3	The credentialing process requires that the critical access hospital verifies in writing and from the primary source whenever feasible, or from a credentials verification organization (CVO), the following information for the applicant: • Current licensure at the time of initial granting, renewal, and revision of privileges and at the time of license expiration • Relevant training • Current competence
		MS.17.02.01	**The decision to grant or deny a privilege(s) and/or to renew an existing privilege(s) is an objective, evidence-based process.**
		EP 9	All physicians and other licensed practitioners that provide care, treatment, and services possess a current license, certification, or registration, as required by law and regulation.
§482.12	**TAG: A-0043**	**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
§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.		**EP 1**	The critical access hospital has a governing body or an individual that assumes full legal responsibility for determining, implementing, and monitoring policies governing the critical access hospital's total operation and for administering those policies to provide quality health care in a safe environment.
§482.12(a)	**TAG: A-0044**		
§482.12(a) Standard: Medical Staff. The governing body must:			

CFR Number §482.12(a)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.12(a)(1) **TAG: A-0045**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(1) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff;		**EP 2**	The governing body does the following: • Approves and is responsible for the effective operation of the grievance process • Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body also does the following: • Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff • Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff • Makes certain that the medical staff has bylaws • Approves medical staff bylaws and other medical staff rules and regulations • Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients • Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment • Makes certain that under no circumstances is the accordance of staff membership or professional privileges in the critical access hospital dependent solely upon certification, fellowship, or membership in a specialty body or society • Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the locations without emergency services when emergency services are not provided at the critical access hospital, or are provided at the critical access hospital but not at one or more off-campus locations
§482.12(a)(2) **TAG: A-0046**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(2) Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff;		**EP 2**	The governing body does the following: • Approves and is responsible for the effective operation of the grievance process • Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body also does the following: • Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff • Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff • Makes certain that the medical staff has bylaws • Approves medical staff bylaws and other medical staff rules and regulations • Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients • Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment • Makes certain that under no circumstances is the accordance of staff membership or professional privileges in the critical access hospital dependent solely upon certification, fellowship, or membership in a specialty body or society • Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the locations without emergency services when emergency services are not provided at the critical access hospital, or are provided at the critical access hospital but not at one or more off-campus locations

CFR Number §482.12(a)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.12(a)(3) **TAG: A-0047**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(3) Assure that the medical staff has bylaws;		**EP 2**	The governing body does the following: • Approves and is responsible for the effective operation of the grievance process • Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body also does the following: • Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff • Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff • Makes certain that the medical staff has bylaws • Approves medical staff bylaws and other medical staff rules and regulations • Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients • Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment • Makes certain that under no circumstances is the accordance of staff membership or professional privileges in the critical access hospital dependent solely upon certification, fellowship, or membership in a specialty body or society • Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the locations without emergency services when emergency services are not provided at the critical access hospital, or are provided at the critical access hospital but not at one or more off-campus locations
§482.12(a)(4) **TAG: A-0048**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(4) Approve medical staff bylaws and other medical staff rules and regulations;		**EP 2**	The governing body does the following: • Approves and is responsible for the effective operation of the grievance process • Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body also does the following: • Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff • Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff • Makes certain that the medical staff has bylaws • Approves medical staff bylaws and other medical staff rules and regulations • Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients • Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment • Makes certain that under no circumstances is the accordance of staff membership or professional privileges in the critical access hospital dependent solely upon certification, fellowship, or membership in a specialty body or society • Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the locations without emergency services when emergency services are not provided at the critical access hospital, or are provided at the critical access hospital but not at one or more off-campus locations

CFR Number §482.12(a)(5)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.12(a)(5) **TAG: A-0049**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(5) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients;		**EP 2**	The governing body does the following: • Approves and is responsible for the effective operation of the grievance process • Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body also does the following: • Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff • Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff • Makes certain that the medical staff has bylaws • Approves medical staff bylaws and other medical staff rules and regulations • Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients • Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment • Makes certain that under no circumstances is the accordance of staff membership or professional privileges in the critical access hospital dependent solely upon certification, fellowship, or membership in a specialty body or society • Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the locations without emergency services when emergency services are not provided at the critical access hospital, or are provided at the critical access hospital but not at one or more off-campus locations
§482.12(a)(6) **TAG: A-0050**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(6) Ensure the criteria for selection are individual character, competence, training, experience, and judgment; and		**EP 2**	The governing body does the following: • Approves and is responsible for the effective operation of the grievance process • Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body also does the following: • Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff • Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff • Makes certain that the medical staff has bylaws • Approves medical staff bylaws and other medical staff rules and regulations • Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients • Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment • Makes certain that under no circumstances is the accordance of staff membership or professional privileges in the critical access hospital dependent solely upon certification, fellowship, or membership in a specialty body or society • Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the locations without emergency services when emergency services are not provided at the critical access hospital, or are provided at the critical access hospital but not at one or more off-campus locations

CFR Number §482.12(a)(7)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.12(a)(7) **TAG: A-0051**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(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.		**EP 2**	The governing body does the following: • Approves and is responsible for the effective operation of the grievance process • Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body also does the following: • Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff • Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff • Makes certain that the medical staff has bylaws • Approves medical staff bylaws and other medical staff rules and regulations • Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients • Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment • Makes certain that under no circumstances is the accordance of staff membership or professional privileges in the critical access hospital dependent solely upon certification, fellowship, or membership in a specialty body or society • Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the locations without emergency services when emergency services are not provided at the critical access hospital, or are provided at the critical access hospital but not at one or more off-campus locations

CFR Number §482.12(a)(8)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.12(a)(8) **TAG: A-0052**		**MS.20.01.01**	**Physicians or other licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.**
(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 recommendations that rely on information provided by the distant-site hospital.		**EP 1**	When telemedicine services are furnished to the critical access hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating critical access hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing such services if the critical access hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity: • The distant site telemedicine entity provides services in accordance with contract service requirements. • The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the critical access hospital's process and standards, at a minimum. • The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. • The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity. • The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the critical access hospital whose patients are receiving the telemedicine services is located. • For distant-site physicians or other licensed practitioners privileged by the originating critical access hospital, the originating critical access hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the critical access hospital's patients and complaints the critical access hospital has received about the distant-site physician or other licensed practitioner. Note 1: In the case of distant-site physicians and licensed practitioners providing telemedicine services to the critical access hospital's patients under a written agreement between the critical access hospital and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare participating provider or supplier. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2). (See also MS.14.01.01, EP 2)

CFR Number §482.12(a)(9)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.12(a)(9)	**TAG: A-0052**	**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
(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 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.		**EP 3**	When telemedicine services are furnished to the critical access hospital's patients, the originating site has a written agreement with the distant site that specifies the following: • The distant site is a contractor of services to the critical access hospital. • The distant site furnishes services in a manner that permits the originating site to be in compliance with all applicable Medicare Conditions of Participation for the contracted services, in accordance with 42 CFR 485.635(c)(4)(ii). • The originating site makes certain through the written agreement that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 485.616(c)(1)(i) through (c)(1)(vii). Note: For the language of the Medicare Conditions of Participation pertaining to telemedicine, refer to https://www.ecfr.gov. If the originating site chooses to use the credentialing and privileging decision of the distant-site telemedicine provider, then the following requirements apply: • The governing body of the distant site is responsible for having a process that is consistent with the credentialing and privileging requirements in the "Medical Staff" (MS) chapter (Standards MS.17.01.01 through MS.17.04.01). • The governing body of the originating site grants privileges to a distant-site physician or other licensed practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site. The written agreement includes that it is the responsibility of the governing body of the distant-site hospital to meet the requirements of this element of performance.
§482.12(a)(10)	**TAG: A-0053**	**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(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 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).		**EP 5**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body consults directly with the individual assigned the responsibility for the organization and conduct of the critical access 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 critical access hospital's patients. For a multihospital system using a single governing body, the single multihospital system governing body consults directly with the individual responsible for the organized medical staff (or the individual's designee) of each hospital within its system.
§482.12(b)	**TAG: A-0057**	**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
§482.12(b) Standard: Chief Executive Officer The governing body must appoint a chief executive officer who is responsible for managing the hospital.		**EP 6**	The governing body appoints the chief executive officer responsible for managing the critical access hospital.
§482.12(c)	**TAG: A-0063**		
§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)	**TAG: A-0064**		
(1) Every Medicare patient is under the care of:			

CFR Number §482.12(c)(1)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.12(c)(1)(i) **TAG: A-0064**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(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.);		**EP 7**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body makes certain that patients are under the care of the appropriate licensed practitioners.
		MS.16.01.03	**The management and coordination of each patient's care, treatment, and services is the responsibility of a physician or other licensed practitioner with appropriate privileges.**
		EP 4	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 law (See also LD.14.01.03, EP 5)
§482.12(c)(1)(ii) **TAG: A-0064**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(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;		**EP 7**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body makes certain that patients are under the care of the appropriate licensed practitioners.
		MS.16.01.03	**The management and coordination of each patient's care, treatment, and services is the responsibility of a physician or other licensed practitioner with appropriate privileges.**
		EP 4	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 law (See also LD.14.01.03, EP 5)
§482.12(c)(1)(iii) **TAG: A-0064**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(iii) A doctor of podiatric medicine, but only with respect to functions which he or she is legally authorized by the State to perform;		**EP 7**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body makes certain that patients are under the care of the appropriate licensed practitioners.

CFR Number §482.12(c)(1)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		MS.16.01.03	**The management and coordination of each patient's care, treatment, and services is the responsibility of a physician or other licensed practitioner with appropriate privileges.**
		EP 4	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 law (See also LD.14.01.03, EP 5)
§482.12(c)(1)(iv) **TAG: A-0064** (iv) A doctor of optometry who is legally authorized to practice optometry by the State in which he or she practices;		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
		EP 7	For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body makes certain that patients are under the care of the appropriate licensed practitioners.
		MS.16.01.03	**The management and coordination of each patient's care, treatment, and services is the responsibility of a physician or other licensed practitioner with appropriate privileges.**
		EP 4	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 law (See also LD.14.01.03, EP 5)
§482.12(c)(1)(v) **TAG: A-0064** (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		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
		EP 7	For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body makes certain that patients are under the care of the appropriate licensed practitioners.

CFR Number §482.12(c)(1)(v)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		MS.16.01.03	**The management and coordination of each patient's care, treatment, and services is the responsibility of a physician or other licensed practitioner with appropriate privileges.**
		EP 4	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 law (See also LD.14.01.03, EP 5)
§482.12(c)(1)(vi) **TAG: A-0064** (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.		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
		EP 7	For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body makes certain that patients are under the care of the appropriate licensed practitioners.
		MS.16.01.03	**The management and coordination of each patient's care, treatment, and services is the responsibility of a physician or other licensed practitioner with appropriate privileges.**
		EP 4	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 law (See also LD.14.01.03, EP 5)
§482.12(c)(2) **TAG: A-0065, A-0066** (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.		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
		EP 7	For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body makes certain that patients are under the care of the appropriate licensed practitioners.

CFR Number §482.12(c)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		MS.16.01.03	**The management and coordination of each patient's care, treatment, and services is the responsibility of a physician or other licensed practitioner with appropriate privileges.**
		EP 1	For rehabilitation and psychiatric distinct part units in critical access hospitals: Patients are admitted to the critical access 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 MS.16.01.03, EP 4, that patient is under the care of a doctor of medicine or osteopathy.
§482.12(c)(3) **TAG: A-0067**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(3) A doctor of medicine or osteopathy is on duty or on call at all times.		**EP 7**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body makes certain that patients are under the care of the appropriate licensed practitioners.
		MS.16.01.03	**The management and coordination of each patient's care, treatment, and services is the responsibility of a physician or other licensed practitioner with appropriate privileges.**
		EP 2	For rehabilitation and psychiatric distinct part units in critical access hospitals: A doctor of medicine or osteopathy is on duty or on call at all times.
§482.12(c)(4) **TAG: A-0068**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(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--		**EP 7**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body makes certain that patients are under the care of the appropriate licensed practitioners.
		MS.16.01.03	**The management and coordination of each patient's care, treatment, and services is the responsibility of a physician or other licensed practitioner with appropriate privileges.**
		EP 3	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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) **TAG: A-0068**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(i) Is present on admission or develops during hospitalization; and		**EP 7**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body makes certain that patients are under the care of the appropriate licensed practitioners.
		MS.16.01.03	**The management and coordination of each patient's care, treatment, and services is the responsibility of a physician or other licensed practitioner with appropriate privileges.**
		EP 3	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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) **TAG: A-0068**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(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--		**EP 7**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body makes certain that patients are under the care of the appropriate licensed practitioners.

CFR Number §482.12(c)(4)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		MS.16.01.03	**The management and coordination of each patient's care, treatment, and services is the responsibility of a physician or other licensed practitioner with appropriate privileges.**
		EP 3	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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) **TAG: A-0068**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(A) Defined by the medical staff;		**EP 7**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body makes certain that patients are under the care of the appropriate licensed practitioners.
		MS.16.01.03	**The management and coordination of each patient's care, treatment, and services is the responsibility of a physician or other licensed practitioner with appropriate privileges.**
		EP 3	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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)(B) **TAG: A-0068**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(B) Permitted by State law; and		**EP 7**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body makes certain that patients are under the care of the appropriate licensed practitioners.
		MS.16.01.03	**The management and coordination of each patient's care, treatment, and services is the responsibility of a physician or other licensed practitioner with appropriate privileges.**
		EP 3	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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)(C) **TAG: A-0068**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(C) Limited, under paragraph (c)(1)(v) of this section, with respect to chiropractors.		**EP 7**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body makes certain that patients are under the care of the appropriate licensed practitioners.
		MS.16.01.03	**The management and coordination of each patient's care, treatment, and services is the responsibility of a physician or other licensed practitioner with appropriate privileges.**
		EP 3	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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) **TAG: A-0073**			
§482.12(d) Standard: Institutional Plan and Budget The institution must have an overall institutional plan that meets the following conditions:			

CFR Number §482.12(d)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.12(d)(1)	**TAG: A-0073**	**LD.13.01.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The leaders develop an annual operating budget and, when needed, a long-term capital expenditure plan.**
(1) The plan must include an annual operating budget that is prepared according to generally accepted accounting principles.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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)(2)	**TAG: A-0073**	**LD.13.01.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The leaders develop an annual operating budget and, when needed, a long-term capital expenditure plan.**
(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.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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)	**TAG: A-0073**	**LD.13.01.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The leaders develop an annual operating budget and, when needed, a long-term capital expenditure plan.**
(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.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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)(4)	**TAG: A-0073**	**LD.13.01.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The leaders develop an annual operating budget and, when needed, a long-term capital expenditure plan.**
(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:		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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], by the state in which the critical access 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)	**TAG: A-0073**	**LD.13.01.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The leaders develop an annual operating budget and, when needed, a long-term capital expenditure plan.**
(i) Acquisition of land;		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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], by the state in which the critical access 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

CFR Number §482.12(d)(4)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.12(d)(4)(ii)	**TAG: A-0073**	**LD.13.01.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The leaders develop an annual operating budget and, when needed, a long-term capital expenditure plan.**
(ii) Improvement of land, buildings, and equipment; or		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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], by the state in which the critical access 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)	**TAG: A-0073**	**LD.13.01.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The leaders develop an annual operating budget and, when needed, a long-term capital expenditure plan.**
(iii) The replacement, modernization, and expansion of buildings and equipment.		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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], by the state in which the critical access 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)	**TAG: A-0074, A-0075**	**LD.13.01.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The leaders develop an annual operating budget and, when needed, a long-term capital expenditure plan.**
(5) The plan must be submitted for review to the planning agency designated in accordance with section 1122(b) of the Act, or if an agency is not designated, to the appropriate health planning agency in the State. (See part 100 of this title.) A capital expenditure is not subject to section 1122 review if 75 percent of the health care facility's patients who are expected to use the service for which the capital expenditure is made are individuals enrolled in a health maintenance organization (HMO) or competitive medical plan (CMP) that meets the requirements of section 1876(b) of the Act, and if the Department determines that 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--		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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.

CFR Number §482.12(d)(5)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.12(d)(5)(i) **TAG: A-0075**		**LD.13.01.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The leaders develop an annual operating budget and, when needed, a long-term capital expenditure plan.**
(i) The facilities do not provide common services at the same site;		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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)(ii) **TAG: A-0075**		**LD.13.01.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The leaders develop an annual operating budget and, when needed, a long-term capital expenditure plan.**
(ii) The facilities are not available under a contract of reasonable duration;		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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.

CFR Number §482.12(d)(5)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.12(d)(5)(iii) **TAG: A-0075**		**LD.13.01.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The leaders develop an annual operating budget and, when needed, a long-term capital expenditure plan.**
(iii) Full and equal medical staff privileges in the facilities are not available;		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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) **TAG: A-0075**		**LD.13.01.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The leaders develop an annual operating budget and, when needed, a long-term capital expenditure plan.**
(iv) Arrangements with these facilities are not administratively feasible; or		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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.

CFR Number §482.12(d)(5)(v)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.12(d)(5)(v)	**TAG: A-0075**	**LD.13.01.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The leaders develop an annual operating budget and, when needed, a long-term capital expenditure plan.**
(v) The purchase of these services is more costly than if the HMO or CMP provided the services directly.		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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)(6)	**TAG: A-0076**	**LD.13.01.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The leaders develop an annual operating budget and, when needed, a long-term capital expenditure plan.**
(6) The plan must be reviewed and updated annually		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The institutional plan is prepared by representatives of the critical access 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)	**TAG: A-0077**		
(7) The plan must be prepared--			
§482.12(d)(7)(i)	**TAG: A-0077**	**LD.13.01.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The leaders develop an annual operating budget and, when needed, a long-term capital expenditure plan.**
(i) Under the direction of the governing body; and		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The institutional plan is prepared by representatives of the critical access 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)	**TAG: A-0077**	**LD.13.01.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The leaders develop an annual operating budget and, when needed, a long-term capital expenditure plan.**
(ii) By a committee consisting of representatives of the governing body, the administrative staff, and the medical staff of the institution.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The institutional plan is prepared by representatives of the critical access 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)	**TAG: A-0083**	**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
§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.		**EP 1**	The critical access hospital maintains a current list of all patient care services provided under contract, arrangement, or agreement. The list describes nature and scope of services provided.
		EP 2	The governing body is responsible for all services provided in the critical access 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 rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body makes certain that a contractor of services (including one for shared services and joint ventures) provides services that permit the critical access hospital to that comply with applicable Centers for Medicare & Medicaid Services (CMS) Conditions of Participation and standards for contract services.

CFR Number §482.12(e)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.12(e)(1)	**TAG: A-0084**	**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
(1) The governing body must ensure that the services performed under a contract are provided in a safe and effective manner.		**EP 2**	The governing body is responsible for all services provided in the critical access 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 rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body makes certain that a contractor of services (including one for shared services and joint ventures) provides services that permit the critical access hospital to that comply with applicable Centers for Medicare & Medicaid Services (CMS) Conditions of Participation and standards for contract services.
§482.12(e)(2)	**TAG: A-0085**	**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
(2) The hospital must maintain a list of all contracted services, including the scope and nature of the services provided.		**EP 1**	The critical access hospital maintains a current list of all patient care services provided under contract, arrangement, or agreement. The list describes nature and scope of services provided.
§482.12(f)	**TAG: A-0091**		
§482.12(f) Standard: Emergency Services			
§482.12(f)(1)	**TAG: A-0092**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(1) If emergency services are provided at the hospital, the hospital must comply with the requirements of §482.55.		**EP 8**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If emergency services are provided at the critical access hospital, the critical access hospital complies with the requirements of 42 CFR 482.55.
§482.12(f)(2)	**TAG: A-0093**	**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(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.		**EP 2**	The governing body does the following: • Approves and is responsible for the effective operation of the grievance process • Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body also does the following: • Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff • Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff • Makes certain that the medical staff has bylaws • Approves medical staff bylaws and other medical staff rules and regulations • Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients • Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment • Makes certain that under no circumstances is the accordance of staff membership or professional privileges in the critical access hospital dependent solely upon certification, fellowship, or membership in a specialty body or society • Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the locations without emergency services when emergency services are not provided at the critical access hospital, or are provided at the critical access hospital but not at one or more off-campus locations

CFR Number §482.12(f)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.12(f)(3) **TAG: A-0094**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(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.		**EP 2**	The governing body does the following: • Approves and is responsible for the effective operation of the grievance process • Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body also does the following: • Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff • Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff • Makes certain that the medical staff has bylaws • Approves medical staff bylaws and other medical staff rules and regulations • Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients • Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment • Makes certain that under no circumstances is the accordance of staff membership or professional privileges in the critical access hospital dependent solely upon certification, fellowship, or membership in a specialty body or society • Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the locations without emergency services when emergency services are not provided at the critical access hospital, or are provided at the critical access hospital but not at one or more off-campus locations
§482.13 **TAG: A-0115**		**RI.11.01.01**	**The critical access hospital respects, protects, and promotes patient rights.**
§482.13 Condition of Participation: Patient's Rights A hospital must protect and promote each patient's rights.		**EP 1**	The critical access hospital develops and implements written policies to protect and promote patient rights.
§482.13(a) **TAG: A-0116**			
§482.13(a) Standard: Notice of Rights			
§482.13(a)(1) **TAG: A-0117**		**RI.11.01.01**	**The critical access hospital respects, protects, and promotes patient rights.**
(1) A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.		**EP 2**	The critical access hospital informs each patient, or when appropriate, the patient's representative (as allowed, under state law) of the patient's rights in advance of providing or discontinuing care, treatment, or services whenever possible.

CFR Number §482.13(a)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.13(a)(2)	**TAG: A-0118, A-0119, A-0120**	**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(2) The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's governing body must approve and be responsible for the effective operation of the grievance process and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. At a minimum:		**EP 2**	The governing body does the following: • Approves and is responsible for the effective operation of the grievance process • Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body also does the following: • Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff • Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff • Makes certain that the medical staff has bylaws • Approves medical staff bylaws and other medical staff rules and regulations • Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients • Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment • Makes certain that under no circumstances is the accordance of staff membership or professional privileges in the critical access hospital dependent solely upon certification, fellowship, or membership in a specialty body or society • Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the locations without emergency services when emergency services are not provided at the critical access hospital, or are provided at the critical access hospital but not at one or more off-campus locations
		RI.14.01.01	**The patient and their family have the right to have grievances reviewed by the critical access hospital.**
		EP 1	The process for resolving grievances includes a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization.
		EP 2	The critical access hospital develops and implements policies and procedures for the prompt resolution of patient grievances. The policies clearly explain the procedure for patients to submit written or verbal grievances and specify timeframes for the review of and response to the grievance.
§482.13(a)(2)(i)	**TAG: A-0121**	**RI.14.01.01**	**The patient and their family have the right to have grievances reviewed by the critical access hospital.**
(i) The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital.		**EP 2**	The critical access hospital develops and implements policies and procedures for the prompt resolution of patient grievances. The policies clearly explain the procedure for patients to submit written or verbal grievances and specify timeframes for the review of and response to the grievance.
§482.13(a)(2)(ii)	**TAG: A-0122**	**RI.14.01.01**	**The patient and their family have the right to have grievances reviewed by the critical access hospital.**
(ii) The grievance process must specify time frames for review of the grievance and the provision of a response.		**EP 2**	The critical access hospital develops and implements policies and procedures for the prompt resolution of patient grievances. The policies clearly explain the procedure for patients to submit written or verbal grievances and specify timeframes for the review of and response to the grievance.

CFR Number §482.13(a)(2)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.13(a)(2)(iii)	**TAG: A-0123**	**RI.14.01.01**	**The patient and their family have the right to have grievances reviewed by the critical access hospital.**
(iii) In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.		**EP 3**	In its resolution of grievances, the critical access hospital provides the patient with a written notice of its decision, which contains the following: • Name of the critical access hospital contact person • Steps taken on behalf of the individual to investigate the grievances • Results of the process • Date of completion of the grievance process
§482.13(b)	**TAG: A-0129**		
§482.13(b) Standard: Exercise of Rights			
§482.13(b)(1)	**TAG: A-0130**	**PC.11.03.01**	**The critical access hospital plans the patient's care.**
(1) The patient has the right to participate in the development and implementation of his or her plan of care.		**EP 2**	The critical access hospital involves the patient in the development and implementation of their plan of care. Note: For swing beds in critical access hospitals: The resident has the right to be informed, in advance, of changes to their plan of care.
§482.13(b)(2)	**TAG: A-0131**	**RI.12.01.01**	**The critical access hospital respects the patient's right to participate in decisions about their care, treatment, and services. Note: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.**
(2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.		**EP 1**	The patient or their representative (as allowed, in accordance with state law) has the right to make informed decisions regarding their care. The patient's rights include being informed of their health status, being involved in care planning and treatment, and being able to request or refuse treatment. This does not mean the patient has the right to demand the provision of treatment or services deemed medically unnecessary or inappropriate.
§482.13(b)(3)	**TAG: A-0132**	**RI.12.01.01**	**The critical access hospital respects the patient's right to participate in decisions about their care, treatment, and services. Note: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.**
(3) The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with §489.100 of this part (Definition), §489.102 of this part (Requirements for providers), and §489.104 of this part (Effective dates).		**EP 5**	Staff and licensed practitioners who provide care, treatment, or services in the critical access hospital honor the patient's right to formulate advance directives and comply with these directives, in accordance with law and regulation. Note: Law and regulation includes, at a minimum, 42 CFR 489.100, 489.102, and 489.104.
§482.13(b)(4)	**TAG: A-0133**	**RI.12.01.01**	**The critical access hospital respects the patient's right to participate in decisions about their care, treatment, and services. Note: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.**
(4) The patient has the right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital.		**EP 2**	The critical access hospital asks the patient whether they want a family member, representative, or physician or other licensed practitioner notified of their admission to the critical access hospital. The critical access hospital promptly notifies the identified individual(s). Note: The patient is informed, prior to the notification occurring, of any process to automatically notify the patient's established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well as all applicable post–acute care service providers and suppliers. The critical access hospital has a process for documenting a patient's refusal to permit notification of registration to the emergency department, admission to an inpatient unit, or discharge or transfer from the emergency department or inpatient unit. Notifications with primary care practitioners and entities are in accordance with all applicable federal and state laws and regulations.
§482.13(c)	**TAG: A-0142**		
§482.13(c) Standard: Privacy and Safety			

CFR Number §482.13(c)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.13(c)(1)	**TAG: A-0143**	**RI.11.01.01**	**The critical access hospital respects, protects, and promotes patient rights.**
(1) The patient has the right to personal privacy.		**EP 5**	The critical access hospital respects the patient's right to personal privacy. Note 1: This element of performance (EP) addresses a patient's personal privacy. For EPs addressing the privacy of a patient's health information, refer to Standard IM.12.01.01. Note 2: For swing beds in critical access hospitals: Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.
§482.13(c)(2)	**TAG: A-0144**	**NPG.08.01.01**	**The critical access hospital reduces the risk for suicide. Note: EPs 2–7 apply to patients in psychiatric distinct part units in critical access hospitals or patients being evaluated or treated for behavioral health conditions as their primary reason for care in critical access hospitals. In addition, EPs 3–7 apply to all patients who express suicidal ideation during the course of care.**
(2) The patient has the right to receive care in a safe setting.		**EP 1**	For psychiatric distinct part units in critical access hospitals: The critical access hospital conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the critical access 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 critical access 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 critical access hospital. Note: Nonpsychiatric units in critical access 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).
		EP 2	The critical access 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: Joint Commission requires screening for suicidal ideation using a validated tool starting at age 12 and above.
		EP 3	The critical access hospital uses an evidence-based process to conduct a suicide assessment of patients who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens patients for suicidal ideation and assesses the severity of suicidal ideation.
		EP 4	The critical access hospital documents patients' overall level of risk for suicide and the plan to mitigate the risk for suicide.
		EP 5	The critical access 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
		EP 7	The critical access 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	**The critical access hospital respects, protects, and promotes patient rights.**
		EP 3	The patient has the right to receive care in a safe setting.

CFR Number §482.13(c)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.13(c)(3) **TAG: A-0145**		**RI.13.01.01**	**The patient has the right to be free from harassment, neglect, exploitation, and verbal, mental, physical, and sexual abuse.**
(3) The patient has the right to be free from all forms of abuse or harassment.		**EP 1**	The critical access hospital protects the patient from harassment, neglect, exploitation, corporal punishment, involuntary seclusion, and verbal, mental, sexual, or physical abuse that could occur while the patient is receiving care, treatment, and services. For swing beds in critical access hospitals: The critical access hospital also protects the resident from misappropriation of property.
§482.13(d) **TAG: A-0146**			
§482.13(d) Standard: Confidentiality of Patient Records			
§482.13(d)(1) **TAG: A-0147**		**IM.12.01.01**	**The critical access hospital protects the privacy and confidentiality of health information.**
(1) The patient has the right to the confidentiality of his or her clinical records.		**EP 1**	The critical access hospital develops and implements policies and procedures addressing the privacy and confidentiality of health information. Note: For swing beds in critical access hospitals: Policies and procedures also address the resident's personal records.
§482.13(d)(2) **TAG: A-0148**		**RI.11.01.01**	**The critical access hospital respects, protects, and promotes patient rights.**
(2) The patient has the right to access their medical records, including current medical records, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such medical records are maintained electronically); or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, and within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits.		**EP 6**	The critical access hospital provides the patient, upon an oral or written request, with access to medical records, including past and current records, in the form and format requested (including in electronic form or format when available). If electronic is unavailable, the medical record is provided in hard copy or another form agreed to by the critical access hospital and patient. The critical access hospital does not impede the legitimate efforts of individuals to gain access to their own medical records and fulfills these electronic or hard-copy requests within a reasonable time frame (that is, as quickly as its recordkeeping system permits).
§482.13(e) **TAG: A-0154**		**PC.13.02.01**	**The critical access hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others. Note: See Glossary for the definitions of restraint and seclusion.**
§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.		**EP 1**	The critical access hospital does not use restraint or seclusion of any form as a means of coercion, discipline, convenience, or staff retaliation. Restraint or seclusion is only used to protect the immediate physical safety of the patient, staff, or others when less restrictive interventions have been ineffective and is discontinued at the earliest possible time, regardless of the length of time specified in the order.
		RI.13.01.01	**The patient has the right to be free from harassment, neglect, exploitation, and verbal, mental, physical, and sexual abuse.**
		EP 1	The critical access hospital protects the patient from harassment, neglect, exploitation, corporal punishment, involuntary seclusion, and verbal, mental, sexual, or physical abuse that could occur while the patient is receiving care, treatment, and services. For swing beds in critical access hospitals: The critical access hospital also protects the resident from misappropriation of property.
§482.13(e)(1) **TAG: A-0159**			
(1) Definitions.			
§482.13(e)(1)(i) **TAG: A-0159**			
(i) A restraint is—			

CFR Number §482.13(e)(1)(i)(A)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.13(e)(1)(i)(A)	**TAG: A-0159**	**PC.13.02.01**	**The critical access hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others. Note: See Glossary for the definitions of restraint and seclusion.**
(A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or		**EP 4**	The critical access hospital restraint policies are followed when any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or when a drug or medication is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. Note: A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).
§482.13(e)(1)(i)(B)	**TAG: A-0160**	**PC.13.02.01**	**The critical access hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others. Note: See Glossary for the definitions of restraint and seclusion.**
(B) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.		**EP 4**	The critical access hospital restraint policies are followed when any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or when a drug or medication is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. Note: A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).
§482.13(e)(1)(i)(C)	**TAG: A-0161**	**PC.13.02.01**	**The critical access hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others. Note: See Glossary for the definitions of restraint and seclusion.**
(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).		**EP 4**	The critical access hospital restraint policies are followed when any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or when a drug or medication is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. Note: A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).
§482.13(e)(1)(ii)	**TAG: A-0162**	**PC.13.02.01**	**The critical access hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others. Note: See Glossary for the definitions of restraint and seclusion.**
(ii) Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.		**EP 5**	The critical access hospital seclusion policies are followed when a patient is involuntarily confined alone in a room or area from which the patient is physically prevented from leaving. Note: Seclusion is only used for the management of violent or self-destructive behavior.
§482.13(e)(2)	**TAG: A-0164**	**PC.13.02.01**	**The critical access hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others. Note: See Glossary for the definitions of restraint and seclusion.**
(2) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.		**EP 1**	The critical access hospital does not use restraint or seclusion of any form as a means of coercion, discipline, convenience, or staff retaliation. Restraint or seclusion is only used to protect the immediate physical safety of the patient, staff, or others when less restrictive interventions have been ineffective and is discontinued at the earliest possible time, regardless of the length of time specified in the order.

CFR Number §482.13(e)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.13(e)(3)	**TAG: A-0165**	**PC.13.02.01**	**The critical access hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others. Note: See Glossary for the definitions of restraint and seclusion.**
(3) The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.		**EP 2**	The critical access hospital uses the least restrictive form of restraint or seclusion that will be effective to protect the patient, a staff member, or others from harm.
§482.13(e)(4)	**TAG: A-0166**		
(4) The use of restraint or seclusion must be --			
§482.13(e)(4)(i)	**TAG: A-0166**	**PC.13.02.03**	**The critical access hospital uses restraint or seclusion safely.**
(i) in accordance with a written modification to the patient's plan of care.		**EP 1**	The critical access hospital's use of restraint or seclusion meets the following requirements: • In accordance with a written modification to the patient's plan of care • Implemented by trained staff using safe techniques identified by the critical access hospital's policies and procedures in accordance with law and regulation
§482.13(e)(4)(ii)	**TAG: A-0167**	**PC.13.02.03**	**The critical access hospital uses restraint or seclusion safely.**
(ii) implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law.		**EP 1**	The critical access hospital's use of restraint or seclusion meets the following requirements: • In accordance with a written modification to the patient's plan of care • Implemented by trained staff using safe techniques identified by the critical access hospital's policies and procedures in accordance with law and regulation
§482.13(e)(5)	**TAG: A-0168**	**PC.13.02.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital initiates restraint or seclusion based on an individual order.**
(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.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital uses restraint or seclusion as ordered by a physician or other authorized licensed practitioner responsible for the patient's care in accordance with critical access hospital policy and state law and regulation.
§482.13(e)(6)	**TAG: A-0169**	**PC.13.02.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital initiates restraint or seclusion based on an individual order.**
(6) Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital does not use standing orders or PRN (also known as "as needed") orders for restraint or seclusion.
§482.13(e)(7)	**TAG: A-0170**	**PC.13.02.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital initiates restraint or seclusion based on an individual order.**
(7) The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The attending physician or clinical psychologist is consulted as soon as possible, in accordance with critical access 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)	**TAG: A-0171**		
(8) Unless superseded by State law that is more restrictive --			

CFR Number §482.13(e)(8)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.13(e)(8)(i) **TAG: A-0171**		**PC.13.02.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital initiates restraint or seclusion based on an individual order.**
(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:		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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)(A) **TAG: A-0171**		**PC.13.02.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital initiates restraint or seclusion based on an individual order.**
(A) 4 hours for adults 18 years of age or older;		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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) **TAG: A-0171**		**PC.13.02.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital initiates restraint or seclusion based on an individual order.**
(B) 2 hours for children and adolescents 9 to 17 years of age; or		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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) **TAG: A-0171**		**PC.13.02.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital initiates restraint or seclusion based on an individual order.**
(C) 1 hour for children under 9 years of age; and		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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)(ii) **TAG: A-0172**		**PC.13.02.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital initiates restraint or seclusion based on an individual order.**
(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.		**EP 5**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access hospital policy and state law and regulation.

CFR Number §482.13(e)(8)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.13(e)(8)(iii)	**TAG: A-0173**	**PC.13.02.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital initiates restraint or seclusion based on an individual order.**
(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.		**EP 6**	For rehabilitation and psychiatric distinct part units in critical access hospitals: Orders for restraint used to protect the physical safety of a nonviolent or non-self-destructive patient are renewed in accordance with critical access hospital policy.
§482.13(e)(9)	**TAG: A-0174**	**PC.13.02.01**	**The critical access hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others. Note: See Glossary for the definitions of restraint and seclusion.**
(9) Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.		**EP 1**	The critical access hospital does not use restraint or seclusion of any form as a means of coercion, discipline, convenience, or staff retaliation. Restraint or seclusion is only used to protect the immediate physical safety of the patient, staff, or others when less restrictive interventions have been ineffective and is discontinued at the earliest possible time, regardless of the length of time specified in the order.
§482.13(e)(10)	**TAG: A-0175**	**PC.13.02.07**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital monitors patients who are restrained or secluded.**
(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.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 at an interval determined by the critical access hospital.
§482.13(e)(11)	**TAG: A-0176**	**PC.13.02.09**	**The critical access hospital has written policies and procedures that guide the use of restraint or seclusion.**
(11) Physician and other licensed practitioner training requirements must be specified in hospital policy. At a minimum, physicians and other licensed practitioners authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint or seclusion.		**EP 1**	The critical access hospital's policies and procedures regarding the use of restraint or seclusion that are consistent with current standards of practice. For rehabilitation and psychiatric distinct part units in critical access hospitals: The policies and procedures include the following: • Definitions for restraint and seclusion that are consistent with state and federal law and regulation • Physician and other licensed practitioner training requirements • Staff training requirements • Who has authority to order restraint or seclusion • Who has authority to discontinue the use of restraint or seclusion • Who can initiate the use of restraint or seclusion • Circumstances under which restraint or seclusion is discontinued • Requirement that restraint or seclusion is discontinued as soon as is safely possible • Who can assess and monitor patients in restraint or seclusion • Time frames for assessing and monitoring patients in restraint or seclusion
		EP 2	For rehabilitation and psychiatric distinct part units in critical access hospitals: Physicians and other licensed practitioners authorized to order restraint or seclusion (through critical access hospital policy in accordance with law and regulation) have a working knowledge of the critical access hospital policy regarding the use of restraint or seclusion.
§482.13(e)(12)	**TAG: A-0178**		
(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 seen face-to-face within 1 hour after the initiation of the intervention --			
§482.13(e)(12)(i)	**TAG: A-0178**		
(i) By a --			

CFR Number §482.13(e)(12)(i)(A)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.13(e)(12)(i)(A) **TAG: A-0178**		**PC.13.02.11**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital evaluates and reevaluates the patient who is restrained or secluded.**
(A) Physician or other licensed practitioner; or		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access 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) **TAG: A-0178**		**PC.13.02.11**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital evaluates and reevaluates the patient who is restrained or secluded.**
(B) Registered nurse who has been trained in accordance with the requirements specified in paragraph (f) of this section.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access 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) **TAG: A-0179**			
(ii)To evaluate –			
§482.13(e)(12)(ii)(A) **TAG: A-0179**		**PC.13.02.11**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital evaluates and reevaluates the patient who is restrained or secluded.**
(A) the patient's immediate situation;		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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) **TAG: A-0179**		**PC.13.02.11**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital evaluates and reevaluates the patient who is restrained or secluded.**
(B) The patient's reaction to the intervention;		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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

CFR Number §482.13(e)(12)(ii)(C)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.13(e)(12)(ii)(C) **TAG: A-0179** (C) The patient's medical and behavioral condition; and		**PC.13.02.11**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital evaluates and reevaluates the patient who is restrained or secluded.**
		EP 2	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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) **TAG: A-0179** (D)The need to continue or terminate the restraint or seclusion.		**PC.13.02.11**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital evaluates and reevaluates the patient who is restrained or secluded.**
		EP 2	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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)(13) **TAG: A-0180** (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.13.02.11**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital evaluates and reevaluates the patient who is restrained or secluded.**
		EP 1	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access 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) **TAG: A-0182** (14) If the face-to-face evaluation specified in paragraph (e)(12) of this section is conducted by a trained registered nurse, the trained registered nurse must consult the attending physician or other licensed practitioner who is responsible for the care of the patient as soon as possible after the completion of the 1 hour face-to-face evaluation.		**PC.13.02.11**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital evaluates and reevaluates the patient who is restrained or secluded.**
		EP 3	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access hospital policy.
§482.13(e)(15) **TAG: A-0183** (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) **TAG: A-0183** (i) Face-to-face by an assigned, trained staff member; or		**PC.13.02.13**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital continually monitors patients who are simultaneously restrained and secluded.**
		EP 1	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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.

CFR Number §482.13(e)(15)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.13(e)(15)(ii) **TAG: A-0183**		**PC.13.02.13**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital continually monitors patients who are simultaneously restrained and secluded.**
(ii) By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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) **TAG: A-0184**			
(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) **TAG: A-0184**		**PC.13.02.15**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital documents the use of restraint or seclusion.**
(i) The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior;		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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
§482.13(e)(16)(ii) **TAG: A-0185**		**PC.13.02.15**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital documents the use of restraint or seclusion.**
(ii) A description of the patient's behavior and the intervention used.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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
§482.13(e)(16)(iii) **TAG: A-0186**		**PC.13.02.15**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital documents the use of restraint or seclusion.**
(iii) Alternatives or other less restrictive interventions attempted (as applicable).		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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

CFR Number §482.13(e)(16)(iv)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.13(e)(16)(iv)	**TAG: A-0187**	**PC.13.02.15**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital documents the use of restraint or seclusion.**
(iv) The patient's condition or symptom(s) that warranted the use of the restraint or seclusion.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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
§482.13(e)(16)(v)	**TAG: A-0188**	**PC.13.02.15**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital documents the use of restraint or seclusion.**
(v) The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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
§482.13(f)	**TAG: A-0194**	**PC.13.02.03**	**The critical access hospital uses restraint or seclusion safely.**
§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.		**EP 1**	The critical access hospital's use of restraint or seclusion meets the following requirements: • In accordance with a written modification to the patient's plan of care • Implemented by trained staff using safe techniques identified by the critical access hospital's policies and procedures in accordance with law and regulation
§482.13(f)(1)	**TAG: A-0196**		
(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 –			
§482.13(f)(1)(i)	**TAG: A-0196**	**PC.13.02.17**	**The critical access hospital trains staff to safely implement the use of restraint or seclusion.**
(i) Before performing any of the actions specified in this paragraph;		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 critical access hospital policy
§482.13(f)(1)(ii)	**TAG: A-0196**	**PC.13.02.17**	**The critical access hospital trains staff to safely implement the use of restraint or seclusion.**
(ii) As part of orientation; and		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 critical access hospital policy
§482.13(f)(1)(iii)	**TAG: A-0196**	**PC.13.02.17**	**The critical access hospital trains staff to safely implement the use of restraint or seclusion.**
(iii) Subsequently on a periodic basis consistent with hospital policy.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 critical access hospital policy

CFR Number §482.13(f)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.13(f)(2) **TAG: A-0199**			
(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) **TAG: A-0199**		**PC.13.02.17**	**The critical access hospital trains staff to safely implement the use of restraint or seclusion.**
(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.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access 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 critical access 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)(ii) **TAG: A-0200**		**PC.13.02.17**	**The critical access hospital trains staff to safely implement the use of restraint or seclusion.**
(ii) The use of nonphysical intervention skills.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access 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 critical access 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

CFR Number §482.13(f)(2)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.13(f)(2)(iii)	**TAG: A-0201**	**PC.13.02.17**	**The critical access hospital trains staff to safely implement the use of restraint or seclusion.**
(iii) Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access 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 critical access 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)	**TAG: A-0202**	**PC.13.02.17**	**The critical access hospital trains staff to safely implement the use of restraint or seclusion.**
(iv) The safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia).		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access 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 critical access 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

CFR Number §482.13(f)(2)(v)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.13(f)(2)(v)	**TAG: A-0204**	**PC.13.02.17**	**The critical access hospital trains staff to safely implement the use of restraint or seclusion.**
(v) Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access 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 critical access 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)	**TAG: A-0205**	**PC.13.02.17**	**The critical access hospital trains staff to safely implement the use of restraint or seclusion.**
(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.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access 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 critical access 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

CFR Number §482.13(f)(2)(vii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.13(f)(2)(vii)	**TAG: A-0206**	**PC.13.02.17**	**The critical access hospital trains staff to safely implement the use of restraint or seclusion.**
(vii) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access 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 critical access 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)	**TAG: A-0207**	**PC.13.02.17**	**The critical access hospital trains staff to safely implement the use of restraint or seclusion.**
(3) Trainer Requirements. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors.		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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)	**TAG: A-0208**	**PC.13.02.17**	**The critical access hospital trains staff to safely implement the use of restraint or seclusion.**
(4) Training Documentation. The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.		**EP 5**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital documents in staff records that they have completed restraint and seclusion training and demonstrated competence.
§482.13(g)	**TAG: A-0213**	**PC.13.02.19**	**The critical access hospital reports deaths associated with the use of restraint or seclusion.**
§482.13(g) Standard: Death Reporting Requirements: Hospitals must report deaths associated with the use of seclusion or restraint.		**EP 1**	The critical access hospital reports the following information to the Centers for Medicare & Medicaid Services regarding deaths related to restraint or seclusion: • Each death that occurs while a patient is in restraint or seclusion • Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion • Each death known to the critical access hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death Note 1: This reporting requirement includes all restraints except soft wrist restraints. For more information on deaths related to the use of soft wrist restraints, refer to EP 3 in this standard. Note 2: In this element of performance "reasonable to assume" includes but is not limited to deaths related to restrictions of movement for prolonged periods of time or deaths related to chest compression, restriction of breathing, or asphyxiation.
§482.13(g)(1)	**TAG: A-0213**	**PC.13.02.19**	**The critical access hospital reports deaths associated with the use of restraint or seclusion.**
(1) With the exception of deaths described under paragraph (g)(2) of this section, the hospital must report the following information to CMS by telephone, facsimile, or electronically, as determined by CMS, no later than the close of business on the next business day following knowledge of the patient's death:		**EP 2**	The deaths addressed in PC.13.02.19, EP 1, are reported to the Centers for Medicare & Medicaid Services by telephone, by facsimile, or electronically no later than the close of the next business day following knowledge of the patient's death. The date and time that the patient's death was reported is documented in the patient's medical record.

CFR Number §482.13(g)(1)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.13(g)(1)(i) **TAG: A-0213**		**PC.13.02.19**	**The critical access hospital reports deaths associated with the use of restraint or seclusion.**
(i) Each death that occurs while a patient is in restraint or seclusion.		**EP 1**	The critical access hospital reports the following information to the Centers for Medicare & Medicaid Services regarding deaths related to restraint or seclusion: • Each death that occurs while a patient is in restraint or seclusion • Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion • Each death known to the critical access hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death Note 1: This reporting requirement includes all restraints except soft wrist restraints. For more information on deaths related to the use of soft wrist restraints, refer to EP 3 in this standard. Note 2: In this element of performance "reasonable to assume" includes but is not limited to deaths related to restrictions of movement for prolonged periods of time or deaths related to chest compression, restriction of breathing, or asphyxiation.
§482.13(g)(1)(ii) **TAG: A-0213**		**PC.13.02.19**	**The critical access hospital reports deaths associated with the use of restraint or seclusion.**
(ii) Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.		**EP 1**	The critical access hospital reports the following information to the Centers for Medicare & Medicaid Services regarding deaths related to restraint or seclusion: • Each death that occurs while a patient is in restraint or seclusion • Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion • Each death known to the critical access hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death Note 1: This reporting requirement includes all restraints except soft wrist restraints. For more information on deaths related to the use of soft wrist restraints, refer to EP 3 in this standard. Note 2: In this element of performance "reasonable to assume" includes but is not limited to deaths related to restrictions of movement for prolonged periods of time or deaths related to chest compression, restriction of breathing, or asphyxiation.
§482.13(g)(1)(iii) **TAG: A-0213**		**PC.13.02.19**	**The critical access hospital reports deaths associated with the use of restraint or seclusion.**
(iii) Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death, regardless of the type(s) of restraint used on the patient during this time. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing, or asphyxiation.		**EP 1**	The critical access hospital reports the following information to the Centers for Medicare & Medicaid Services regarding deaths related to restraint or seclusion: • Each death that occurs while a patient is in restraint or seclusion • Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion • Each death known to the critical access hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death Note 1: This reporting requirement includes all restraints except soft wrist restraints. For more information on deaths related to the use of soft wrist restraints, refer to EP 3 in this standard. Note 2: In this element of performance "reasonable to assume" includes but is not limited to deaths related to restrictions of movement for prolonged periods of time or deaths related to chest compression, restriction of breathing, or asphyxiation.
§482.13(g)(2) **TAG: A-0214**			
(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:			

CFR Number §482.13(g)(2)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.13(g)(2)(i)	**TAG: A-0214**	**PC.13.02.19**	**The critical access hospital reports deaths associated with the use of restraint or seclusion.**
(i) Any death that occurs while a patient is in such restraints.		**EP 3**	When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, nonrigid, cloth-like material, the critical access hospital does the following: • Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. • Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. • Documents in the patient record the date and time that the death was recorded in the log or other system. • Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the patient's care, medical record number, and primary diagnosis(es). • Makes the information in the log or other system available to the Centers for Medicare & Medicaid Services, either electronically or in writing, immediately upon request.
§482.13(g)(2)(ii)	**TAG: A-0214**	**PC.13.02.19**	**The critical access hospital reports deaths associated with the use of restraint or seclusion.**
(ii) Any death that occurs within 24 hours after a patient has been removed from such restraints.		**EP 3**	When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, nonrigid, cloth-like material, the critical access hospital does the following: • Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. • Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. • Documents in the patient record the date and time that the death was recorded in the log or other system. • Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the patient's care, medical record number, and primary diagnosis(es). • Makes the information in the log or other system available to the Centers for Medicare & Medicaid Services, either electronically or in writing, immediately upon request.
§482.13(g)(3)	**TAG: A-0213, A-0214**		
(3) The staff must document in the patient's medical record the date and time the death was:			
§482.13(g)(3)(i)	**TAG: A-0213**	**PC.13.02.19**	**The critical access hospital reports deaths associated with the use of restraint or seclusion.**
(i) Reported to CMS for deaths described in paragraph (g)(1) of this section; or		**EP 2**	The deaths addressed in PC.13.02.19, EP 1, are reported to the Centers for Medicare & Medicaid Services by telephone, by facsimile, or electronically no later than the close of the next business day following knowledge of the patient's death. The date and time that the patient's death was reported is documented in the patient's medical record.
§482.13(g)(3)(ii)	**TAG: A-0214**	**PC.13.02.19**	**The critical access hospital reports deaths associated with the use of restraint or seclusion.**
(ii) Recorded in the internal log or other system for deaths described in paragraph (g)(2) of this section.		**EP 3**	When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, nonrigid, cloth-like material, the critical access hospital does the following: • Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. • Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. • Documents in the patient record the date and time that the death was recorded in the log or other system. • Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the patient's care, medical record number, and primary diagnosis(es). • Makes the information in the log or other system available to the Centers for Medicare & Medicaid Services, either electronically or in writing, immediately upon request.

CFR Number §482.13(g)(4)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.13(g)(4) **TAG: A-0214**			
(4) For deaths described in paragraph (g)(2) of this section, entries into the internal log or other system must be documented as follows:			
§482.13(g)(4)(i) **TAG: A-0214**		**PC.13.02.19**	**The critical access hospital reports deaths associated with the use of restraint or seclusion.**
(i) Each entry must be made not later than seven days after the date of death of the patient.		**EP 3**	When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, nonrigid, cloth-like material, the critical access hospital does the following: • Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. • Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. • Documents in the patient record the date and time that the death was recorded in the log or other system. • Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the patient's care, medical record number, and primary diagnosis(es). • Makes the information in the log or other system available to the Centers for Medicare & Medicaid Services, either electronically or in writing, immediately upon request.
§482.13(g)(4)(ii) **TAG: A-0214**		**PC.13.02.19**	**The critical access hospital reports deaths associated with the use of restraint or seclusion.**
(ii) Each entry must document the patient’s name, date of birth, date of death, name of attending physician or other licensed practitioner who is responsible for the care of the patient, medical record number, and primary diagnosis(es).		**EP 3**	When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, nonrigid, cloth-like material, the critical access hospital does the following: • Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. • Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. • Documents in the patient record the date and time that the death was recorded in the log or other system. • Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the patient's care, medical record number, and primary diagnosis(es). • Makes the information in the log or other system available to the Centers for Medicare & Medicaid Services, either electronically or in writing, immediately upon request.
§482.13(g)(4)(iii) **TAG: A-0214**		**PC.13.02.19**	**The critical access hospital reports deaths associated with the use of restraint or seclusion.**
(iii) The information must be made available in either written or electronic form to CMS immediately upon request.		**EP 3**	When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, nonrigid, cloth-like material, the critical access hospital does the following: • Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. • Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. • Documents in the patient record the date and time that the death was recorded in the log or other system. • Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the patient's care, medical record number, and primary diagnosis(es). • Makes the information in the log or other system available to the Centers for Medicare & Medicaid Services, either electronically or in writing, immediately upon request.

CFR Number §482.13(h)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.13(h)	**TAG: A-0215, A-0216, A-0217**	**RI.11.01.01**	**The critical access hospital respects, protects, and promotes patient rights.**
§482.13(h) Standard: Patient visitation rights. A hospital must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation. A hospital must meet the following requirements:		**EP 7**	The critical access hospital develops and implements policies and procedures for patient visitation rights. Visitation rights include the right to receive visitors designated by the patient, including but not limited to a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. The patient also has the right to withdraw or deny consent for visitors at any time. Note 1: The critical access hospital's written policies and procedures include any restrictions or limitations that are clinically necessary or reasonable that need to be placed on visitation rights and the reasons for the restriction or limitation. Note 2: The critical access hospital informs the patient (or support person, where appropriate) of the patient's visitation rights, including any clinical restriction or limitation on such rights.
§482.13(h)(1)	**TAG: A-0216**	**RI.11.01.01**	**The critical access hospital respects, protects, and promotes patient rights.**
(1) Inform each patient (or support person, where appropriate) of his or her visitation rights, including any clinical restriction or limitation on such rights, when he or she is informed of his or her other rights under this section.		**EP 7**	The critical access hospital develops and implements policies and procedures for patient visitation rights. Visitation rights include the right to receive visitors designated by the patient, including but not limited to a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. The patient also has the right to withdraw or deny consent for visitors at any time. Note 1: The critical access hospital's written policies and procedures include any restrictions or limitations that are clinically necessary or reasonable that need to be placed on visitation rights and the reasons for the restriction or limitation. Note 2: The critical access hospital informs the patient (or support person, where appropriate) of the patient's visitation rights, including any clinical restriction or limitation on such rights.
§482.13(h)(2)	**TAG: A-0216**	**RI.11.01.01**	**The critical access hospital respects, protects, and promotes patient rights.**
(2) Inform each patient (or support person, where appropriate) of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.		**EP 7**	The critical access hospital develops and implements policies and procedures for patient visitation rights. Visitation rights include the right to receive visitors designated by the patient, including but not limited to a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. The patient also has the right to withdraw or deny consent for visitors at any time. Note 1: The critical access hospital's written policies and procedures include any restrictions or limitations that are clinically necessary or reasonable that need to be placed on visitation rights and the reasons for the restriction or limitation. Note 2: The critical access hospital informs the patient (or support person, where appropriate) of the patient's visitation rights, including any clinical restriction or limitation on such rights.
§482.13(h)(3)	**TAG: A-0217**	**RI.11.01.01**	**The critical access hospital respects, protects, and promotes patient rights.**
(3) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.		**EP 4**	The critical access hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression. Note: This includes prohibiting discrimination through restricting, limiting, or otherwise denying visitation privileges. The critical access hospital allows all visitors to have full and equal visitation privileges consistent with patient preferences.
§482.13(h)(4)	**TAG: A-0217**	**RI.11.01.01**	**The critical access hospital respects, protects, and promotes patient rights.**
(4) Ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences.		**EP 4**	The critical access hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression. Note: This includes prohibiting discrimination through restricting, limiting, or otherwise denying visitation privileges. The critical access hospital allows all visitors to have full and equal visitation privileges consistent with patient preferences.

CFR Number §482.15	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15	**TAG: E-0001**	**EM.09.01.01**	**The critical access hospital has a comprehensive emergency management program that utilizes an all-hazards approach.**
§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 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:		**EP 1**	The critical access hospital has a written comprehensive emergency management program that utilizes an all-hazards approach. The program includes, but is not limited to, the following: • Leadership structure and program accountability • Hazard vulnerability analysis • Mitigation and preparedness activities • Emergency operations plan and policies and procedures • Education and training • Exercises and testing • Continuity of operations plan • Disaster recovery • Program evaluation
		EP 3	The critical access hospital complies with all applicable federal, state, and local emergency preparedness laws and regulations.
§482.15(a)	**TAG: E-0004**	**EM.12.01.01**	**The critical access hospital develops an emergency operations plan based on an all-hazards approach. Note: The critical access hospital considers its prioritized hazards identified as part of its hazards vulnerability analysis when developing an emergency operations plan.**
(a) Emergency plan. The 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:		**EP 1**	The critical access hospital has a written all-hazards emergency operations plan (EOP) with supporting policies and procedures that provides guidance to staff and volunteers on actions to take during emergency or disaster incidents. The EOP and policies and procedures include, but are not limited to, the following: • Mobilizing incident command • Communications plan • Maintaining, expanding, curtailing, or closing operations • Protecting critical systems and infrastructure • Conserving and/or supplementing resources • Surge plans (such as flu or pandemic plans) • Identifying alternate treatment areas or locations • Sheltering in place • Evacuating (partial or complete) or relocating services • Safety and security • Securing information and records
		EM.17.01.01	**The critical access hospital evaluates its emergency management program, emergency operations plan, and continuity of operations plans.**
		EP 3	The critical access hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: • Hazard vulnerability analysis • Emergency management program • Emergency operations plan, policies, and procedures • Communications plan • Continuity of operations plan • Education and training program • Testing program

CFR Number §482.15(a)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(a)(1)	**TAG: E-0006**	**EM.11.01.01**	**The critical access hospital conducts a hazard vulnerability analysis utilizing an all-hazards approach.**
(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.		**EP 1**	The critical access hospital conducts a facility-based hazard vulnerability analysis (HVA) using an all-hazards approach that includes the following: • Hazards that are likely to impact the critical access hospital's geographic region, community, facility, and patient population • A community-based risk assessment (such as those developed by external emergency management agencies) • Separate HVAs for its other accredited facilities if they significantly differ from the main site The findings are documented. Note: A separate HVA is only required if the accredited facilities are in different geographic locations, experience different hazards or threats, or the patient population and services offered are unique to this facility.
		EP 2	The critical access hospital's hazard vulnerability analysis includes the following: • Natural hazards (such as flooding, wildfires) • Human-caused hazards (such as bomb threats or cyber/information technology crimes) • Technological hazards (such as utility or information technology outages) • Hazardous materials (such as radiological, nuclear, chemical) • Emerging infectious diseases (such as the Ebola, Zika, or SARS-CoV-2 viruses)
§482.15(a)(2)	**TAG: E-0006**	**EM.11.01.01**	**The critical access hospital conducts a hazard vulnerability analysis utilizing an all-hazards approach.**
(2) Include strategies for addressing emergency events identified by the risk assessment.		**EP 3**	The critical access hospital evaluates and prioritizes the findings of the hazard vulnerability analysis to determine what presents the highest likelihood of occurring and the impacts those hazards will have on the operating status of the critical access hospital and its ability to provide services. The findings are documented.
		EP 4	The critical access hospital uses its prioritized hazards from the hazard vulnerability analysis to identify and implement mitigation and preparedness actions to increase the resilience of the critical access hospital and helps reduce disruption of essential services or functions.
§482.15(a)(3)	**TAG: E-0007**	**EM.12.01.01**	**The critical access hospital develops an emergency operations plan based on an all-hazards approach. Note: The critical access hospital considers its prioritized hazards identified as part of its hazards vulnerability analysis when developing an emergency operations plan.**
(3) Address patient population, including, but not limited to, persons at-risk; the type of services the hospital has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.		**EP 2**	The critical access hospital's emergency operations plan identifies the patient population(s) that it will serve, including at-risk populations, and the types of services it would have the ability to provide in an emergency or disaster event. Note: At-risk populations such as the elderly, dialysis patients, or persons with physical or mental disabilities may have additional needs to be addressed during an emergency or disaster incident such as medical care, communication, transportation, supervision, and maintaining independence.
		EM.13.01.01	**The critical access hospital has a continuity of operations plan. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a continuity of operations plan.**
		EP 1	The critical access hospital has a written continuity of operations plan (COOP) that is developed with the participation of key executive leaders, business and finance leaders, and other department leaders as determined by the critical access hospital. These key leaders identify and prioritize the services and functions that are considered essential or critical for maintaining operations. Note: The COOP provides guidance on how the critical access hospital will continue to perform its essential business functions to deliver essential or critical services. Essential business functions to consider include administrative/vital records, information technology, financial services, security systems, communications/ telecommunications, and building operations to support essential and critical services that cannot be deferred during an emergency; these activities must be performed continuously or resumed quickly following a disruption.

CFR Number §482.15(a)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		EP 2	The critical access hospital's continuity of operations plan identifies in writing how and where it will continue to provide its essential business functions when the location of the essential or critical service has been compromised due to an emergency or disaster incident. Note: Example of options to consider for providing essential services include use of off-site locations, space maintained by another organization, existing facilities or space, telework (remote work), or telehealth.
		EP 3	The critical access hospital has a written order of succession plan that identifies who is authorized to assume a particular leadership or management role when that person(s) is unable to fulfill their function or perform their duties.
		EP 4	The critical access hospital has a written delegation of authority plan that provides the individual(s) with the legal authorization to act on behalf of the critical access hospital for specified purposes and to carry out specific duties. Note: Delegations of authority are an essential part of an organization's continuity program and should be sufficiently detailed to make certain the critical access hospital can perform its essential functions. Delegations of authority will specify a particular function that an individual is authorized to perform and includes restrictions and limitations associated with that authority.
§482.15(a)(4) TAG: E-0009 (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**	**The critical access hospital develops an emergency operations plan based on an all-hazards approach. Note: The critical access hospital considers its prioritized hazards identified as part of its hazards vulnerability analysis when developing an emergency operations plan.**
		EP 6	The critical access hospital's emergency operations plan includes a process for cooperating and collaborating with other health care facilities; health care coalitions; and local, tribal, regional, state, and federal emergency preparedness officials' efforts to leverage support and resources and to provide an integrated response during an emergency or disaster incident.
§482.15(b) TAG: E-0013 (b) Policies and procedures. The hospital must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:		**EM.12.01.01**	**The critical access hospital develops an emergency operations plan based on an all-hazards approach. Note: The critical access hospital considers its prioritized hazards identified as part of its hazards vulnerability analysis when developing an emergency operations plan.**
		EP 1	The critical access hospital has a written all-hazards emergency operations plan (EOP) with supporting policies and procedures that provides guidance to staff and volunteers on actions to take during emergency or disaster incidents. The EOP and policies and procedures include, but are not limited to, the following: • Mobilizing incident command • Communications plan • Maintaining, expanding, curtailing, or closing operations • Protecting critical systems and infrastructure • Conserving and/or supplementing resources • Surge plans (such as flu or pandemic plans) • Identifying alternate treatment areas or locations • Sheltering in place • Evacuating (partial or complete) or relocating services • Safety and security • Securing information and records
		EM.17.01.01	**The critical access hospital evaluates its emergency management program, emergency operations plan, and continuity of operations plans.**
		EP 3	The critical access hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: • Hazard vulnerability analysis • Emergency management program • Emergency operations plan, policies, and procedures • Communications plan • Continuity of operations plan • Education and training program • Testing program

CFR Number §482.15(b)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(b)(1) **TAG: E-0015**			
(1) The provision of subsistence needs for staff and patients, whether they evacuate or shelter in place, include, but are not limited to the following:			
§482.15(b)(1)(i) **TAG: E-0015**		**EM.12.01.01**	**The critical access hospital develops an emergency operations plan based on an all-hazards approach. Note: The critical access hospital considers its prioritized hazards identified as part of its hazards vulnerability analysis when developing an emergency operations plan.**
(i) Food, water, medical, and pharmaceutical supplies.		**EP 4**	The emergency operations plan includes written procedures for how the critical access hospital will provide essential needs for its staff, volunteers, and patients, whether they shelter in place or evacuate, that includes, but is not limited to, the following: • Food and other nutritional supplies • Medications and related supplies • Medical/surgical supplies • Medical oxygen and supplies • Potable or bottled water
§482.15(b)(1)(ii) **TAG: E-0015**			
(ii) Alternate sources of energy to maintain the following:			
§482.15(b)(1)(ii)(A) **TAG: E-0015**		**EM.12.02.11**	**The critical access hospital has a plan for managing essential or critical utilities during an emergency or disaster incident. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for utilities management.**
(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.		**EP 4**	The critical access hospital's plan for managing utilities includes alternate sources for maintaining energy to the following: • Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions • Emergency lighting • Fire detection, extinguishing, and alarm systems • Sewage and waste disposal Note: It is important for critical access hospitals to consider alternative means for maintaining temperatures at a level that protects the health and safety of all persons within the facility. For example, when safe temperature levels cannot be maintained, the critical access hospital considers partial or full evacuation or closure.
§482.15(b)(1)(ii)(B) **TAG: E-0015**		**EM.12.02.11**	**The critical access hospital has a plan for managing essential or critical utilities during an emergency or disaster incident. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for utilities management.**
(B) Emergency lighting.		**EP 4**	The critical access hospital's plan for managing utilities includes alternate sources for maintaining energy to the following: • Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions • Emergency lighting • Fire detection, extinguishing, and alarm systems • Sewage and waste disposal Note: It is important for critical access hospitals to consider alternative means for maintaining temperatures at a level that protects the health and safety of all persons within the facility. For example, when safe temperature levels cannot be maintained, the critical access hospital considers partial or full evacuation or closure.

CFR Number §482.15(b)(1)(ii)(C)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(b)(1)(ii)(C) **TAG: E-0015**		**EM.12.02.11**	**The critical access hospital has a plan for managing essential or critical utilities during an emergency or disaster incident. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for utilities management.**
(C) Fire detection, extinguishing, and alarm systems.		**EP 4**	The critical access hospital's plan for managing utilities includes alternate sources for maintaining energy to the following: • Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions • Emergency lighting • Fire detection, extinguishing, and alarm systems • Sewage and waste disposal Note: It is important for critical access hospitals to consider alternative means for maintaining temperatures at a level that protects the health and safety of all persons within the facility. For example, when safe temperature levels cannot be maintained, the critical access hospital considers partial or full evacuation or closure.
§482.15(b)(1)(ii)(D) **TAG: E-0015**		**EM.12.02.11**	**The critical access hospital has a plan for managing essential or critical utilities during an emergency or disaster incident. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for utilities management.**
(D) Sewage and waste disposal.		**EP 4**	The critical access hospital's plan for managing utilities includes alternate sources for maintaining energy to the following: • Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions • Emergency lighting • Fire detection, extinguishing, and alarm systems • Sewage and waste disposal Note: It is important for critical access hospitals to consider alternative means for maintaining temperatures at a level that protects the health and safety of all persons within the facility. For example, when safe temperature levels cannot be maintained, the critical access hospital considers partial or full evacuation or closure.
§482.15(b)(2) **TAG: E-0018**		**EM.12.02.07**	**The critical access hospital has a plan for safety and security measures to take during an emergency or disaster incident. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for safety and security.**
(2) A system to track the location of on-duty staff and sheltered patients in the 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.		**EP 2**	The critical access hospital's plan for safety and security measures includes a system to track the location of its on-duty staff and volunteers and patients when sheltered in place, relocated, or evacuated. If on-duty staff and volunteers and patients are relocated during an emergency, the critical access hospital documents the specific name and location of the receiving facility or evacuation location. Note: Examples of systems used for tracking purposes include the use of established technology or tracking systems or taking head counts at defined intervals.
§482.15(b)(3) **TAG: E-0020**		**EM.12.01.01**	**The critical access hospital develops an emergency operations plan based on an all-hazards approach. Note: The critical access hospital considers its prioritized hazards identified as part of its hazards vulnerability analysis when developing an emergency operations plan.**
(3) Safe evacuation from the 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.		**EP 3**	The critical access hospital's emergency operations plan includes written procedures for when and how it will shelter in place or evacuate (partial or complete) its staff, volunteers, and patients. Note 1: Shelter-in-place plans may vary by department and facility and may vary based on the type of emergency or situation. Note 2: Safe evacuation from the critical access hospital includes consideration of care, treatment, and service needs of evacuees, staff responsibilities, and transportation.

CFR Number §482.15(b)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		EM.12.02.01	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
		EP 5	The critical access hospital's communications plan identifies its primary and alternate means for communicating with staff and relevant authorities (such as federal, state, tribal, regional, and local emergency preparedness staff). The plan includes procedures for the following: • How and when alternate/backup communication methods are used • Verifying that its communications systems are compatible with those of community partners and relevant authorities the critical access hospital plans to communicate with • Testing the functionality of the critical access hospital's alternate/backup communication systems or equipment Note: Examples of alternate/backup communication systems include amateur radios, portable radios, text-based notifications, cell and satellite phones, and reverse 911 notification systems.
§482.15(b)(4) TAG: E-0022 (4) A means to shelter in place for patients, staff, and volunteers who remain in the facility.		**EM.12.01.01**	**The critical access hospital develops an emergency operations plan based on an all-hazards approach. Note: The critical access hospital considers its prioritized hazards identified as part of its hazards vulnerability analysis when developing an emergency operations plan.**
		EP 3	The critical access hospital's emergency operations plan includes written procedures for when and how it will shelter in place or evacuate (partial or complete) its staff, volunteers, and patients. Note 1: Shelter-in-place plans may vary by department and facility and may vary based on the type of emergency or situation. Note 2: Safe evacuation from the critical access hospital includes consideration of care, treatment, and service needs of evacuees, staff responsibilities, and transportation.
§482.15(b)(5) TAG: E-0023 (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.		**IM.11.01.01**	**The critical access hospital plans for continuity of its information management processes.**
		EP 1	The critical access hospital develops and implements policies and procedures regarding medical documentation and patient information during emergencies and other interruptions to information management systems, including security and availability of patient records to support continuity of care. Note: These policies and procedures are based on the emergency plan, risk assessment, and emergency communication plan and are reviewed and updated at least every 2 years.
§482.15(b)(6) TAG: E-0024 (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**	**The critical access hospital has a staffing plan for managing all staff and volunteers during an emergency or disaster incident. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a staffing plan.**
		EP 1	The critical access hospital develops a staffing plan for managing all staff and volunteers to meet patient care needs during the duration of an emergency or disaster incident or during a patient surge. The plan includes the following: • Methods for contacting off-duty staff • Acquisition of staff from its other health care facilities • Use of volunteer staffing, such as staffing agencies, health care coalition support, and those deployed as part of the disaster medical assistance teams Note: If the critical access hospital determines that it will never use volunteers during disasters, this is documented in its plan.
		EP 2	The critical access hospital's staffing plan addresses the management of all staff and volunteers as follows: • Reporting processes • Roles and responsibilities for essential functions • Integration of staffing agencies, volunteer staffing, or deployed medical assistance teams into assigned roles and responsibilities

CFR Number §482.15(b)(7)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(b)(7)	**TAG: E-0025**	**EM.12.02.05**	**The critical access hospital has a plan for providing patient care and clinical support during an emergency or disaster incident. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for patient care and clinical support.**
(7) The development of arrangements with other hospitals and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to hospital patients.		**EP 1**	The critical access hospital's plan for providing patient care and clinical support includes written procedures and arrangements with other hospitals and providers for how it will share patient care information and medical documentation and how it will transfer patients to other health care facilities to maintain continuity of care.
§482.15(b)(8)	**TAG: E-0026**	**EM.12.01.01**	**The critical access hospital develops an emergency operations plan based on an all-hazards approach. Note: The critical access hospital considers its prioritized hazards identified as part of its hazards vulnerability analysis when developing an emergency operations plan.**
(8) The role of the 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.		**EP 7**	The critical access hospital must develop and implement emergency preparedness policies and procedures that address the role of the critical access hospital under a waiver declared by the Secretary, in accordance with section 1135 of the Social Security Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. Note 1: This element of performance is applicable only to critical access hospitals that receive Medicare, Medicaid, or Children's Health Insurance Program reimbursement. Note 2: For more information on 1135 waivers, visit https://www.cms.gov/about-cms/what-we-do/emergency-response/how-can-we-help/waivers-flexibilities and https://www.cms.gov/about-cms/agency-information/emergency/downloads/consolidated_medicare_ffs_emergency_qsas.pdf.
§482.15(c)	**TAG: E-0029**	**EM.09.01.01**	**The critical access hospital has a comprehensive emergency management program that utilizes an all-hazards approach.**
(c) Communication plan. The 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:		**EP 3**	The critical access hospital complies with all applicable federal, state, and local emergency preparedness laws and regulations.
		EM.12.01.01	**The critical access hospital develops an emergency operations plan based on an all-hazards approach. Note: The critical access hospital considers its prioritized hazards identified as part of its hazards vulnerability analysis when developing an emergency operations plan.**
		EP 1	The critical access hospital has a written all-hazards emergency operations plan (EOP) with supporting policies and procedures that provides guidance to staff and volunteers on actions to take during emergency or disaster incidents. The EOP and policies and procedures include, but are not limited to, the following: • Mobilizing incident command • Communications plan • Maintaining, expanding, curtailing, or closing operations • Protecting critical systems and infrastructure • Conserving and/or supplementing resources • Surge plans (such as flu or pandemic plans) • Identifying alternate treatment areas or locations • Sheltering in place • Evacuating (partial or complete) or relocating services • Safety and security • Securing information and records

CFR Number §482.15(c)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		EM.17.01.01	**The critical access hospital evaluates its emergency management program, emergency operations plan, and continuity of operations plans.**
		EP 3	The critical access hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: • Hazard vulnerability analysis • Emergency management program • Emergency operations plan, policies, and procedures • Communications plan • Continuity of operations plan • Education and training program • Testing program
§482.15(c)(1)	**TAG: E-0030**		
(1) Names and contact information for the following:			
§482.15(c)(1)(i)	**TAG: E-0030**	**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(i) Staff.		**EP 1**	The critical access hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes the following: • Staff • Physicians and other licensed practitioners • Volunteers • Other health care organizations • Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies • Relevant community partners (such as fire, police, local incident command, public health departments) • Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) • Other sources of assistance (such as health care coalitions) Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident.
§482.15(c)(1)(ii)	**TAG: E-0030**	**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(ii) Entities providing services under arrangement.		**EP 1**	The critical access hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes the following: • Staff • Physicians and other licensed practitioners • Volunteers • Other health care organizations • Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies • Relevant community partners (such as fire, police, local incident command, public health departments) • Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) • Other sources of assistance (such as health care coalitions) Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident.

CFR Number §482.15(c)(1)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(c)(1)(iii) **TAG: E-0030**		**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(iii) Patients' physicians.		**EP 1**	The critical access hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes the following: • Staff • Physicians and other licensed practitioners • Volunteers • Other health care organizations • Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies • Relevant community partners (such as fire, police, local incident command, public health departments) • Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) • Other sources of assistance (such as health care coalitions) Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident.
§482.15(c)(1)(iv) **TAG: E-0030**		**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(iv) Other hospitals and CAHs		**EP 1**	The critical access hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes the following: • Staff • Physicians and other licensed practitioners • Volunteers • Other health care organizations • Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies • Relevant community partners (such as fire, police, local incident command, public health departments) • Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) • Other sources of assistance (such as health care coalitions) Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident.

CFR Number §482.15(c)(1)(v)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(c)(1)(v) **TAG: E-0030**		**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(v) Volunteers.		**EP 1**	The critical access hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes the following: • Staff • Physicians and other licensed practitioners • Volunteers • Other health care organizations • Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies • Relevant community partners (such as fire, police, local incident command, public health departments) • Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) • Other sources of assistance (such as health care coalitions) Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident.
§482.15(c)(2) **TAG: E-0031**			
(2) Contact information for the following:			
§482.15(c)(2)(i) **TAG: E-0031**		**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(i) Federal, State, tribal, regional, and local emergency preparedness staff.		**EP 1**	The critical access hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes the following: • Staff • Physicians and other licensed practitioners • Volunteers • Other health care organizations • Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies • Relevant community partners (such as fire, police, local incident command, public health departments) • Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) • Other sources of assistance (such as health care coalitions) Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident.

CFR Number §482.15(c)(2)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(c)(2)(ii) **TAG: E-0031**		**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(ii) Other sources of assistance.		**EP 1**	The critical access hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes the following: • Staff • Physicians and other licensed practitioners • Volunteers • Other health care organizations • Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies • Relevant community partners (such as fire, police, local incident command, public health departments) • Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) • Other sources of assistance (such as health care coalitions) Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident.
§482.15(c)(3) **TAG: E-0032**			
(3) Primary and alternate means for communicating with the following:			
§482.15(c)(3)(i) **TAG: E-0032**		**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(i) Hospital's staff.		**EP 5**	The critical access hospital's communications plan identifies its primary and alternate means for communicating with staff and relevant authorities (such as federal, state, tribal, regional, and local emergency preparedness staff). The plan includes procedures for the following: • How and when alternate/backup communication methods are used • Verifying that its communications systems are compatible with those of community partners and relevant authorities the critical access hospital plans to communicate with • Testing the functionality of the critical access hospital's alternate/backup communication systems or equipment Note: Examples of alternate/backup communication systems include amateur radios, portable radios, text-based notifications, cell and satellite phones, and reverse 911 notification systems.
§482.15(c)(3)(ii) **TAG: E-0032**		**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(ii) Federal, State, tribal, regional, and local emergency management agencies.		**EP 5**	The critical access hospital's communications plan identifies its primary and alternate means for communicating with staff and relevant authorities (such as federal, state, tribal, regional, and local emergency preparedness staff). The plan includes procedures for the following: • How and when alternate/backup communication methods are used • Verifying that its communications systems are compatible with those of community partners and relevant authorities the critical access hospital plans to communicate with • Testing the functionality of the critical access hospital's alternate/backup communication systems or equipment Note: Examples of alternate/backup communication systems include amateur radios, portable radios, text-based notifications, cell and satellite phones, and reverse 911 notification systems.

CFR Number §482.15(c)(4)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(c)(4)	**TAG: E-0033**	**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(4) A method for sharing information and medical documentation for patients under the hospital's care, as necessary, with other health care providers to maintain the continuity of care.		**EP 4**	In the event of an emergency or evacuation, the critical access hospital's communications plan includes a method for sharing and/or releasing location information and medical documentation for patients under the hospital's care to the following individuals or entities, in accordance with law and regulation: • Patient's family, representative, or others involved in the care of the patient • Disaster relief organizations and relevant authorities • Other health care providers Note: Sharing and releasing of patient information is consistent with 45 CFR 164.510(b)(1)(ii) and (b)(4).
		EM.12.02.05	**The critical access hospital has a plan for providing patient care and clinical support during an emergency or disaster incident. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for patient care and clinical support.**
		EP 1	The critical access hospital's plan for providing patient care and clinical support includes written procedures and arrangements with other hospitals and providers for how it will share patient care information and medical documentation and how it will transfer patients to other health care facilities to maintain continuity of care.
§482.15(c)(5)	**TAG: E-0033**	**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii).		**EP 4**	In the event of an emergency or evacuation, the critical access hospital's communications plan includes a method for sharing and/or releasing location information and medical documentation for patients under the hospital's care to the following individuals or entities, in accordance with law and regulation: • Patient's family, representative, or others involved in the care of the patient • Disaster relief organizations and relevant authorities • Other health care providers Note: Sharing and releasing of patient information is consistent with 45 CFR 164.510(b)(1)(ii) and (b)(4).
§482.15(c)(6)	**TAG: E-0033**	**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(6) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).		**EP 4**	In the event of an emergency or evacuation, the critical access hospital's communications plan includes a method for sharing and/or releasing location information and medical documentation for patients under the hospital's care to the following individuals or entities, in accordance with law and regulation: • Patient's family, representative, or others involved in the care of the patient • Disaster relief organizations and relevant authorities • Other health care providers Note: Sharing and releasing of patient information is consistent with 45 CFR 164.510(b)(1)(ii) and (b)(4).
§482.15(c)(7)	**TAG: E-0034**	**EM.12.02.01**	**The critical access hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency. Note: The critical access hospital considers prioritized hazards identified as part of its hazard vulnerability analysis when developing an emergency response communications plan.**
(7) A means of providing information about the hospital's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.		**EP 3**	The critical access hospital's communication plan describes how the critical access hospital will communicate with and report information about its organizational needs, available occupancy, and ability to provide assistance to relevant authorities. Note: Examples of critical access hospital needs include shortages in personal protective equipment, staffing shortages, evacuation or transfer of patients, and temporary loss of part or all organization function.

CFR Number §482.15(d)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(d) TAG: E-0036		**EM.15.01.01**	**The critical access hospital has an emergency management education and training program. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing education and training.**
(d) Training and testing. The 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.		**EP 1**	The critical access hospital has a written education and training program in emergency management that is based on the critical access hospital's prioritized risks identified as part of its hazard vulnerability analysis, emergency operations plan, communications plan, and policies and procedures. Note: If the critical access hospital has developed multiple hazard vulnerability analyses based on the location of other services offered, the education and training for those facilities are specific to their needs.
		EM.16.01.01	**The critical access hospital plans and conducts exercises to test its emergency operations plan and response procedures. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing emergency exercises.**
		EP 1	The critical access hospital describes in writing a plan for when and how it will conduct annual testing of its emergency operations plan (EOP). The planned exercises are based on the following: • Likely emergencies or disaster scenarios • EOP and policies and procedures • After-action reports (AAR) and improvement plans • Six critical areas (communications, staffing, patient care and clinical support, safety and security, resources and assets, utilities) Note 1: The planned exercises should attempt to stress the limits of its emergency response procedures to assess how prepared the critical access hospital may be if a real event or disaster were to occur based on past experiences. Note 2: An AAR is a detailed critical summary or analysis of an emergency or disaster incident, including both planned and unplanned events. The report summarizes what took place during the event, analyzes the actions taken by participants, and provides areas needing improvement.
		EM.17.01.01	**The critical access hospital evaluates its emergency management program, emergency operations plan, and continuity of operations plans.**
		EP 3	The critical access hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: • Hazard vulnerability analysis • Emergency management program • Emergency operations plan, policies, and procedures • Communications plan • Continuity of operations plan • Education and training program • Testing program
§482.15(d)(1) TAG: E-0037			
(1) Training program. The hospital must do all of the following:			

CFR Number §482.15(d)(1)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(d)(1)(i) **TAG: E-0037**		**EM.15.01.01**	**The critical access hospital has an emergency management education and training program. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing education and training.**
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.		**EP 2**	The critical access hospital provides initial education and training in emergency management to all new and existing staff, individuals providing services under arrangement, and volunteers that are consistent with their roles and responsibilities in an emergency. The initial education and training include the following: • Activation and deactivation of the emergency operations plan • Communications plan • Emergency response policies and procedures • Evacuation, shelter-in-place, lockdown, and surge procedures • Where and how to obtain resources and supplies for emergencies (such as procedure manuals or equipment) Documentation is required.
§482.15(d)(1)(ii) **TAG: E-0037**		**EM.15.01.01**	**The critical access hospital has an emergency management education and training program. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing education and training.**
(ii) Provide emergency preparedness training at least every 2 years.		**EP 3**	The critical access hospital provides ongoing education and training to all staff, individuals providing services under arrangement, and volunteers that are consistent with their roles and responsibilities in an emergency. The education and training occur at the following times: • At least every two years • When roles or responsibilities change • When there are significant revisions to the emergency operations plan, policies, and/or procedures • When procedural changes are made during an emergency or disaster incident requiring just-in-time education and training. Documentation is required. Note 1: Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization. Note 2: Critical access hospitals are not required to retrain staff on the entire emergency operations plan but can choose to provide education and training specific to the new or revised elements of the emergency management program.
§482.15(d)(1)(iii) **TAG: E-0037**		**EM.15.01.01**	**The critical access hospital has an emergency management education and training program. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing education and training.**
(iii) Maintain documentation of the training.		**EP 2**	The critical access hospital provides initial education and training in emergency management to all new and existing staff, individuals providing services under arrangement, and volunteers that are consistent with their roles and responsibilities in an emergency. The initial education and training include the following: • Activation and deactivation of the emergency operations plan • Communications plan • Emergency response policies and procedures • Evacuation, shelter-in-place, lockdown, and surge procedures • Where and how to obtain resources and supplies for emergencies (such as procedure manuals or equipment) Documentation is required.

CFR Number §482.15(d)(1)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		EP 3	The critical access hospital provides ongoing education and training to all staff, individuals providing services under arrangement, and volunteers that are consistent with their roles and responsibilities in an emergency. The education and training occur at the following times: • At least every two years • When roles or responsibilities change • When there are significant revisions to the emergency operations plan, policies, and/or procedures • When procedural changes are made during an emergency or disaster incident requiring just-in-time education and training. Documentation is required. Note 1: Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization. Note 2: Critical access hospitals are not required to retrain staff on the entire emergency operations plan but can choose to provide education and training specific to the new or revised elements of the emergency management program.
§482.15(d)(1)(iv) TAG: E-0037 (iv) Demonstrate staff knowledge of emergency procedures.		**EM.15.01.01**	**The critical access hospital has an emergency management education and training program.** **Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing education and training.**
		EP 2	The critical access hospital provides initial education and training in emergency management to all new and existing staff, individuals providing services under arrangement, and volunteers that are consistent with their roles and responsibilities in an emergency. The initial education and training include the following: • Activation and deactivation of the emergency operations plan • Communications plan • Emergency response policies and procedures • Evacuation, shelter-in-place, lockdown, and surge procedures • Where and how to obtain resources and supplies for emergencies (such as procedure manuals or equipment) Documentation is required.
		EP 3	The critical access hospital provides ongoing education and training to all staff, individuals providing services under arrangement, and volunteers that are consistent with their roles and responsibilities in an emergency. The education and training occur at the following times: • At least every two years • When roles or responsibilities change • When there are significant revisions to the emergency operations plan, policies, and/or procedures • When procedural changes are made during an emergency or disaster incident requiring just-in-time education and training. Documentation is required. Note 1: Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization. Note 2: Critical access hospitals are not required to retrain staff on the entire emergency operations plan but can choose to provide education and training specific to the new or revised elements of the emergency management program.

CFR Number §482.15(d)(1)(v)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(d)(1)(v) **TAG: E-0037**		**EM.15.01.01**	**The critical access hospital has an emergency management education and training program. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing education and training.**
(v) If the emergency preparedness policies and procedures are significantly updated, the hospital must conduct training on the updated policies and procedures.		**EP 3**	The critical access hospital provides ongoing education and training to all staff, individuals providing services under arrangement, and volunteers that are consistent with their roles and responsibilities in an emergency. The education and training occur at the following times: • At least every two years • When roles or responsibilities change • When there are significant revisions to the emergency operations plan, policies, and/or procedures • When procedural changes are made during an emergency or disaster incident requiring just-in-time education and training. Documentation is required. Note 1: Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization. Note 2: Critical access hospitals are not required to retrain staff on the entire emergency operations plan but can choose to provide education and training specific to the new or revised elements of the emergency management program.
§482.15(d)(2) **TAG: E-0039**		**EM.16.01.01**	**The critical access hospital plans and conducts exercises to test its emergency operations plan and response procedures. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing emergency exercises.**

(2) Testing. The hospital must conduct exercises to test the emergency plan at least twice per year. The hospital must do all of the following:		**EP 2**	The critical access hospital is required to conduct two exercises per year to test the emergency operations plan.
			• One of the annual exercises must consist of an operations-based exercise as follows:
			  • Full-scale, community-based exercise; or
			  • Functional, facility-based exercise when a community-based exercise is not possible
			• The other annual exercise must consist of either an operations-based or discussion-based exercise as follows:
			  • Full-scale, community-based exercise; or
			  • Functional, facility-based exercise; or
			  • Mock disaster drill; or
			  • Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
			Exercises and actual emergency or disaster incidents are documented (after-action reports).
			Note 1: The critical access hospital would be exempt from conducting its next annual operations-based exercise if it experiences an actual emergency or disaster incident (discussion-based exercises are excluded from exemption). An exemption only applies if the critical access hospital provides documentation that it activated its emergency operations plan.
			Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises.

CFR Number §482.15(d)(2)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(d)(2)(i) **TAG: E-0039**		**EM.16.01.01**	**The critical access hospital plans and conducts exercises to test its emergency operations plan and response procedures. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing emergency exercises.**

(i) Participate in an annual full-scale exercise that is community-based; or		**EP 2**	The critical access hospital is required to conduct two exercises per year to test the emergency operations plan.
			• One of the annual exercises must consist of an operations-based exercise as follows:
			  • Full-scale, community-based exercise; or
			  • Functional, facility-based exercise when a community-based exercise is not possible
			• The other annual exercise must consist of either an operations-based or discussion-based exercise as follows:
			  • Full-scale, community-based exercise; or
			  • Functional, facility-based exercise; or
			  • Mock disaster drill; or
			  • Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
			Exercises and actual emergency or disaster incidents are documented (after-action reports).
			Note 1: The critical access hospital would be exempt from conducting its next annual operations-based exercise if it experiences an actual emergency or disaster incident (discussion-based exercises are excluded from exemption). An exemption only applies if the critical access hospital provides documentation that it activated its emergency operations plan.
			Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises.

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

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.		**EP 2**	The critical access hospital is required to conduct two exercises per year to test the emergency operations plan.
			• One of the annual exercises must consist of an operations-based exercise as follows:
			  • Full-scale, community-based exercise; or
			  • Functional, facility-based exercise when a community-based exercise is not possible
			• The other annual exercise must consist of either an operations-based or discussion-based exercise as follows:
			  • Full-scale, community-based exercise; or
			  • Functional, facility-based exercise; or
			  • Mock disaster drill; or
			  • Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
			Exercises and actual emergency or disaster incidents are documented (after-action reports).
			Note 1: The critical access hospital would be exempt from conducting its next annual operations-based exercise if it experiences an actual emergency or disaster incident (discussion-based exercises are excluded from exemption). An exemption only applies if the critical access hospital provides documentation that it activated its emergency operations plan.
			Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises.

CFR Number §482.15(d)(2)(i)(B)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(d)(2)(i)(B)	**TAG: E-0039**	**EM.16.01.01**	**The critical access hospital plans and conducts exercises to test its emergency operations plan and response procedures. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing emergency exercises.**

(B) If the hospital experiences an actual natural or man-made emergency that 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.		**EP 2**	The critical access hospital is required to conduct two exercises per year to test the emergency operations plan.
			• One of the annual exercises must consist of an operations-based exercise as follows:
			  • Full-scale, community-based exercise; or
			  • Functional, facility-based exercise when a community-based exercise is not possible
			• The other annual exercise must consist of either an operations-based or discussion-based exercise as follows:
			  • Full-scale, community-based exercise; or
			  • Functional, facility-based exercise; or
			  • Mock disaster drill; or
			  • Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
			Exercises and actual emergency or disaster incidents are documented (after-action reports).
			Note 1: The critical access hospital would be exempt from conducting its next annual operations-based exercise if it experiences an actual emergency or disaster incident (discussion-based exercises are excluded from exemption). An exemption only applies if the critical access hospital provides documentation that it activated its emergency operations plan.
			Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises.

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

(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or		**EP 2**	The critical access hospital is required to conduct two exercises per year to test the emergency operations plan.
			• One of the annual exercises must consist of an operations-based exercise as follows:
			  • Full-scale, community-based exercise; or
			  • Functional, facility-based exercise when a community-based exercise is not possible
			• The other annual exercise must consist of either an operations-based or discussion-based exercise as follows:
			  • Full-scale, community-based exercise; or
			  • Functional, facility-based exercise; or
			  • Mock disaster drill; or
			  • Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
			Exercises and actual emergency or disaster incidents are documented (after-action reports).
			Note 1: The critical access hospital would be exempt from conducting its next annual operations-based exercise if it experiences an actual emergency or disaster incident (discussion-based exercises are excluded from exemption). An exemption only applies if the critical access hospital provides documentation that it activated its emergency operations plan.
			Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises.

CFR Number §482.15(d)(2)(ii)(B)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(d)(2)(ii)(B) **TAG: E-0039**		**EM.16.01.01**	**The critical access hospital plans and conducts exercises to test its emergency operations plan and response procedures. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing emergency exercises.**

(B) A mock disaster drill; or		**EP 2**	The critical access hospital is required to conduct two exercises per year to test the emergency operations plan.
			• One of the annual exercises must consist of an operations-based exercise as follows:
			  • Full-scale, community-based exercise; or
			  • Functional, facility-based exercise when a community-based exercise is not possible
			• The other annual exercise must consist of either an operations-based or discussion-based exercise as follows:
			  • Full-scale, community-based exercise; or
			  • Functional, facility-based exercise; or
			  • Mock disaster drill; or
			  • Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
			Exercises and actual emergency or disaster incidents are documented (after-action reports).
			Note 1: The critical access hospital would be exempt from conducting its next annual operations-based exercise if it experiences an actual emergency or disaster incident (discussion-based exercises are excluded from exemption). An exemption only applies if the critical access hospital provides documentation that it activated its emergency operations plan.
			Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises.

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

(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 problem statements, directed messages, or prepared questions designed to challenge an emergency plan.		**EP 2**	The critical access hospital is required to conduct two exercises per year to test the emergency operations plan.
			• One of the annual exercises must consist of an operations-based exercise as follows:
			  • Full-scale, community-based exercise; or
			  • Functional, facility-based exercise when a community-based exercise is not possible
			• The other annual exercise must consist of either an operations-based or discussion-based exercise as follows:
			  • Full-scale, community-based exercise; or
			  • Functional, facility-based exercise; or
			  • Mock disaster drill; or
			  • Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
			Exercises and actual emergency or disaster incidents are documented (after-action reports).
			Note 1: The critical access hospital would be exempt from conducting its next annual operations-based exercise if it experiences an actual emergency or disaster incident (discussion-based exercises are excluded from exemption). An exemption only applies if the critical access hospital provides documentation that it activated its emergency operations plan.
			Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises.

CFR Number §482.15(d)(2)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(d)(2)(iii) **TAG: E-0039**		**EM.17.01.01**	**The critical access hospital evaluates its emergency management program, emergency operations plan, and continuity of operations plans.**
(iii) Analyze the hospital's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the hospital's emergency plan, as needed.		**EP 1**	The multidisciplinary committee that oversees the emergency management program reviews and evaluates all exercises and actual emergency or disaster incidents. The committee reviews after-action reports (AARs), identifies opportunities for improvement, and recommends actions to take to improve the emergency management program. The AARs and improvement plans are documented. Note 1: The review and evaluation address the effectiveness of its emergency response procedure, continuity of operations plans (if activated), training and exercise programs, evacuation procedures, surge response procedures, and activities related to communications, resources and assets, security, staff, utilities, and patients. Note 2: An AAR provides a detailed critical summary or analysis of a planned exercise or an actual emergency or disaster incident. The report summarizes what took place during the event, analyzes the actions taken by participants, and provides areas needing improvement.
		EP 3	The critical access hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: • Hazard vulnerability analysis • Emergency management program • Emergency operations plan, policies, and procedures • Communications plan • Continuity of operations plan • Education and training program • Testing program
§482.15(e) **TAG: E-0041**		**EM.12.02.11**	**The critical access hospital has a plan for managing essential or critical utilities during an emergency or disaster incident. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for utilities management.**
(e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.		**EP 1**	The critical access hospital's plan for managing utilities describes in writing the utility systems that it considers as essential or critical to provide care, treatment, and services. Note: Essential or critical utilities to consider may include systems for electrical distribution; emergency power; vertical and horizontal transport; heating, ventilation, and air conditioning; plumbing and steam boilers; medical gas; medical/surgical vacuum; and network or communication systems.
		EP 2	The critical access hospital's plan for managing utilities describes in writing how it will continue to maintain essential or critical utility systems if one or more are impacted during an emergency or disaster incident.
		EP 3	The critical access hospital's plan for managing utilities describes in writing alternative means for providing essential or critical utilities, such as water supply, emergency power supply systems, fuel storage tanks, and emergency generators.

CFR Number §482.15(e)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(e)(1)	**TAG: E-0041**	**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.		**EP 3**	The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
		PE.04.01.01	**The critical access hospital addresses building safety and facility management.**
		EP 1	The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
		PE.04.01.03	**The critical access hospital manages utility systems.**
		EP 3	The critical access hospital meets the emergency power system and generator requirements found in NFPA 99-2012 Health Care Facilities Code, NFPA 110-2010 Standard for Emergency and Standby Power Systems, and NFPA 101-2012 Life Safety Code requirements.
§482.15(e)(2)	**TAG: E-0041**	**PE.04.01.03**	**The critical access hospital manages utility systems.**
(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.		**EP 3**	The critical access hospital meets the emergency power system and generator requirements found in NFPA 99-2012 Health Care Facilities Code, NFPA 110-2010 Standard for Emergency and Standby Power Systems, and NFPA 101-2012 Life Safety Code requirements.

CFR Number §482.15(e)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(e)(3)	**TAG: E-0041**	**EM.12.02.09**	**The critical access hospital has a plan for managing resources and assets during an emergency or disaster incident. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for resources and assets.**
(3) Emergency generator fuel. 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.		**EP 1**	The critical access hospital's plan for managing its resources and assets describes in writing how it will document, track, monitor, and locate the following resources (on-site and off-site inventories) and assets during and after an emergency or disaster incident: • Medications and related supplies • Medical/surgical supplies • Medical gases, including oxygen and supplies • Potable or bottled water and nutrition • Non-potable water • Laboratory equipment and supplies • Personal protective equipment • Fuel for operations • Equipment and nonmedical supplies to sustain operations Note: The critical access hospital should be aware of the resources and assets it has readily available and what resources and assets may be quickly depleted depending on the type of emergency or disaster incident.
		EP 2	The critical access hospital's plan for managing its resources and assets describes in writing how it will obtain, allocate, mobilize, replenish, and conserve its resources and assets during and after an emergency or disaster incident, including the following: • If part of a health care system, coordinating within the system to request resources • Coordinating with local supply chains or vendors • Coordinating with local, state, or federal agencies for additional resources • Coordinating with regional health care coalitions for additional resources • Managing donations (such as food, water, equipment, materials) Note: High priority should be given to resources that are known to deplete quickly and are extremely competitive to acquire and replenish (such as fuel, oxygen, personal protective equipment, ventilators, intravenous fluids, antiviral and antibiotic medications).
		EM.12.02.11	**The critical access hospital has a plan for managing essential or critical utilities during an emergency or disaster incident. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a plan for utilities management.**
		EP 2	The critical access hospital's plan for managing utilities describes in writing how it will continue to maintain essential or critical utility systems if one or more are impacted during an emergency or disaster incident.
		EP 3	The critical access hospital's plan for managing utilities describes in writing alternative means for providing essential or critical utilities, such as water supply, emergency power supply systems, fuel storage tanks, and emergency generators.
§482.15(f)	**TAG: E-0042**		
(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 system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must--			

CFR Number §482.15(f)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(f)(1) **TAG: E-0042**		**EM.09.01.01**	**The critical access hospital has a comprehensive emergency management program that utilizes an all-hazards approach.**
(1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.		**EP 2**	If the critical access hospital is part of a health care system that has a unified and integrated emergency management program and it chooses to participate in the program, the following must be demonstrated within the coordinated emergency management program: • Each separately certified critical access hospital within the system actively participates in the development of the unified and integrated emergency management program • The program is developed and maintained in a manner that takes into account each separately certified critical access hospital's unique circumstances, patient population, and services offered • Each separately certified critical access hospital is capable of actively using the unified and integrated emergency management program and is in compliance with the program • Documented community-based risk assessment utilizing an all-hazards approach • Documented individual, facility-based risk assessment utilizing an all-hazards approach for each separately certified critical access hospital within the health care system • Unified and integrated emergency plan • Integrated policies and procedures • Coordinated communication plan • Training and testing program
§482.15(f)(2) **TAG: E-0042**		**EM.09.01.01**	**The critical access hospital has a comprehensive emergency management program that utilizes an all-hazards approach.**
(2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered.		**EP 2**	If the critical access hospital is part of a health care system that has a unified and integrated emergency management program and it chooses to participate in the program, the following must be demonstrated within the coordinated emergency management program: • Each separately certified critical access hospital within the system actively participates in the development of the unified and integrated emergency management program • The program is developed and maintained in a manner that takes into account each separately certified critical access hospital's unique circumstances, patient population, and services offered • Each separately certified critical access hospital is capable of actively using the unified and integrated emergency management program and is in compliance with the program • Documented community-based risk assessment utilizing an all-hazards approach • Documented individual, facility-based risk assessment utilizing an all-hazards approach for each separately certified critical access hospital within the health care system • Unified and integrated emergency plan • Integrated policies and procedures • Coordinated communication plan • Training and testing program

CFR Number §482.15(f)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(f)(3) **TAG: E-0042**		**EM.09.01.01**	**The critical access hospital has a comprehensive emergency management program that utilizes an all-hazards approach.**
(3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program.		**EP 2**	If the critical access hospital is part of a health care system that has a unified and integrated emergency management program and it chooses to participate in the program, the following must be demonstrated within the coordinated emergency management program: • Each separately certified critical access hospital within the system actively participates in the development of the unified and integrated emergency management program • The program is developed and maintained in a manner that takes into account each separately certified critical access hospital's unique circumstances, patient population, and services offered • Each separately certified critical access hospital is capable of actively using the unified and integrated emergency management program and is in compliance with the program • Documented community-based risk assessment utilizing an all-hazards approach • Documented individual, facility-based risk assessment utilizing an all-hazards approach for each separately certified critical access hospital within the health care system • Unified and integrated emergency plan • Integrated policies and procedures • Coordinated communication plan • Training and testing program
§482.15(f)(4) **TAG: E-0042**		**EM.09.01.01**	**The critical access hospital has a comprehensive emergency management program that utilizes an all-hazards approach.**
(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following:		**EP 2**	If the critical access hospital is part of a health care system that has a unified and integrated emergency management program and it chooses to participate in the program, the following must be demonstrated within the coordinated emergency management program: • Each separately certified critical access hospital within the system actively participates in the development of the unified and integrated emergency management program • The program is developed and maintained in a manner that takes into account each separately certified critical access hospital's unique circumstances, patient population, and services offered • Each separately certified critical access hospital is capable of actively using the unified and integrated emergency management program and is in compliance with the program • Documented community-based risk assessment utilizing an all-hazards approach • Documented individual, facility-based risk assessment utilizing an all-hazards approach for each separately certified critical access hospital within the health care system • Unified and integrated emergency plan • Integrated policies and procedures • Coordinated communication plan • Training and testing program
		EM.11.01.01	**The critical access hospital conducts a hazard vulnerability analysis utilizing an all-hazards approach.**
		EP 3	The critical access hospital evaluates and prioritizes the findings of the hazard vulnerability analysis to determine what presents the highest likelihood of occurring and the impacts those hazards will have on the operating status of the critical access hospital and its ability to provide services. The findings are documented.
		EP 4	The critical access hospital uses its prioritized hazards from the hazard vulnerability analysis to identify and implement mitigation and preparedness actions to increase the resilience of the critical access hospital and helps reduce disruption of essential services or functions.

CFR Number §482.15(f)(4)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		EM.12.01.01	**The critical access hospital develops an emergency operations plan based on an all-hazards approach. Note: The critical access hospital considers its prioritized hazards identified as part of its hazards vulnerability analysis when developing an emergency operations plan.**
		EP 2	The critical access hospital's emergency operations plan identifies the patient population(s) that it will serve, including at-risk populations, and the types of services it would have the ability to provide in an emergency or disaster event. Note: At-risk populations such as the elderly, dialysis patients, or persons with physical or mental disabilities may have additional needs to be addressed during an emergency or disaster incident such as medical care, communication, transportation, supervision, and maintaining independence.
		EP 6	The critical access hospital's emergency operations plan includes a process for cooperating and collaborating with other health care facilities; health care coalitions; and local, tribal, regional, state, and federal emergency preparedness officials' efforts to leverage support and resources and to provide an integrated response during an emergency or disaster incident.
		EM.13.01.01	**The critical access hospital has a continuity of operations plan. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a continuity of operations plan.**
		EP 1	The critical access hospital has a written continuity of operations plan (COOP) that is developed with the participation of key executive leaders, business and finance leaders, and other department leaders as determined by the critical access hospital. These key leaders identify and prioritize the services and functions that are considered essential or critical for maintaining operations. Note: The COOP provides guidance on how the critical access hospital will continue to perform its essential business functions to deliver essential or critical services. Essential business functions to consider include administrative/vital records, information technology, financial services, security systems, communications/ telecommunications, and building operations to support essential and critical services that cannot be deferred during an emergency; these activities must be performed continuously or resumed quickly following a disruption.
		EP 2	The critical access hospital's continuity of operations plan identifies in writing how and where it will continue to provide its essential business functions when the location of the essential or critical service has been compromised due to an emergency or disaster incident. Note: Example of options to consider for providing essential services include use of off-site locations, space maintained by another organization, existing facilities or space, telework (remote work), or telehealth.
		EP 3	The critical access hospital has a written order of succession plan that identifies who is authorized to assume a particular leadership or management role when that person(s) is unable to fulfill their function or perform their duties.
		EP 4	The critical access hospital has a written delegation of authority plan that provides the individual(s) with the legal authorization to act on behalf of the critical access hospital for specified purposes and to carry out specific duties. Note: Delegations of authority are an essential part of an organization's continuity program and should be sufficiently detailed to make certain the critical access hospital can perform its essential functions. Delegations of authority will specify a particular function that an individual is authorized to perform and includes restrictions and limitations associated with that authority.

CFR Number §482.15(f)(4)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(f)(4)(i) TAG: E-0042		**EM.09.01.01**	**The critical access hospital has a comprehensive emergency management program that utilizes an all-hazards approach.**
(i) A documented community-based risk assessment, utilizing an all-hazards approach.		**EP 2**	If the critical access hospital is part of a health care system that has a unified and integrated emergency management program and it chooses to participate in the program, the following must be demonstrated within the coordinated emergency management program: • Each separately certified critical access hospital within the system actively participates in the development of the unified and integrated emergency management program • The program is developed and maintained in a manner that takes into account each separately certified critical access hospital's unique circumstances, patient population, and services offered • Each separately certified critical access hospital is capable of actively using the unified and integrated emergency management program and is in compliance with the program • Documented community-based risk assessment utilizing an all-hazards approach • Documented individual, facility-based risk assessment utilizing an all-hazards approach for each separately certified critical access hospital within the health care system • Unified and integrated emergency plan • Integrated policies and procedures • Coordinated communication plan • Training and testing program
§482.15(f)(4)(ii) TAG: E-0042		**EM.09.01.01**	**The critical access hospital has a comprehensive emergency management program that utilizes an all-hazards approach.**
(ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.		**EP 2**	If the critical access hospital is part of a health care system that has a unified and integrated emergency management program and it chooses to participate in the program, the following must be demonstrated within the coordinated emergency management program: • Each separately certified critical access hospital within the system actively participates in the development of the unified and integrated emergency management program • The program is developed and maintained in a manner that takes into account each separately certified critical access hospital's unique circumstances, patient population, and services offered • Each separately certified critical access hospital is capable of actively using the unified and integrated emergency management program and is in compliance with the program • Documented community-based risk assessment utilizing an all-hazards approach • Documented individual, facility-based risk assessment utilizing an all-hazards approach for each separately certified critical access hospital within the health care system • Unified and integrated emergency plan • Integrated policies and procedures • Coordinated communication plan • Training and testing program

CFR Number §482.15(f)(5)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(f)(5) **TAG: E-0042**		**EM.09.01.01**	**The critical access hospital has a comprehensive emergency management program that utilizes an all-hazards approach.**
(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.		**EP 2**	If the critical access hospital is part of a health care system that has a unified and integrated emergency management program and it chooses to participate in the program, the following must be demonstrated within the coordinated emergency management program: • Each separately certified critical access hospital within the system actively participates in the development of the unified and integrated emergency management program • The program is developed and maintained in a manner that takes into account each separately certified critical access hospital's unique circumstances, patient population, and services offered • Each separately certified critical access hospital is capable of actively using the unified and integrated emergency management program and is in compliance with the program • Documented community-based risk assessment utilizing an all-hazards approach • Documented individual, facility-based risk assessment utilizing an all-hazards approach for each separately certified critical access hospital within the health care system • Unified and integrated emergency plan • Integrated policies and procedures • Coordinated communication plan • Training and testing program
		EP 3	The critical access hospital complies with all applicable federal, state, and local emergency preparedness laws and regulations.
		EM.12.01.01	**The critical access hospital develops an emergency operations plan based on an all-hazards approach. Note: The critical access hospital considers its prioritized hazards identified as part of its hazards vulnerability analysis when developing an emergency operations plan.**
		EP 1	The critical access hospital has a written all-hazards emergency operations plan (EOP) with supporting policies and procedures that provides guidance to staff and volunteers on actions to take during emergency or disaster incidents. The EOP and policies and procedures include, but are not limited to, the following: • Mobilizing incident command • Communications plan • Maintaining, expanding, curtailing, or closing operations • Protecting critical systems and infrastructure • Conserving and/or supplementing resources • Surge plans (such as flu or pandemic plans) • Identifying alternate treatment areas or locations • Sheltering in place • Evacuating (partial or complete) or relocating services • Safety and security • Securing information and records
		EM.15.01.01	**The critical access hospital has an emergency management education and training program. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing education and training.**
		EP 1	The critical access hospital has a written education and training program in emergency management that is based on the critical access hospital's prioritized risks identified as part of its hazard vulnerability analysis, emergency operations plan, communications plan, and policies and procedures. Note: If the critical access hospital has developed multiple hazard vulnerability analyses based on the location of other services offered, the education and training for those facilities are specific to their needs.

CFR Number §482.15(f)(5)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		EM.16.01.01	**The critical access hospital plans and conducts exercises to test its emergency operations plan and response procedures. Note: The critical access hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing emergency exercises.**
		EP 1	The critical access hospital describes in writing a plan for when and how it will conduct annual testing of its emergency operations plan (EOP). The planned exercises are based on the following: • Likely emergencies or disaster scenarios • EOP and policies and procedures • After-action reports (AAR) and improvement plans • Six critical areas (communications, staffing, patient care and clinical support, safety and security, resources and assets, utilities) Note 1: The planned exercises should attempt to stress the limits of its emergency response procedures to assess how prepared the critical access hospital may be if a real event or disaster were to occur based on past experiences. Note 2: An AAR is a detailed critical summary or analysis of an emergency or disaster incident, including both planned and unplanned events. The report summarizes what took place during the event, analyzes the actions taken by participants, and provides areas needing improvement.
		EM.17.01.01	**The critical access hospital evaluates its emergency management program, emergency operations plan, and continuity of operations plans.**
		EP 3	The critical access hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: • Hazard vulnerability analysis • Emergency management program • Emergency operations plan, policies, and procedures • Communications plan • Continuity of operations plan • Education and training program • Testing program
§482.15(g) **TAG: E-0043**			
(g) Transplant hospitals. If a hospital has one or more transplant programs (as defined in § 482.70)--			
§482.15(g)(1) **TAG: E-0043**		**EM.09.01.01**	**The critical access hospital has a comprehensive emergency management program that utilizes an all-hazards approach.**
(1) A representative from each transplant program must be included in the development and maintenance of the hospital's emergency preparedness program; and		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If a critical access 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 critical access hospital's emergency preparedness program • The critical access hospital must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the critical access hospital, each transplant program, and the organ procurement organization (OPO) for the donation service area where the critical access hospital is situated, unless the critical access hospital has been granted a waiver to work with another OPO, during an emergency

CFR Number §482.15(g)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(g)(2)	**TAG: E-0043**	**EM.09.01.01**	**The critical access hospital has a comprehensive emergency management program that utilizes an all-hazards approach.**
(2) The hospital must develop and maintain mutually agreed upon protocols that address 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.		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If a critical access 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 critical access hospital's emergency preparedness program • The critical access hospital must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the critical access hospital, each transplant program, and the organ procurement organization (OPO) for the donation service area where the critical access hospital is situated, unless the critical access hospital has been granted a waiver to work with another OPO, during an emergency
§482.15(h)	**TAG: E-0041**		
(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.			
§482.15(h)(1)	**TAG: E-0041**		
(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.			
§482.15(h)(1)(i)	**TAG: E-0041**	**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.		**EP 1**	The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§482.15(h)(1)(ii)	**TAG: E-0041**	**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.		**EP 1**	The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.

CFR Number §482.15(h)(1)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(h)(1)(iii)	**TAG: E-0041**	**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.		**EP 1**	The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§482.15(h)(1)(iv)	**TAG: E-0041**	**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.		**EP 1**	The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§482.15(h)(1)(v)	**TAG: E-0041**	**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(v) TIA 12-5 to NFPA 99, issued August 1, 2013.		**EP 1**	The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§482.15(h)(1)(vi)	**TAG: E-0041**	**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.		**EP 1**	The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.

CFR Number §482.15(h)(1)(vii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(h)(1)(vii) **TAG: E-0041**		**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.		**EP 3**	The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§482.15(h)(1)(viii) **TAG: E-0041**		**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.		**EP 3**	The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.

CFR Number §482.15(h)(1)(ix)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(h)(1)(ix) **TAG: E-0041**		**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.		**EP 3**	The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§482.15(h)(1)(x) **TAG: E-0041**		**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(x) TIA 12-3 to NFPA 101, issued October 22, 2013.		**EP 3**	The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.

CFR Number §482.15(h)(1)(xi)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.15(h)(1)(xi)	**TAG: E-0041**	**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.		**EP 3**	The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§482.15(h)(1)(xii)	**TAG: E-0041**	**PE.04.01.03**	**The critical access hospital manages utility systems.**
(xii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.		**EP 3**	The critical access hospital meets the emergency power system and generator requirements found in NFPA 99-2012 Health Care Facilities Code, NFPA 110-2010 Standard for Emergency and Standby Power Systems, and NFPA 101-2012 Life Safety Code requirements.
§482.15(h)(2)	**TAG: E-0041**		
(2) [Reserved]			
§482.21	**TAG: A-0308, A-0263**	**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
§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.		**EP 8**	The governing body or designated individual is responsible and accountable for the quality assessment and performance improvement program. The governing body makes sure that performance improvement activities reflect the complexity of the critical access hospital's organization and services; are ongoing and comprehensive; involve all departments and services, including those services provided under contract or arrangement; and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors and objective measures to evaluate its organizational processes, functions, and services. (For more information on contracted services, see Standard LD.13.03.03) Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: If the hospital does not have a governing body, it identifies the leadership structure that is responsible for these activities.
		LD.12.01.01	**Leaders establish priorities for performance improvement. (Refer to the "Performance Improvement" [PI] chapter.)**
		EP 1	The critical access hospital develops, implements, maintains, and documents an effective, ongoing, data-driven, hospitalwide quality assessment and performance improvement program. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital maintains and demonstrates evidence of its QAPI program for review by CMS.
		PI.14.01.01	**The critical access hospital improves performance.**
		EP 1	The critical access hospital acts on improvement priorities.
§482.21(a)	**TAG: A-0273**		
§482.21(a) Standard: Program Scope			

CFR Number §482.21(a)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.21(a)(1)	**TAG: A-0286**	**PI.11.01.01**	**The critical access hospital has an ongoing quality assessment and performance improvement program.**
(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.		**EP 2**	The critical access hospital has an ongoing quality assessment and performance improvement program that shows measurable improvement for indicators that are selected based on evidence that they will improve health outcomes and aid in the identification and reduction of medical errors. The program incorporates quality indicator data, including patient care data and other relevant data to achieve the goals of the program. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: Relevant data includes data submitted to or received from Medicare quality reporting and quality performance programs including but not limited to data related to hospital readmissions and hospital-acquired conditions.
§482.21(a)(2)	**TAG: A-0286**	**PI.12.01.01**	**The critical access hospital collects data.**
(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.		**EP 3**	The critical access 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.
§482.21(b)	**TAG: A-0273**		
§482.21(b) Standard: Program Data			
§482.21(b)(1)	**TAG: A-0273**	**PI.11.01.01**	**The critical access hospital has an ongoing quality assessment and performance improvement program.**
(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.		**EP 2**	The critical access hospital has an ongoing quality assessment and performance improvement program that shows measurable improvement for indicators that are selected based on evidence that they will improve health outcomes and aid in the identification and reduction of medical errors. The program incorporates quality indicator data, including patient care data and other relevant data to achieve the goals of the program. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: Relevant data includes data submitted to or received from Medicare quality reporting and quality performance programs including but not limited to data related to hospital readmissions and hospital-acquired conditions.
§482.21(b)(2)	**TAG: A-0273**		
(2) The hospital must use the data collected to--			
§482.21(b)(2)(i)	**TAG: A-0273**	**PI.13.01.01**	**The critical access hospital compiles, analyzes, and uses data.**
(i) Monitor the effectiveness and safety of services and quality of care; and		**EP 1**	The critical access 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)	**TAG: A-0283**	**PI.13.01.01**	**The critical access hospital compiles, analyzes, and uses data.**
(ii) Identify opportunities for improvement and changes that will lead to improvement.		**EP 1**	The critical access 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

CFR Number §482.21(b)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.21(b)(3) **TAG: A-0273**		**LD.12.01.01**	**Leaders establish priorities for performance improvement. (Refer to the "Performance Improvement" [PI] chapter.)**
(3) The frequency and detail of data collection must be specified by the hospital's governing body.		**EP 2**	As part of performance improvement, leaders (including the governing body) do the following: • Set priorities for performance improvement activities related to improved health outcomes that are shown to be predictive of desired patient outcomes, patient safety, and quality of care • Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities and consider the incidence, prevalence, and severity of problems in those areas • Identify the frequency and detail of data collection for performance improvement activities • Use measures to analyze and track performance
§482.21(c) **TAG: A-0283**			
§482.21(c) Standard: Program Activities			
§482.21(c)(1) **TAG: A-0283**			
(1) The hospital must set priorities for its performance improvement activities that--			
§482.21(c)(1)(i) **TAG: A-0283**		**LD.12.01.01**	**Leaders establish priorities for performance improvement. (Refer to the "Performance Improvement" [PI] chapter.)**
(i) Focus on high-risk, high-volume, or problem-prone areas;		**EP 2**	As part of performance improvement, leaders (including the governing body) do the following: • Set priorities for performance improvement activities related to improved health outcomes that are shown to be predictive of desired patient outcomes, patient safety, and quality of care • Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities and consider the incidence, prevalence, and severity of problems in those areas • Identify the frequency and detail of data collection for performance improvement activities • Use measures to analyze and track performance
§482.21(c)(1)(ii) **TAG: A-0283**		**LD.12.01.01**	**Leaders establish priorities for performance improvement. (Refer to the "Performance Improvement" [PI] chapter.)**
(ii) Consider the incidence, prevalence, and severity of problems in those areas; and		**EP 2**	As part of performance improvement, leaders (including the governing body) do the following: • Set priorities for performance improvement activities related to improved health outcomes that are shown to be predictive of desired patient outcomes, patient safety, and quality of care • Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities and consider the incidence, prevalence, and severity of problems in those areas • Identify the frequency and detail of data collection for performance improvement activities • Use measures to analyze and track performance
§482.21(c)(1)(iii) **TAG: A-0283**		**LD.12.01.01**	**Leaders establish priorities for performance improvement. (Refer to the "Performance Improvement" [PI] chapter.)**
(iii) Affect health outcomes, patient safety, and quality of care.		**EP 2**	As part of performance improvement, leaders (including the governing body) do the following: • Set priorities for performance improvement activities related to improved health outcomes that are shown to be predictive of desired patient outcomes, patient safety, and quality of care • Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities and consider the incidence, prevalence, and severity of problems in those areas • Identify the frequency and detail of data collection for performance improvement activities • Use measures to analyze and track performance

CFR Number §482.21(c)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.21(c)(2)	**TAG: A-0286**	**PI.12.01.01**	**The critical access hospital collects data.**
(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.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital tracks medical errors and adverse patient events, analyzes their causes, and implements preventive actions and mechanisms that include feedback and learning throughout the critical access 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
§482.21(c)(3)	**TAG: A-0283**	**PI.12.01.01**	**The critical access hospital collects data.**
(3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.		**EP 4**	The critical access hospital takes action to improve its performance. After implementing changes, the critical access hospital measures its success and tracks performance to ensure that improvements are sustained.
		PI.14.01.01	**The critical access hospital improves performance.**
		EP 1	The critical access hospital acts on improvement priorities.
§482.21(d)	**TAG: A-0297**	**PI.11.01.01**	**The critical access hospital has an ongoing quality assessment and performance improvement program.**
§482.21(d) Standard: Performance Improvement Projects As part of its quality assessment and performance improvement program, the hospital must conduct performance improvement projects.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 critical access hospital's services and operations. Note 1: The critical access 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: The critical access 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)	**TAG: A-0297**	**PI.11.01.01**	**The critical access hospital has an ongoing quality assessment and performance improvement program.**
(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.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 critical access hospital's services and operations. Note 1: The critical access 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: The critical access hospital is not required to participate in a quality improvement organization cooperative project, but its own projects are required to be of comparable effort.

CFR Number §482.21(d)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.21(d)(2)	**TAG: A-0297**	**PI.11.01.01**	**The critical access hospital has an ongoing quality assessment and performance improvement program.**
(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.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 critical access hospital's services and operations. Note 1: The critical access 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: The critical access 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)(3)	**TAG: A-0297**	**PI.12.01.01**	**The critical access hospital collects data.**
(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.		**EP 2**	The critical access hospital documents what quality improvement projects it is conducting, the reasons for conducting these projects, and the measurable progress achieved on these projects.
§482.21(d)(4)	**TAG: A-0297**	**PI.11.01.01**	**The critical access hospital has an ongoing quality assessment and performance improvement program.**
(4) A hospital is not required to participate in a QIO cooperative project, but its own projects are required to be of comparable effort.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 critical access hospital's services and operations. Note 1: The critical access 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: The critical access 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	**The critical access hospital improves performance.**
		EP 1	The critical access hospital acts on improvement priorities.
§482.21(e)	**TAG: A-0309**		
§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:			

CFR Number §482.21(e)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.21(e)(1)	**TAG: A-0309**	**LD.12.01.01**	**Leaders establish priorities for performance improvement. (Refer to the "Performance Improvement" [PI] chapter.)**
(1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the critical access 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 critical access hospital's performance and reducing risk to patients • The determination of the number of distinct improvement projects is conducted annually
		PI.14.01.01	**The critical access hospital improves performance.**
		EP 1	The critical access hospital acts on improvement priorities.
§482.21(e)(2)	**TAG: A-0309**	**LD.12.01.01**	**Leaders establish priorities for performance improvement. (Refer to the "Performance Improvement" [PI] chapter.)**
(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.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the critical access 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 critical access hospital's performance and reducing risk to patients • The determination of the number of distinct improvement projects is conducted annually
§482.21(e)(3)	**TAG: A-0286**	**LD.12.01.01**	**Leaders establish priorities for performance improvement. (Refer to the "Performance Improvement" [PI] chapter.)**
(3) That clear expectations for safety are established.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the critical access 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 critical access hospital's performance and reducing risk to patients • The determination of the number of distinct improvement projects is conducted annually

CFR Number §482.21(e)(4)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.21(e)(4)	**TAG: A-0315**	**LD.12.01.01**	**Leaders establish priorities for performance improvement. (Refer to the "Performance Improvement" [PI] chapter.)**
(4) That adequate resources are allocated for measuring, assessing, improving, and sustaining the hospital's performance and reducing risk to patients.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the critical access 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 critical access hospital’s performance and reducing risk to patients • The determination of the number of distinct improvement projects is conducted annually
§482.21(e)(5)	**TAG: A-0309**	**LD.12.01.01**	**Leaders establish priorities for performance improvement. (Refer to the "Performance Improvement" [PI] chapter.)**
(5) That the determination of the number of distinct improvement projects is conducted annually.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the critical access 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 critical access hospital’s performance and reducing risk to patients • The determination of the number of distinct improvement projects is conducted annually
§482.21(f)	**TAG: A-0320**	**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(f) Standard: Unified and integrated QAPI program for 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:		**EP 9**	If a critical access hospital is part of a system consisting of multiple separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency hospitals, the system governing body can elect to have a unified and integrated quality assessment and performance improvement program for all of its member facilities after determining that such decision is in accordance with all applicable state and local laws. Each separately certified critical access hospital subject to the system governing body demonstrates that the unified and integrated quality assessment and performance improvement program does the following: • Accounts for each member critical access hospital’s unique circumstances and any significant differences in patient populations and services offered • Establishes and implements policies and procedures to make certain that the needs and concerns of each of its separately certified hospitals, regardless of practice or location, are given due consideration, and that the unified and integrated program has mechanisms in place to ensure that issues localized to particular critical access hospitals are duly considered and addressed Note: The system governing body is responsible and accountable for making certain that each of its separately certified critical access hospitals meets the requirements for quality assessment and performance improvement at 42 CFR 485.641.

CFR Number §482.21(f)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.21(f)(1)	**TAG: A-0321**	**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(1) The unified and integrated QAPI program is established in a manner that takes into account each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital; and		**EP 9**	If a critical access hospital is part of a system consisting of multiple separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency hospitals, the system governing body can elect to have a unified and integrated quality assessment and performance improvement program for all of its member facilities after determining that such decision is in accordance with all applicable state and local laws. Each separately certified critical access hospital subject to the system governing body demonstrates that the unified and integrated quality assessment and performance improvement program does the following: • Accounts for each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered • Establishes and implements policies and procedures to make certain that the needs and concerns of each of its separately certified hospitals, regardless of practice or location, are given due consideration, and that the unified and integrated program has mechanisms in place to ensure that issues localized to particular critical access hospitals are duly considered and addressed Note: The system governing body is responsible and accountable for making certain that each of its separately certified critical access hospitals meets the requirements for quality assessment and performance improvement at 42 CFR 485.641.
§482.21(f)(2)	**TAG: A-0322**	**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(2) The unified and integrated QAPI program establishes and implements policies and procedures to ensure that the needs and concerns of each of its separately certified 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.		**EP 9**	If a critical access hospital is part of a system consisting of multiple separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency hospitals, the system governing body can elect to have a unified and integrated quality assessment and performance improvement program for all of its member facilities after determining that such decision is in accordance with all applicable state and local laws. Each separately certified critical access hospital subject to the system governing body demonstrates that the unified and integrated quality assessment and performance improvement program does the following: • Accounts for each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered • Establishes and implements policies and procedures to make certain that the needs and concerns of each of its separately certified hospitals, regardless of practice or location, are given due consideration, and that the unified and integrated program has mechanisms in place to ensure that issues localized to particular critical access hospitals are duly considered and addressed Note: The system governing body is responsible and accountable for making certain that each of its separately certified critical access hospitals meets the requirements for quality assessment and performance improvement at 42 CFR 485.641.
§482.22	**TAG: A-0338**	**MS.16.01.01**	**The organized medical staff oversees the quality of patient care, treatment, and services provided by physicians and other licensed practitioners privileged through the medical staff process.**
§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.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 critical access hospital.

CFR Number §482.22(a)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.22(a)	**TAG: A-0339**	**MS.14.01.01**	**Medical staff bylaws address self-governance and accountability to the governing body.**
§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.		**EP 2**	The medical staff bylaws include the qualifications for appointment and reappointment to the medical staff. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: 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. (See also MS.20.01.01, EP 1)
§482.22(a)(1)	**TAG: A-0340**	**MS.18.02.03**	**Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.**
(1) The medical staff must periodically conduct appraisals of its members.		**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: For rehabilitation or psychiatric distinct part units in critical access hospitals: Privileges are granted for a period not to exceed three years or for the period required by law and regulation if shorter.
§482.22(a)(2)	**TAG: A-0341**	**MS.17.01.03**	**The critical access hospital collects information regarding each physician's or other licensed practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.**
(2) 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.		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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: 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).

CFR Number §482.22(a)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.22(a)(3) **TAG: A-0342**		**MS.20.01.01**	**Physicians or other licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.**
(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:		**EP 1**	When telemedicine services are furnished to the critical access hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating critical access hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing such services if the critical access hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity: • The distant site telemedicine entity provides services in accordance with contract service requirements. • The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the critical access hospital's process and standards, at a minimum. • The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. • The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity. • The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the critical access hospital whose patients are receiving the telemedicine services is located. • For distant-site physicians or other licensed practitioners privileged by the originating critical access hospital, the originating critical access hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the critical access hospital's patients and complaints the critical access hospital has received about the distant-site physician or other licensed practitioner. Note 1: In the case of distant-site physicians and licensed practitioners providing telemedicine services to the critical access hospital's patients under a written agreement between the critical access hospital and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare participating provider or supplier. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2). (See also MS.14.01.01, EP 2)

CFR Number §482.22(a)(3)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.22(a)(3)(i) TAG: A-0342		**MS.20.01.01**	**Physicians or other licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.**
(i) The distant-site hospital providing the telemedicine services is a Medicare-participating hospital.		**EP 1**	When telemedicine services are furnished to the critical access hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating critical access hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing such services if the critical access hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity: • The distant site telemedicine entity provides services in accordance with contract service requirements. • The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the critical access hospital's process and standards, at a minimum. • The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. • The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity. • The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the critical access hospital whose patients are receiving the telemedicine services is located. • For distant-site physicians or other licensed practitioners privileged by the originating critical access hospital, the originating critical access hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the critical access hospital's patients and complaints the critical access hospital has received about the distant-site physician or other licensed practitioner. Note 1: In the case of distant-site physicians and licensed practitioners providing telemedicine services to the critical access hospital's patients under a written agreement between the critical access hospital and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare participating provider or supplier. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2). (See also MS.14.01.01, EP 2)

CFR Number §482.22(a)(3)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.22(a)(3)(ii) TAG: A-0342		**MS.20.01.01**	**Physicians or other licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.**
(ii) The individual distant-site physician or practitioner is privileged at the distant-site hospital providing the telemedicine services, which provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital.		**EP 1**	When telemedicine services are furnished to the critical access hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating critical access hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing such services if the critical access hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity: • The distant site telemedicine entity provides services in accordance with contract service requirements. • The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the critical access hospital's process and standards, at a minimum. • The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. • The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity. • The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the critical access hospital whose patients are receiving the telemedicine services is located. • For distant-site physicians or other licensed practitioners privileged by the originating critical access hospital, the originating critical access hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the critical access hospital's patients and complaints the critical access hospital has received about the distant-site physician or other licensed practitioner. Note 1: In the case of distant-site physicians and licensed practitioners providing telemedicine services to the critical access hospital's patients under a written agreement between the critical access hospital and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare participating provider or supplier. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2). (See also MS.14.01.01, EP 2)

CFR Number §482.22(a)(3)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.22(a)(3)(iii) TAG: A-0342		**MS.20.01.01**	**Physicians or other licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.**
(iii) The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the hospital whose patients are receiving the telemedicine services is located.		**EP 1**	When telemedicine services are furnished to the critical access hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating critical access hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing such services if the critical access hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity: • The distant site telemedicine entity provides services in accordance with contract service requirements. • The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the critical access hospital's process and standards, at a minimum. • The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. • The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity. • The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the critical access hospital whose patients are receiving the telemedicine services is located. • For distant-site physicians or other licensed practitioners privileged by the originating critical access hospital, the originating critical access hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the critical access hospital's patients and complaints the critical access hospital has received about the distant-site physician or other licensed practitioner. Note 1: In the case of distant-site physicians and licensed practitioners providing telemedicine services to the critical access hospital's patients under a written agreement between the critical access hospital and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare participating provider or supplier. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2). (See also MS.14.01.01, EP 2)

CFR Number §482.22(a)(3)(iv)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.22(a)(3)(iv) TAG: A-0342		**MS.20.01.01**	**Physicians or other licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.**
(iv) With respect to a distant-site physician or practitioner, who holds current privileges at the hospital whose patients are receiving the telemedicine services, the hospital has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site hospital such performance information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the hospital's patients and all complaints the hospital has received about the distant-site physician or practitioner.		**EP 1**	When telemedicine services are furnished to the critical access hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating critical access hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing such services if the critical access hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity: • The distant site telemedicine entity provides services in accordance with contract service requirements. • The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the critical access hospital's process and standards, at a minimum. • The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. • The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity. • The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the critical access hospital whose patients are receiving the telemedicine services is located. • For distant-site physicians or other licensed practitioners privileged by the originating critical access hospital, the originating critical access hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the critical access hospital's patients and complaints the critical access hospital has received about the distant-site physician or other licensed practitioner. Note 1: In the case of distant-site physicians and licensed practitioners providing telemedicine services to the critical access hospital's patients under a written agreement between the critical access hospital and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare participating provider or supplier. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2). (See also MS.14.01.01, EP 2)

CFR Number §482.22(a)(4)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.22(a)(4) TAG: A-0343		MS.20.01.01	**Physicians or other licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.**
4) When telemedicine services are furnished to the 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 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:		**EP 1**	When telemedicine services are furnished to the critical access hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating critical access hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing such services if the critical access hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity: • The distant site telemedicine entity provides services in accordance with contract service requirements. • The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the critical access hospital's process and standards, at a minimum. • The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. • The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity. • The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the critical access hospital whose patients are receiving the telemedicine services is located. • For distant-site physicians or other licensed practitioners privileged by the originating critical access hospital, the originating critical access hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the critical access hospital's patients and complaints the critical access hospital has received about the distant-site physician or other licensed practitioner. Note 1: In the case of distant-site physicians and licensed practitioners providing telemedicine services to the critical access hospital's patients under a written agreement between the critical access hospital and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare participating provider or supplier. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2). (See also MS.14.01.01, EP 2)

CFR Number §482.22(a)(4)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.22(a)(4)(i) **TAG: A-0343**		**MS.20.01.01**	**Physicians or other licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.**
(i) The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at §482.12(a)(1) through (a)(7) and §482.22(a)(1) through (a)(2).		**EP 1**	When telemedicine services are furnished to the critical access hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating critical access hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing such services if the critical access hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity: • The distant site telemedicine entity provides services in accordance with contract service requirements. • The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the critical access hospital's process and standards, at a minimum. • The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. • The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity. • The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the critical access hospital whose patients are receiving the telemedicine services is located. • For distant-site physicians or other licensed practitioners privileged by the originating critical access hospital, the originating critical access hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the critical access hospital's patients and complaints the critical access hospital has received about the distant-site physician or other licensed practitioner. Note 1: In the case of distant-site physicians and licensed practitioners providing telemedicine services to the critical access hospital's patients under a written agreement between the critical access hospital and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare participating provider or supplier. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2). (See also MS.14.01.01, EP 2)

CFR Number §482.22(a)(4)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.22(a)(4)(ii) TAG: A-0343		**MS.20.01.01**	**Physicians or other licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.**
(ii) The individual distant-site physician or practitioner is privileged at the distant-site telemedicine entity providing the telemedicine services, which provides the hospital with a current list of the distant-site physician's or practitioner's privileges at the distant-site telemedicine entity.		**EP 1**	When telemedicine services are furnished to the critical access hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating critical access hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing such services if the critical access hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity: • The distant site telemedicine entity provides services in accordance with contract service requirements. • The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the critical access hospital's process and standards, at a minimum. • The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. • The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity. • The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the critical access hospital whose patients are receiving the telemedicine services is located. • For distant-site physicians or other licensed practitioners privileged by the originating critical access hospital, the originating critical access hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the critical access hospital's patients and complaints the critical access hospital has received about the distant-site physician or other licensed practitioner. Note 1: In the case of distant-site physicians and licensed practitioners providing telemedicine services to the critical access hospital's patients under a written agreement between the critical access hospital and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare participating provider or supplier. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2). (See also MS.14.01.01, EP 2)

CFR Number §482.22(a)(4)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.22(a)(4)(iii) TAG: A-0343		**MS.20.01.01**	**Physicians or other licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.**
(iii) The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the hospital whose patients are receiving such telemedicine services is located.		**EP 1**	When telemedicine services are furnished to the critical access hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating critical access hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing such services if the critical access hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity: • The distant site telemedicine entity provides services in accordance with contract service requirements. • The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the critical access hospital's process and standards, at a minimum. • The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. • The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity. • The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the critical access hospital whose patients are receiving the telemedicine services is located. • For distant-site physicians or other licensed practitioners privileged by the originating critical access hospital, the originating critical access hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the critical access hospital's patients and complaints the critical access hospital has received about the distant-site physician or other licensed practitioner. Note 1: In the case of distant-site physicians and licensed practitioners providing telemedicine services to the critical access hospital's patients under a written agreement between the critical access hospital and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare participating provider or supplier. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2). (See also MS.14.01.01, EP 2)

CFR Number §482.22(a)(4)(iv)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.22(a)(4)(iv) **TAG: A-0343**		**MS.20.01.01**	**Physicians or other licensed practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.**
(iv) With respect to a distant-site physician or practitioner, who holds current privileges at the hospital whose patients are receiving the telemedicine services, the hospital has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site telemedicine entity such performance information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the hospital's patients, and all complaints the hospital has received about the distant-site physician or practitioner.		**EP 1**	When telemedicine services are furnished to the critical access hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating critical access hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing such services if the critical access hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity: • The distant site telemedicine entity provides services in accordance with contract service requirements. • The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the critical access hospital's process and standards, at a minimum. • The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. • The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity. • The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the critical access hospital whose patients are receiving the telemedicine services is located. • For distant-site physicians or other licensed practitioners privileged by the originating critical access hospital, the originating critical access hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the critical access hospital's patients and complaints the critical access hospital has received about the distant-site physician or other licensed practitioner. Note 1: In the case of distant-site physicians and licensed practitioners providing telemedicine services to the critical access hospital's patients under a written agreement between the critical access hospital and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare participating provider or supplier. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2). (See also MS.14.01.01, EP 2)
§482.22(b) **TAG: A-0347**		**LD.11.02.01**	**The critical access hospital has an organized medical staff that is accountable to the governing body.**
§482.22(b) Standard: Medical Staff Organization and Accountability The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients.		**EP 1**	The critical access hospital has an organized medical staff that is accountable to the governing body for the quality of care provided to patients.
§482.22(b)(1) **TAG: A-0347**		**LD.11.02.01**	**The critical access hospital has an organized medical staff that is accountable to the governing body.**
(1) The medical staff must be organized in a manner approved by the governing body.		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body approves the structure of the organized medical staff.

CFR Number §482.22(b)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.22(b)(2)	**TAG: A-0347**	**MS.15.01.01**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: There is a medical staff executive committee. Note: The medical staff as a whole may serve as the executive committee. In smaller, less complex critical access hospitals where the entire medical staff functions as the executive committee, it is often designated as a committee of the whole.**
(2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The majority of voting medical staff executive committee members are fully licensed doctors of medicine or osteopathy actively practicing in the critical access hospital.
§482.22(b)(3)	**TAG: A-0347**		
(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)	**TAG: A-0347**	**LD.11.02.01**	**The critical access hospital has an organized medical staff that is accountable to the governing body.**
(i) An individual doctor of medicine or osteopathy.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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)	**TAG: A-0347**	**LD.11.02.01**	**The critical access hospital has an organized medical staff that is accountable to the governing body.**
(ii) A doctor of dental surgery or dental medicine, when permitted by State law of the State in which the hospital is located.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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)(iii)	**TAG: A-0347**	**LD.11.02.01**	**The critical access hospital has an organized medical staff that is accountable to the governing body.**
(iii) A doctor of podiatric medicine, when permitted by State law of the State in which the hospital is located.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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)	**TAG: A-0348**		
(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)	**TAG: A-0349**	**MS.14.03.01**	**Multihospital systems can choose to establish a unified and integrated medical staff in accordance with state and local laws.**
(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;		**EP 1**	If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals, and the system chooses to establish a unified and integrated medical staff, in accordance with state and local laws, the following occurs: Each separately accredited critical access hospital demonstrates that its medical staff members (that is, all medical staff members who hold privileges to practice at that specific hospital) have voted by majority, in accordance with medical staff bylaws, either to accept the unified and integrated medical staff structure or to opt out of such a structure and maintain a separate and distinct medical staff for their critical access hospital.

CFR Number §482.22(b)(4)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.22(b)(4)(ii)	**TAG: A-0350**	**MS.14.03.01**	**Multihospital systems can choose to establish a unified and integrated medical staff in accordance with state and local laws.**
(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;		**EP 4**	If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals, and the system chooses to establish a unified and integrated medical staff, the unified and integrated medical staff bylaws, rules, and requirements include the following: • Process for self-governance, appointment, credentialing, privileging, and oversight, as well as its peer review policies and due process rights guarantees • Description of the process by which medical staff members at each separately accredited hospital (that is, all medical staff members who hold privileges to practice at that specific hospital) are advised of their right to opt out of the unified and integrated medical staff structure after a majority vote by the members to maintain a separate and distinct medical staff for their respective critical access hospital
§482.22(b)(4)(iii)	**TAG: A-0351**	**MS.14.03.01**	**Multihospital systems can choose to establish a unified and integrated medical staff in accordance with state and local laws.**
(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		**EP 2**	If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals, and the system chooses to establish a unified and integrated medical staff, the following occurs: The unified and integrated medical staff takes into account each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital, critical access hospital, and rural emergency hospital.
§482.22(b)(4)(iv)	**TAG: A-0352**	**MS.14.03.01**	**Multihospital systems can choose to establish a unified and integrated medical staff in accordance with state and local laws.**
(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.		**EP 3**	If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals, and the system chooses to establish a unified and integrated medical staff, the following occurs: The unified and integrated medical staff develops and implements policies and procedures and mechanisms to make certain that the needs and concerns expressed by members of the medical staff at each of its separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals, regardless of practice or location, are duly considered and addressed.
§482.22(c)	**TAG: A-0353**		
§482.22(c) Standard: Medical Staff Bylaws The medical staff must adopt and enforce bylaws to carry out its responsibilities. The bylaws must:			
§482.22(c)(1)	**TAG: A-0354**	**MS.14.01.01**	**Medical staff bylaws address self-governance and accountability to the governing body.**
(1) Be approved by the governing body.		**EP 1**	The medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following: • Description of the organization of the medical staff, including criteria for medical staff membership • 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 • For rehabilitation or psychiatric distinct part units in critical access hospitals: Statement of the duties and privileges of each category of medical staff (for example, active, courtesy) Note: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the critical access 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).

CFR Number §482.22(c)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.22(c)(2)	**TAG: A-0355**	**MS.14.01.01**	**Medical staff bylaws address self-governance and accountability to the governing body.**
(2) Include a statement of the duties and privileges of each category of medical staff (e.g., active, courtesy, etc.)		**EP 1**	The medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following: • Description of the organization of the medical staff, including criteria for medical staff membership • 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 • For rehabilitation or psychiatric distinct part units in critical access hospitals: Statement of the duties and privileges of each category of medical staff (for example, active, courtesy) Note: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the critical access 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)	**TAG: A-0356**	**MS.14.01.01**	**Medical staff bylaws address self-governance and accountability to the governing body.**
(3) Describe the organization of the medical staff.		**EP 1**	The medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following: • Description of the organization of the medical staff, including criteria for medical staff membership • 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 • For rehabilitation or psychiatric distinct part units in critical access hospitals: Statement of the duties and privileges of each category of medical staff (for example, active, courtesy) Note: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the critical access 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)	**TAG: A-0357**	**MS.14.01.01**	**Medical staff bylaws address self-governance and accountability to the governing body.**
(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.		**EP 1**	The medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following: • Description of the organization of the medical staff, including criteria for medical staff membership • 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 • For rehabilitation or psychiatric distinct part units in critical access hospitals: Statement of the duties and privileges of each category of medical staff (for example, active, courtesy) Note: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the critical access 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)	**TAG: A-0358**		
(5) Include a requirement that --			

CFR Number §482.22(c)(5)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.22(c)(5)(i)	**TAG: A-0358**	**MS.14.01.01**	**Medical staff bylaws address self-governance and accountability to the governing body.**
(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.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The medical staff bylaws include requirements for the following: • Medical history and physical examination for each patient as described in PC.10.01.01, EP 1 • Updated patient examinations as described in PC.10.01.01, EP 2 • Assessments in lieu of medical history and physical examinations for patients as described in PC.10.01.01, EP 3
§482.22(c)(5)(ii)	**TAG: A-0359**	**MS.14.01.01**	**Medical staff bylaws address self-governance and accountability to the governing body.**
(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 licensed individual in accordance with State law and hospital policy.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The medical staff bylaws include requirements for the following: • Medical history and physical examination for each patient as described in PC.10.01.01, EP 1 • Updated patient examinations as described in PC.10.01.01, EP 2 • Assessments in lieu of medical history and physical examinations for patients as described in PC.10.01.01, EP 3
§482.22(c)(5)(iii)	**TAG: A-0360**	**MS.14.01.01**	**Medical staff bylaws address self-governance and accountability to the governing body.**
(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.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The medical staff bylaws include requirements for the following: • Medical history and physical examination for each patient as described in PC.10.01.01, EP 1 • Updated patient examinations as described in PC.10.01.01, EP 2 • Assessments in lieu of medical history and physical examinations for patients as described in PC.10.01.01, EP 3
§482.22(c)(5)(iv)	**TAG: A-0361**	**MS.16.01.01**	**The organized medical staff oversees the quality of patient care, treatment, and services provided by physicians and other licensed practitioners privileged through the medical staff process.**
(iv) The medical staff develop and maintain a policy that identifies those patients for whom the assessment requirements of paragraph (c)(5)(iii) of this section would apply. The provisions of paragraphs (c)(5)(iii), (iv), and (v) of this section do not apply to a medical staff that chooses to maintain a policy that adheres to the requirements of paragraphs of (c)(5)(i) and (ii) of this section for all patients.		**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 critical access hospital demonstrates evidence that the policy applies only to those patients receiving specific outpatient surgical or procedural services. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: 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/.

CFR Number §482.22(c)(5)(v)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.22(c)(5)(v) **TAG: A-0362**		**MS.16.01.01**	**The organized medical staff oversees the quality of patient care, treatment, and services provided by physicians and other licensed practitioners privileged through the medical staff process.**
(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:		**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 critical access hospital demonstrates evidence that the policy applies only to those patients receiving specific outpatient surgical or procedural services. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: 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) **TAG: A-0362**		**MS.16.01.01**	**The organized medical staff oversees the quality of patient care, treatment, and services provided by physicians and other licensed practitioners privileged through the medical staff process.**
(A) Patient age, diagnoses, the type and number of surgeries and procedures scheduled to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure.		**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 critical access hospital demonstrates evidence that the policy applies only to those patients receiving specific outpatient surgical or procedural services. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: 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) **TAG: A-0362**		**MS.16.01.01**	**The organized medical staff oversees the quality of patient care, treatment, and services provided by physicians and other licensed practitioners privileged through the medical staff process.**
(B) Nationally recognized guidelines and standards of practice for assessment of specific types of patients prior to specific outpatient surgeries and procedures.		**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 critical access hospital demonstrates evidence that the policy applies only to those patients receiving specific outpatient surgical or procedural services. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: 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/.

CFR Number §482.22(c)(5)(v)(C)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.22(c)(5)(v)(C)	**TAG: A-0362**	**MS.16.01.01**	**The organized medical staff oversees the quality of patient care, treatment, and services provided by physicians and other licensed practitioners privileged through the medical staff process.**
(C) Applicable state and local health and safety laws.		**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 critical access hospital demonstrates evidence that the policy applies only to those patients receiving specific outpatient surgical or procedural services. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: 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)	**TAG: A-0363**	**MS.14.01.01**	**Medical staff bylaws address self-governance and accountability to the governing body.**
(6) Include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges. For distant-site physicians and practitioners requesting privileges to furnish telemedicine services under an agreement with the hospital, the criteria for determining privileges and the procedure for applying the criteria are also subject to the requirements in §482.12(a)(8) and (a)(9), and §482.22(a)(3) and (a)(4).		**EP 1**	The medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following: • Description of the organization of the medical staff, including criteria for medical staff membership • 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 • For rehabilitation or psychiatric distinct part units in critical access hospitals: Statement of the duties and privileges of each category of medical staff (for example, active, courtesy) Note: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the critical access 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).
§482.23	**TAG: A-0385**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§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.		**EP 2**	The critical access hospital has an organized nursing service, with a plan of administrative authority and delineation of responsibility for patient care, that provides nursing services to meet the needs of its patients. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: Rural hospitals with a 24-hour nursing waiver granted under 42 CFR 488.54(c) are not required to have 24-hour nursing services.
		NPG.12.02.01	**The nurse executive directs the implementation of a nurse staffing plan(s).**
		EP 4	A registered nurse provides (or assign to other staff) the nursing care of each patient, including patients at a skilled nursing facility level of care in a swing-bed critical access hospital. The care is provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available. Note 1: For rehabilitation and psychiatric distinct part units in critical access hospitals: A registered nurse directly provides or supervises the nursing services provided by other staff to patients 24 hours a day, 7 days a week. The critical access hospital has a licensed practical nurse or registered nurse on duty at all times. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: Rural hospitals with a 24-hour nursing waiver granted under 42 CFR 488.54(c) are not required to have 24-hour nursing services.

CFR Number §482.23(a)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.23(a)	**TAG: A-0386**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§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.		**EP 2**	The critical access hospital has an organized nursing service, with a plan of administrative authority and delineation of responsibility for patient care, that provides nursing services to meet the needs of its patients. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: Rural hospitals with a 24-hour nursing waiver granted under 42 CFR 488.54(c) are not required to have 24-hour nursing services.
		NPG.12.02.01	**The nurse executive directs the implementation of a nurse staffing plan(s).**
		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 procedure • Types and numbers of nursing and other staff necessary to provide nursing care for all areas of the hospital
§482.23(b)	**TAG: A-0392**	**NPG.12.02.01**	**The nurse executive directs the implementation of a nurse staffing plan(s).**
§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.		**EP 5**	For rehabilitation and psychiatric distinct part units in critical access hospitals: There is an adequate number of licensed registered nurses, licensed practical (vocational) nurses, and other staff to provide nursing care to all patients. Note: To make certain the immediate availability of a registered nurse for the care of any patient, there are supervisors and staff for each department or nursing unit.
§482.23(b)(1)	**TAG: A-0393**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(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.		**EP 2**	The critical access hospital has an organized nursing service, with a plan of administrative authority and delineation of responsibility for patient care, that provides nursing services to meet the needs of its patients. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: Rural hospitals with a 24-hour nursing waiver granted under 42 CFR 488.54(c) are not required to have 24-hour nursing services.
		NPG.12.02.01	**The nurse executive directs the implementation of a nurse staffing plan(s).**
		EP 4	A registered nurse provides (or assign to other staff) the nursing care of each patient, including patients at a skilled nursing facility level of care in a swing-bed critical access hospital. The care is provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available. Note 1: For rehabilitation and psychiatric distinct part units in critical access hospitals: A registered nurse directly provides or supervises the nursing services provided by other staff to patients 24 hours a day, 7 days a week. The critical access hospital has a licensed practical nurse or registered nurse on duty at all times. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: Rural hospitals with a 24-hour nursing waiver granted under 42 CFR 488.54(c) are not required to have 24-hour nursing services.
§482.23(b)(2)	**TAG: A-0394**	**HR.11.01.03**	**The critical access hospital determines how staff function within the organization.**
(2) The nursing service must have a procedure to ensure that hospital nursing personnel for whom licensure is required have valid and current licensure.		**EP 3**	The critical access 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. • 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 critical access hospital determines the required qualifications for staff based on job responsibilities.

CFR Number §482.23(b)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.23(b)(3)	**TAG: A-0395**	**NR.11.01.01**	**The nurse executive directs the implementation of nursing policies and procedures, nursing standards, and a nurse staffing plan(s).**
(3) A registered nurse must supervise and evaluate the nursing care for each patient.		**EP 4**	A registered nurse (or physician assistant, when permitted by state law) supervises and evaluates the nursing care for each patient, including patients at a skilled nursing facility-level of care in a swing-bed critical access hospital.
§482.23(b)(4)	**TAG: A-0396**	**PC.11.03.01**	**The critical access hospital plans the patient's care.**
(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.		**EP 1**	The critical access hospital develops, implements, and revises a written individualized plan of care based on the following: • Needs identified by the patient's assessment, reassessment, and results of diagnostic testing • The patient's goals and the time frames, settings, and services required to meet those goals Note 1: Nursing staff develops and keeps current a nursing plan of care, which may be a part of an interdisciplinary plan of care, for each inpatient. Note 2: The hospital evaluates the patient's progress and revises the plan of care based on the patient's progress. Note 3: For rehabilitation distinct part units in critical access hospitals: The plan is reviewed and revised as needed by a physician in consultation with other professional staff who provide services to the patient.
§482.23(b)(5)	**TAG: A-0397**	**NR.11.01.01**	**The nurse executive directs the implementation of nursing policies and procedures, nursing standards, and a nurse staffing plan(s).**
(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.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: A registered nurse assigns the nursing care for each patient to other nursing staff in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available.
§482.23(b)(6)	**TAG: A-0398**	**NR.11.01.01**	**The nurse executive directs the implementation of nursing policies and procedures, nursing standards, and a nurse staffing plan(s).**
(6) All licensed nurses who provide services in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of all nursing personnel which occur within the responsibility of the nursing services, regardless of the mechanism through which those personnel are providing services (that is, hospital employee, contract, lease, other agreement, or volunteer).		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: All licensed nurses who provide services in the critical access 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).
		EP 3	The nurse executive provides for the supervision and evaluation of the clinical activities of all nursing staff in accordance with nursing policies and procedures. Note: This applies to all nursing staff who are providing services (that is, hospital employee, contract, lease, other agreement, or volunteer).
§482.23(b)(7)	**TAG: A-0399**	**NPG.12.02.01**	**The nurse executive directs the implementation of a nurse staffing plan(s).**
(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:		**EP 7**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 provided, the general level of acuity of patients served by the department, and established standards of practice for the services provided • Describe alternative staffing plans • Are approved by the nurse executive • Are reviewed at least once every three years

CFR Number §482.23(b)(7)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.23(b)(7)(i)	**TAG: A-0399**	**NPG.12.02.01**	**The nurse executive directs the implementation of a nurse staffing plan(s).**
(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;		**EP 7**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 provided, the general level of acuity of patients served by the department, and established standards of practice for the services provided • Describe alternative staffing plans • Are approved by the nurse executive • Are reviewed at least once every three years
§482.23(b)(7)(ii)	**TAG: A-0399**	**NPG.12.02.01**	**The nurse executive directs the implementation of a nurse staffing plan(s).**
(ii) Establish alternative staffing plans;		**EP 7**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 provided, the general level of acuity of patients served by the department, and established standards of practice for the services provided • Describe alternative staffing plans • Are approved by the nurse executive • Are reviewed at least once every three years
§482.23(b)(7)(iii)	**TAG: A-0399**	**NPG.12.02.01**	**The nurse executive directs the implementation of a nurse staffing plan(s).**
(iii) Be approved by the director of nursing;		**EP 7**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 provided, the general level of acuity of patients served by the department, and established standards of practice for the services provided • Describe alternative staffing plans • Are approved by the nurse executive • Are reviewed at least once every three years
§482.23(b)(7)(iv)	**TAG: A-0399**	**NPG.12.02.01**	**The nurse executive directs the implementation of a nurse staffing plan(s).**
(iv) Be reviewed at least once every 3 years.		**EP 7**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 provided, the general level of acuity of patients served by the department, and established standards of practice for the services provided • Describe alternative staffing plans • Are approved by the nurse executive • Are reviewed at least once every three years
§482.23(c)	**TAG: A-0405**		
(c) Standard: Preparation and administration of drugs.			

CFR Number §482.23(c)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.23(c)(1)	**TAG: A-0405**	**MM.16.01.01**	**The critical access hospital safely administers medications.**
(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.		**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 rehabilitation and psychiatric distinct part units in critical access hospitals: 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).
§482.23(c)(1)(i)	**TAG: A-0405**	**MM.16.01.01**	**The critical access hospital safely administers medications.**
(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.		**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 rehabilitation and psychiatric distinct part units in critical access hospitals: 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).
§482.23(c)(1)(ii)	**TAG: A-0406**	**MM.16.01.01**	**The critical access hospital safely administers medications.**
(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).		**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 rehabilitation and psychiatric distinct part units in critical access hospitals: 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).
§482.23(c)(2)	**TAG: A-0405**	**MM.16.01.01**	**The critical access hospital safely administers medications.**
(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.		**EP 2**	Drugs, biologicals, and intravenous medications are administered by, or under the supervision of, a registered nurse, a doctor of medicine or osteopathy, or, where permitted by state law, a physician assistant. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: Drugs and biologicals are administered by, or under supervision of, nursing or other staff in accordance with federal and state laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures.
§482.23(c)(3)	**TAG: A-0406**	**MM.14.01.01**	**Medication orders are clear and accurate.**
(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.		**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.
§482.23(c)(3)(i)	**TAG: A-0407**	**MM.14.01.01**	**Medication orders are clear and accurate.**
(i) If verbal orders are used, they are to be used infrequently.		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital minimizes the use of verbal and telephone medication orders.

CFR Number §482.23(c)(3)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.23(c)(3)(ii)	**TAG: A-0408**	**RC.12.02.01**	**Qualified staff receive and record verbal orders.**
(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.		**EP 1**	Only staff authorized by critical access hospital policies and procedures consistent with federal and state law accept and record verbal orders.
§482.23(c)(3)(iii)	**TAG: A-0409**	**MM.14.01.01**	**Medication orders are clear and accurate.**
(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.		**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.
§482.23(c)(4)	**TAG: A-0410**	**PC.12.01.01**	**The critical access hospital provides care, treatment, and services as ordered or prescribed and in accordance with law and regulation.**
(4) Blood transfusions and intravenous medications must be administered in accordance with State law and approved medical staff policies and procedures.		**EP 3**	The critical access hospital administers blood transfusions and intravenous medications in accordance with state law and approved medical staff policies and procedures.
§482.23(c)(5)	**TAG: A-0411**	**MM.17.01.01**	**The critical access hospital responds to actual or potential adverse drug events, significant adverse drug reactions, and medication errors.**
(5) There must be a hospital procedure for reporting transfusion reactions, adverse drug reactions, and errors in administration of drugs.		**EP 1**	The critical access hospital develops and implements policies and procedures for reporting transfusion reactions, adverse drug reactions, and errors in administration of drugs. Note: This element of performance is also applicable to sample medications.
§482.23(c)(6)	**TAG: A-0412**	**MM.16.01.01**	**The critical access hospital safely administers medications.**
(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.		**EP 3**	The critical access 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 critical access hospital–issued medications and the patient's own medications brought into the critical access hospital. Note 2: The term "self-administered medication(s)" may refer to medications administered by a family member.
§482.23(c)(6)(i)	**TAG: A-0412**		
(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)	**TAG: A-0412**	**MM.16.01.01**	**The critical access hospital safely administers medications.**
(A) Ensure that a practitioner responsible for the care of the patient has issued an order, consistent with hospital policy, permitting self-administration.		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access hospital allows a patient to self-administer specific hospital-issued medications, the critical access 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 critical access 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.

CFR Number §482.23(c)(6)(i)(B)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.23(c)(6)(i)(B)	**TAG: A-0412**	**MM.16.01.01**	**The critical access hospital safely administers medications.**
(B) Assess the capacity of the patient (or the patient's caregiver/support person where appropriate) to self-administer the specified medication(s).		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access hospital allows a patient to self-administer specific hospital-issued medications, the critical access 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 critical access 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)	**TAG: A-0412**	**MM.16.01.01**	**The critical access hospital safely administers medications.**
(C) Instruct the patient (or the patient's caregiver/support person where appropriate) in the safe and accurate administration of the specified medication(s).		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access hospital allows a patient to self-administer specific hospital-issued medications, the critical access 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 critical access 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)(D)	**TAG: A-0412**	**MM.16.01.01**	**The critical access hospital safely administers medications.**
(D) Address the security of the medication(s) for each patient.		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access hospital allows a patient to self-administer specific hospital-issued medications, the critical access 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 critical access 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.

CFR Number §482.23(c)(6)(i)(E)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.23(c)(6)(i)(E) **TAG: A-0412**		**RC.12.01.01**	**The medical record contains information that reflects the patient's care, treatment, and services.**
(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.		**EP 2**	The medical record contains the following clinical information: • Admitting diagnosis • Any emergency care, treatment, and services provided to the patient before their arrival • Any allergies to food and medications • Any findings of assessments and reassessments • Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient • Treatment goals, plan of care, and revisions to the plan of care • Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia • All practitioners' orders • Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition • Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the critical access hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. • Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) • Records of radiology and nuclear medicine services, including signed interpretation reports • All care, treatment, and services provided to the patient • Patient's response to care, treatment, and services • Medical history and physical examination, including any conclusions or impressions drawn from the information • Discharge plan and discharge planning evaluation • Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge • Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis.
§482.23(c)(6)(ii) **TAG: A-0413**			
(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) **TAG: A-0413**		**MM.16.01.01**	**The critical access hospital safely administers medications.**
(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.		**EP 5**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access hospital allows a patient to self-administer their own specific medications brought into the hospital, the critical access 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 critical access 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.

CFR Number §482.23(c)(6)(ii)(B)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.23(c)(6)(ii)(B)	**TAG: A-0413**	**MM.16.01.01**	**The critical access hospital safely administers medications.**
(B) Assess the capacity of the patient (or the patient's caregiver/support person where appropriate) to self-administer the specified medication(s), and also determine if the patient (or the patient's caregiver/support person where appropriate) needs instruction in the safe and accurate administration of the specified medication(s).		**EP 5**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access hospital allows a patient to self-administer their own specific medications brought into the hospital, the critical access 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 critical access 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)	**TAG: A-0413**	**MM.16.01.01**	**The critical access hospital safely administers medications.**
(C) Identify the specified medication(s) and visually evaluate the medication(s) for integrity.		**EP 5**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access hospital allows a patient to self-administer their own specific medications brought into the hospital, the critical access 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 critical access 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)	**TAG: A-0413**	**MM.16.01.01**	**The critical access hospital safely administers medications.**
(D) Address the security of the medication(s) for each patient.		**EP 5**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access hospital allows a patient to self-administer their own specific medications brought into the hospital, the critical access 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 critical access 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.

CFR Number §482.23(c)(6)(ii)(E)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.23(c)(6)(ii)(E) **TAG: A-0413**		**RC.12.01.01**	**The medical record contains information that reflects the patient's care, treatment, and services.**
(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.		**EP 2**	The medical record contains the following clinical information: • Admitting diagnosis • Any emergency care, treatment, and services provided to the patient before their arrival • Any allergies to food and medications • Any findings of assessments and reassessments • Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient • Treatment goals, plan of care, and revisions to the plan of care • Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia • All practitioners' orders • Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition • Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the critical access hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. • Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) • Records of radiology and nuclear medicine services, including signed interpretation reports • All care, treatment, and services provided to the patient • Patient's response to care, treatment, and services • Medical history and physical examination, including any conclusions or impressions drawn from the information • Discharge plan and discharge planning evaluation • Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge • Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis.

CFR Number §482.24	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.24 **TAG: A-0431**		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§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.		**EP 1**	The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: • Outpatient • Emergency • Medical records • Diagnostic and therapeutic radiology • Nuclear medicine • Surgical • Anesthesia • Laboratory • Respiratory • Dietetic • Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital.
		RC.11.01.01	**The critical access hospital maintains complete and accurate medical records for each individual patient.**
		EP 1	The critical access hospital maintains a medical record for every inpatient and outpatient in the critical access hospital.
§482.24(a) **TAG: A-0432**		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§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.		**EP 1**	The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: • Outpatient • Emergency • Medical records • Diagnostic and therapeutic radiology • Nuclear medicine • Surgical • Anesthesia • Laboratory • Respiratory • Dietetic • Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital.

CFR Number §482.24(a)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		NPG.12.01.01	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
		EP 6	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has a medical record service that has administrative responsibility for medical records. The critical access hospital employs adequate staff to support the prompt completion, filing, and retrieval of records.
§482.24(b)	**TAG: A-0438**	**RC.11.01.01**	**The critical access hospital maintains complete and accurate medical records for each individual patient.**
§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.		**EP 1**	The critical access hospital maintains a medical record for every inpatient and outpatient in the critical access hospital.
		EP 4	The critical access hospital develops and implements policies and procedures for accurate, legible, complete, signed, dated, and timed medical record entries that are authenticated by the person responsible for providing or evaluating the service provided. Medical records are promptly completed, systematically organized, and readily accessible.
		RC.11.02.01	**Entries in the medical record are authenticated.**
		EP 2	The critical access 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.
§482.24(b)(1)	**TAG: A-0439**	**RC.11.03.01**	**The critical access hospital retains its medical records.**
(1) Medical records must be retained in their original or legally reproduced form for a period of at least 5 years.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The retention time of the original or legally reproduced medical record is determined by its use and critical access hospital policy, in accordance with law and regulation. Note: 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)	**TAG: A-0440**	**IM.13.01.03**	**The critical access hospital retrieves, disseminates, and transmits health information in useful formats.**
(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.		**EP 1**	The critical access 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 rehabilitation and psychiatric distinct part units in critical access hospitals: The medical records system allows for timely retrieval of patient information by diagnosis and procedure.
§482.24(b)(3)	**TAG: A-0441**	**IM.12.01.01**	**The critical access hospital protects the privacy and confidentiality of health information.**
(3) The hospital must have a procedure for ensuring the confidentiality of patient records. Information from or copies of records may be released only to authorized individuals, and the hospital must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released by the hospital only in accordance with Federal or State laws, court orders, or subpoenas.		**EP 1**	The critical access hospital develops and implements policies and procedures addressing the privacy and confidentiality of health information. Note: For swing beds in critical access hospitals: Policies and procedures also address the resident's personal records.
		EP 3	The critical access hospital develops and implements policies and procedures for the release of medical records. The policies and procedures are in accordance with law and regulation, court orders, or subpoenas. Note: Information from or copies of records may be released only to authorized individuals, and the critical access hospital makes certain that unauthorized individuals cannot gain access to or alter patient records.
		IM.12.01.03	**The critical access hospital maintains the security and integrity of health information.**
		EP 1	The critical access hospital develops and implements a written policy that addresses the security of health information, including the following: • Access and use • Integrity of health information against loss, damage, unauthorized alteration or use, unintentional change, and accidental destruction • Intentional destruction of health information • When and by whom the removal of health information is permitted Note: Removal refers to those actions that place health information outside the critical access hospital's control.

CFR Number §482.24(c)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.24(c)	**TAG: A-0449**	**RC.11.01.01**	**The critical access hospital maintains complete and accurate medical records for each individual patient.**
§482.24(c) Standard: Content of Record The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.		**EP 2**	The medical record includes the following: • Information needed to justify the patient's admission and continued care, treatment, and services • Information needed to support the patient's diagnosis and condition • Information about the patient's care, treatment, and services that promotes continuity of care among staff and providers Note: For critical access hospitals that elect Joint Commission's Primary Care Medical Home option: This requirement refers to care provided by both internal and external providers.
		RC.12.01.01	**The medical record contains information that reflects the patient's care, treatment, and services.**
		EP 2	The medical record contains the following clinical information: • Admitting diagnosis • Any emergency care, treatment, and services provided to the patient before their arrival • Any allergies to food and medications • Any findings of assessments and reassessments • Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient • Treatment goals, plan of care, and revisions to the plan of care • Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia • All practitioners' orders • Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition • Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the critical access hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. • Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) • Records of radiology and nuclear medicine services, including signed interpretation reports • All care, treatment, and services provided to the patient • Patient's response to care, treatment, and services • Medical history and physical examination, including any conclusions or impressions drawn from the information • Discharge plan and discharge planning evaluation • Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge • Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis.
§482.24(c)(1)	**TAG: A-0450**	**RC.11.01.01**	**The critical access hospital maintains complete and accurate medical records for each individual patient.**
(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.		**EP 4**	The critical access hospital develops and implements policies and procedures for accurate, legible, complete, signed, dated, and timed medical record entries that are authenticated by the person responsible for providing or evaluating the service provided. Medical records are promptly completed, systematically organized, and readily accessible.

CFR Number §482.24(c)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.24(c)(2)	**TAG: A-0454**	**RC.11.02.01**	**Entries in the medical record are authenticated.**
(2) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.		**EP 1**	All orders, including verbal orders, are dated, timed, and authenticated by the ordering physician or other licensed practitioner who is responsible for the patient's care and who is authorized to write orders, in accordance with critical access hospital policy, law and regulation, and medical staff bylaws, rules, and regulations.
§482.24(c)(3)	**TAG: A-0457**		
(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)	**TAG: A-0457**	**RC.12.01.01**	**The medical record contains information that reflects the patient's care, treatment, and services.**
(i) Establishes that such orders and protocols have been reviewed and approved by the medical staff and the hospital’s nursing and pharmacy leadership;		**EP 5**	The critical access 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 critical access 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 critical access 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, critical access hospital policies, and medical staff bylaws, rules, and regulations.
§482.24(c)(3)(ii)	**TAG: A-0457**	**RC.12.01.01**	**The medical record contains information that reflects the patient's care, treatment, and services.**
(ii) Demonstrates that such orders and protocols are consistent with nationally recognized and evidence-based guidelines;		**EP 5**	The critical access 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 critical access 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 critical access 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, critical access hospital policies, and medical staff bylaws, rules, and regulations.

CFR Number §482.24(c)(3)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.24(c)(3)(iii)	**TAG: A-0457**	**RC.12.01.01**	**The medical record contains information that reflects the patient's care, treatment, and services.**
(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		**EP 5**	The critical access 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 critical access 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 critical access 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, critical access hospital policies, and medical staff bylaws, rules, and regulations.
§482.24(c)(3)(iv)	**TAG: A-0457**	**RC.12.01.01**	**The medical record contains information that reflects the patient's care, treatment, and services.**
(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 accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.		**EP 5**	The critical access 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 critical access 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 critical access 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, critical access hospital policies, and medical staff bylaws, rules, and regulations.
§482.24(c)(4)	**TAG: A-0458**		
(4) All records must document the following, as appropriate:			
§482.24(c)(4)(i)	**TAG: A-0458**		
(i) Evidence of--			
§482.24(c)(4)(i)(A)	**TAG: A-0458**	**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(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.		**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 rehabilitation and psychiatric distinct part units in critical access hospitals: 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	**The medical record contains information that reflects the patient's care, treatment, and services.**
		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.

CFR Number §482.24(c)(4)(i)(B)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.24(c)(4)(i)(B)	**TAG: A-0461**	**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(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.		**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 rehabilitation and psychiatric distinct part units in critical access hospitals: 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), refer to https://www.ecfr.gov/.
		RC.12.01.01	**The medical record contains information that reflects the patient's care, treatment, and services.**
		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.
§482.24(c)(4)(i)(C)	**TAG: A-0462**	**RC.12.01.01**	**The medical record contains information that reflects the patient's care, treatment, and services.**
(C) An assessment of the patient (in lieu of the requirements of paragraphs (c)(4)(i)(A) and (B) of this section) completed and documented after registration, but prior to surgery or a procedure requiring anesthesia services, when the patient is receiving specific outpatient surgical or procedural services and when the medical staff has chosen to develop and maintain a policy that identifies, in accordance with the requirements at § 482.22(c)(5)(v), specific patients as not requiring a comprehensive medical history and physical examination, or any update to it, prior to specific outpatient surgical or procedural services.		**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.

CFR Number §482.24(c)(4)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.24(c)(4)(ii)	**TAG: A-0463**	**RC.12.01.01**	**The medical record contains information that reflects the patient's care, treatment, and services.**
(ii) Admitting diagnosis.		**EP 2**	The medical record contains the following clinical information: • Admitting diagnosis • Any emergency care, treatment, and services provided to the patient before their arrival • Any allergies to food and medications • Any findings of assessments and reassessments • Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient • Treatment goals, plan of care, and revisions to the plan of care • Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia • All practitioners' orders • Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition • Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the critical access hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. • Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) • Records of radiology and nuclear medicine services, including signed interpretation reports • All care, treatment, and services provided to the patient • Patient's response to care, treatment, and services • Medical history and physical examination, including any conclusions or impressions drawn from the information • Discharge plan and discharge planning evaluation • Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge • Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis.

CFR Number §482.24(c)(4)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.24(c)(4)(iii) **TAG: A-0464**		**RC.12.01.01**	**The medical record contains information that reflects the patient's care, treatment, and services.**
(iii) Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.		**EP 2**	The medical record contains the following clinical information: • Admitting diagnosis • Any emergency care, treatment, and services provided to the patient before their arrival • Any allergies to food and medications • Any findings of assessments and reassessments • Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient • Treatment goals, plan of care, and revisions to the plan of care • Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia • All practitioners' orders • Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition • Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the critical access hospital defines in policy the urgent/ emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. • Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) • Records of radiology and nuclear medicine services, including signed interpretation reports • All care, treatment, and services provided to the patient • Patient's response to care, treatment, and services • Medical history and physical examination, including any conclusions or impressions drawn from the information • Discharge plan and discharge planning evaluation • Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge • Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis.

CFR Number §482.24(c)(4)(iv)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.24(c)(4)(iv)	**TAG: A-0465**	**RC.12.01.01**	**The medical record contains information that reflects the patient's care, treatment, and services.**
(iv) Documentation of complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia.		**EP 2**	The medical record contains the following clinical information: • Admitting diagnosis • Any emergency care, treatment, and services provided to the patient before their arrival • Any allergies to food and medications • Any findings of assessments and reassessments • Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient • Treatment goals, plan of care, and revisions to the plan of care • Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia • All practitioners' orders • Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition • Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the critical access hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. • Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) • Records of radiology and nuclear medicine services, including signed interpretation reports • All care, treatment, and services provided to the patient • Patient's response to care, treatment, and services • Medical history and physical examination, including any conclusions or impressions drawn from the information • Discharge plan and discharge planning evaluation • Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge • Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis.
§482.24(c)(4)(v)	**TAG: A-0466**	**RC.12.01.01**	**The medical record contains information that reflects the patient's care, treatment, and services.**
(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.		**EP 3**	The medical record contains any informed consent, when required by critical access hospital policy or federal or state law or regulation. Note: The properly executed informed consent is placed in the patient's medical record prior to surgery, except in emergencies. A properly executed informed consent contains documentation of a patient's mutual understanding of and agreement for care, treatment, and services through written signature; electronic signature; or, when a patient is unable to provide a signature, documentation of the verbal agreement by the patient or surrogate decision-maker.

CFR Number §482.24(c)(4)(vi)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.24(c)(4)(vi)	**TAG: A-0467**	**RC.12.01.01**	**The medical record contains information that reflects the patient's care, treatment, and services.**
(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.		**EP 2**	The medical record contains the following clinical information: • Admitting diagnosis • Any emergency care, treatment, and services provided to the patient before their arrival • Any allergies to food and medications • Any findings of assessments and reassessments • Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient • Treatment goals, plan of care, and revisions to the plan of care • Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia • All practitioners' orders • Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition • Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the critical access hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. • Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) • Records of radiology and nuclear medicine services, including signed interpretation reports • All care, treatment, and services provided to the patient • Patient's response to care, treatment, and services • Medical history and physical examination, including any conclusions or impressions drawn from the information • Discharge plan and discharge planning evaluation • Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge • Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis.

CFR Number §482.24(c)(4)(vii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.24(c)(4)(vii) **TAG: A-0468**		**RC.12.01.01**	**The medical record contains information that reflects the patient's care, treatment, and services.**
(vii) Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care.		**EP 2**	The medical record contains the following clinical information: • Admitting diagnosis • Any emergency care, treatment, and services provided to the patient before their arrival • Any allergies to food and medications • Any findings of assessments and reassessments • Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient • Treatment goals, plan of care, and revisions to the plan of care • Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia • All practitioners' orders • Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition • Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the critical access hospital defines in policy the urgent/ emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. • Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) • Records of radiology and nuclear medicine services, including signed interpretation reports • All care, treatment, and services provided to the patient • Patient's response to care, treatment, and services • Medical history and physical examination, including any conclusions or impressions drawn from the information • Discharge plan and discharge planning evaluation • Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge • Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis.

CFR Number §482.24(c)(4)(viii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.24(c)(4)(viii) **TAG: A-0469**		**RC.12.01.01**	**The medical record contains information that reflects the patient's care, treatment, and services.**
(viii) Final diagnosis with completion of medical records within 30 days following discharge.		**EP 2**	The medical record contains the following clinical information: • Admitting diagnosis • Any emergency care, treatment, and services provided to the patient before their arrival • Any allergies to food and medications • Any findings of assessments and reassessments • Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient • Treatment goals, plan of care, and revisions to the plan of care • Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia • All practitioners' orders • Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition • Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the critical access hospital defines in policy the urgent/ emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. • Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) • Records of radiology and nuclear medicine services, including signed interpretation reports • All care, treatment, and services provided to the patient • Patient's response to care, treatment, and services • Medical history and physical examination, including any conclusions or impressions drawn from the information • Discharge plan and discharge planning evaluation • Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge • Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis.
§482.24(d) **TAG: A-0470**			
§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) **TAG: A-0470**		**IM.13.01.05**	**The critical access hospital meets requirements for the electronic exchange of patient health information. Note: This standard only applies to critical access hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).**
(1) The system's notification capacity is fully operational and the hospital uses it in accordance with all State and Federal statutes and regulations applicable to the hospital's exchange of patient health information.		**EP 1**	The critical access hospital demonstrates that its electronic health records system's (or other electronic administrative system's) notification capacity is fully operational and is used in accordance with applicable state and federal laws and regulations for the exchange of patient health information.

CFR Number §482.24(d)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.24(d)(2) **TAG: A-0470**		**IM.13.01.05**	**The critical access hospital meets requirements for the electronic exchange of patient health information. Note: This standard only applies to critical access hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).**
(2) The system sends notifications that must include at least patient name, treating practitioner name, and sending institution name.		**EP 2**	The critical access hospital demonstrates that its electronic health records system (or other electronic administrative system) sends notifications that include, at a minimum, the patient's name, treating licensed practitioner's name, and sending institution's name.
§482.24(d)(3) **TAG: A-0470**		**IM.13.01.05**	**The critical access hospital meets requirements for the electronic exchange of patient health information. Note: This standard only applies to critical access hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).**
(3) To the extent permissible under applicable federal and state law and regulations, and not inconsistent with the patient's expressed privacy preferences, the system sends notifications directly, or through an intermediary that facilitates exchange of health information, at the time of:		**EP 3**	In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the critical access hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, at the following times, when applicable: • The patient's emergency department registration • The patient's inpatient admission
§482.24(d)(3)(i) **TAG: A-0470**		**IM.13.01.05**	**The critical access hospital meets requirements for the electronic exchange of patient health information. Note: This standard only applies to critical access hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).**
(i) The patient's registration in the hospital's emergency department (if applicable).		**EP 3**	In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the critical access hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, at the following times, when applicable: • The patient's emergency department registration • The patient's inpatient admission
§482.24(d)(3)(ii) **TAG: A-0470**		**IM.13.01.05**	**The critical access hospital meets requirements for the electronic exchange of patient health information. Note: This standard only applies to critical access hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).**
(ii) The patient's admission to the hospital's inpatient services (if applicable).		**EP 3**	In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the critical access hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, at the following times, when applicable: • The patient's emergency department registration • The patient's inpatient admission
§482.24(d)(4) **TAG: A-0470**		**IM.13.01.05**	**The critical access hospital meets requirements for the electronic exchange of patient health information. Note: This standard only applies to critical access hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).**
(4) To the extent permissible under applicable federal and state law and regulations and not inconsistent with the patient's expressed privacy preferences, the system sends notifications directly, or through an intermediary that facilitates exchange of health information, either immediately prior to, or at the time of:		**EP 4**	In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the critical access hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, either immediately prior to or at the time of the patient's discharge or transfer from the critical access hospital's emergency department or inpatient services.

CFR Number §482.24(d)(4)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.24(d)(4)(i)	**TAG: A-0470**	**IM.13.01.05**	**The critical access hospital meets requirements for the electronic exchange of patient health information. Note: This standard only applies to critical access hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).**
(i) The patient's discharge or transfer from the hospital's emergency department (if applicable).		**EP 4**	In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the critical access hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, either immediately prior to or at the time of the patient's discharge or transfer from the critical access hospital's emergency department or inpatient services.
§482.24(d)(4)(ii)	**TAG: A-0470**	**IM.13.01.05**	**The critical access hospital meets requirements for the electronic exchange of patient health information. Note: This standard only applies to critical access hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).**
(ii) The patient's discharge or transfer from the hospital's inpatient services (if applicable).		**EP 4**	In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the critical access hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, either immediately prior to or at the time of the patient's discharge or transfer from the critical access hospital's emergency department or inpatient services.
§482.24(d)(5)	**TAG: A-0471**	**IM.13.01.05**	**The critical access hospital meets requirements for the electronic exchange of patient health information. Note: This standard only applies to critical access hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).**
(5) The 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:		**EP 5**	The critical access hospital makes a reasonable effort to confirm that its electronic health records system (or other electronic administrative system) sends the notifications to all applicable post–acute care service providers and suppliers, as well as any of the following who need to receive notification of the patient's status for treatment, care coordination, or quality improvement purposes: • Patient's established primary care licensed practitioner • Patient's established primary care practice group or entity • Other licensed practitioners, or other practice groups or entities, identified by the patient as primarily responsible for the patient's care Note: The term "reasonable effort" means that the critical access hospital has a process to send patient event notifications while working within the constraints of its technology infrastructure. There may be instances in which the critical access hospital (or its intermediary) cannot identify an applicable recipient for a patient event notification despite establishing processes for identifying recipients. In addition, some recipients may not be able to receive patient event notifications in a manner consistent with the critical access hospital system's capabilities.

CFR Number §482.24(d)(5)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.24(d)(5)(i) TAG: A-0471		**IM.13.01.05**	**The critical access hospital meets requirements for the electronic exchange of patient health information. Note: This standard only applies to critical access hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).**
(i) The patient's established primary care practitioner;		**EP 5**	The critical access hospital makes a reasonable effort to confirm that its electronic health records system (or other electronic administrative system) sends the notifications to all applicable post–acute care service providers and suppliers, as well as any of the following who need to receive notification of the patient's status for treatment, care coordination, or quality improvement purposes: • Patient's established primary care licensed practitioner • Patient's established primary care practice group or entity • Other licensed practitioners, or other practice groups or entities, identified by the patient as primarily responsible for the patient's care Note: The term "reasonable effort" means that the critical access hospital has a process to send patient event notifications while working within the constraints of its technology infrastructure. There may be instances in which the critical access hospital (or its intermediary) cannot identify an applicable recipient for a patient event notification despite establishing processes for identifying recipients. In addition, some recipients may not be able to receive patient event notifications in a manner consistent with the critical access hospital system's capabilities.
§482.24(d)(5)(ii) TAG: A-0471		**IM.13.01.05**	**The critical access hospital meets requirements for the electronic exchange of patient health information. Note: This standard only applies to critical access hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).**
(ii) The patient's established primary care practice group or entity; or		**EP 5**	The critical access hospital makes a reasonable effort to confirm that its electronic health records system (or other electronic administrative system) sends the notifications to all applicable post–acute care service providers and suppliers, as well as any of the following who need to receive notification of the patient's status for treatment, care coordination, or quality improvement purposes: • Patient's established primary care licensed practitioner • Patient's established primary care practice group or entity • Other licensed practitioners, or other practice groups or entities, identified by the patient as primarily responsible for the patient's care Note: The term "reasonable effort" means that the critical access hospital has a process to send patient event notifications while working within the constraints of its technology infrastructure. There may be instances in which the critical access hospital (or its intermediary) cannot identify an applicable recipient for a patient event notification despite establishing processes for identifying recipients. In addition, some recipients may not be able to receive patient event notifications in a manner consistent with the critical access hospital system's capabilities.

CFR Number §482.24(d)(5)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.24(d)(5)(iii)	**TAG: A-0471**	**IM.13.01.05**	**The critical access hospital meets requirements for the electronic exchange of patient health information. Note: This standard only applies to critical access hospitals that utilize an electronic health records system or other electronic administrative system that conforms with the content exchange standard at 45 CFR 170.205(d)(2).**
(iii) Other practitioner, or other practice group or entity, identified by the patient as the practitioner, or practice group or entity, primarily responsible for his or her care.		**EP 5**	The critical access hospital makes a reasonable effort to confirm that its electronic health records system (or other electronic administrative system) sends the notifications to all applicable post–acute care service providers and suppliers, as well as any of the following who need to receive notification of the patient's status for treatment, care coordination, or quality improvement purposes: • Patient's established primary care licensed practitioner • Patient's established primary care practice group or entity • Other licensed practitioners, or other practice groups or entities, identified by the patient as primarily responsible for the patient's care Note: The term "reasonable effort" means that the critical access hospital has a process to send patient event notifications while working within the constraints of its technology infrastructure. There may be instances in which the critical access hospital (or its intermediary) cannot identify an applicable recipient for a patient event notification despite establishing processes for identifying recipients. In addition, some recipients may not be able to receive patient event notifications in a manner consistent with the critical access hospital system's capabilities.
§482.25	**TAG: A-0489, A-0490, A-0492**	**LD.13.01.09**	**The critical access hospital has policies and procedures that guide and support patient care, treatment, and services.**
§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.		**EP 5**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
		EP 10	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has a pharmacy that is directed by a registered pharmacist. If the critical access hospital does not have a pharmacy, it has a drug storage area under competent supervision, as defined by the critical access hospital. Note: The pharmacy or drug storage area is administered in accordance with accepted professional principles.
§482.25(a)	**TAG: A-0491**	**MM.11.01.01**	**The critical access hospital safely manages pharmaceutical services.**
§482.25(a) Standard: Pharmacy Management and Administration The pharmacy or drug storage area must be administered in accordance with accepted professional principles.		**EP 1**	Drugs and biologicals are procured, stored, controlled, and distributed, in accordance with federal and state laws and accepted standards of practice.
		MM.14.01.01	**Medication orders are clear and accurate.**
		EP 3	The critical access 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 includes 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 or number of doses are automatically stopped after a reasonable time that is predetermined by the medical staff.

CFR Number §482.25(a)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.25(a)(1)	**TAG: A-0492**	**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(1) A full-time, part-time, or consulting pharmacist must be responsible for developing, supervising, and coordinating all the activities of the pharmacy services.		**EP 11**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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)	**TAG: A-0493**	**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(2) The pharmaceutical service must have an adequate number of personnel to ensure quality pharmaceutical services, including emergency services.		**EP 1**	Leaders provide for an adequate number and mix of qualified individuals to support safe, quality care, treatment, and services. Note 1: The number and mix of individuals is appropriate to the scope and complexity of the services offered. Services may include but are not limited to the following: • Rehabilitation services • Emergency services • Outpatient services • Respiratory services • Pharmaceutical services, including emergency pharmaceutical services • Diagnostic and therapeutic radiology services Note 2: Emergency services staff are qualified in emergency care. Note 3: For rehabilitation and psychiatric distinct part units in critical access hospitals: As of the first day of the first cost reporting period for which all other exclusion requirements are met, the unit is fully equipped and staffed and is capable of providing hospital inpatient psychiatric or rehabilitation care regardless of whether there are any inpatients in the unit on that date.
§482.25(a)(3)	**TAG: A-0494**	**MM.13.01.01**	**The critical access hospital safely stores medications.**
(3) Current and accurate records must be kept of the receipt and disposition of all scheduled drugs.		**EP 1**	The critical access hospital maintains current and accurate records of the receipt and disposition of all scheduled drugs.
§482.25(b)	**TAG: A-0500**	**MM.11.01.01**	**The critical access hospital safely manages pharmaceutical services.**
§482.25(b) Standard: Delivery of Services In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law.		**EP 1**	Drugs and biologicals are procured, stored, controlled, and distributed, in accordance with federal and state laws and accepted standards of practice.
§482.25(b)(1)	**TAG: A-0501**	**MM.15.01.01**	**The critical access hospital safely prepares medications.**
(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.		**EP 1**	A pharmacist or other staff authorized in accordance with state and federal law and regulation compounds, labels, and dispenses drugs and biologicals, regardless of whether the services are provided by critical access hospital staff or under arrangement. Note 1: When an on-site licensed pharmacist is available, a pharmacist, or pharmacy staff under the supervision of a pharmacist, compounds or admixes all compounded sterile preparations. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: 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.
		EP 2	The critical access 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.

CFR Number §482.25(b)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		EP 3	The critical access 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 critical access hospital policies.
		EP 4	The critical access hospital conducts sterile medication compounding of nonhazardous and hazardous medications within a proper environment in accordance with state and federal law and regulation and critical access 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.
		EP 5	The critical access 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 critical access hospital policies.
		EP 6	The critical access hospital conducts quality assurance of compounded sterile preparations of nonhazardous and hazardous medications in accordance with state and federal law and regulation and critical access hospital policies.
		EP 7	For rehabilitation and psychiatric distinct part units in critical access hospitals: An appropriately trained registered pharmacist or doctor of medicine or osteopathy performs or supervises in-house preparation of radiopharmaceuticals.
§482.25(b)(2)(i)	**TAG: A-0502**	**MM.13.01.01**	**The critical access hospital safely stores medications.**
(2)(i) All drugs and biologicals must be kept in a secure area, and locked when appropriate.		**EP 2**	The critical access hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area and locked when necessary to prevent diversion in accordance with law and regulation. Note 1: Scheduled medications include those listed in Schedules II–V of the Comprehensive Drug Abuse Prevention and Control Act of 1970. Note 2: This element of performance is also applicable to sample medications. Note 3: Only authorized staff have access to locked areas.
§482.25(b)(2)(ii)	**TAG: A-0503**	**MM.13.01.01**	**The critical access hospital safely stores medications.**
(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.		**EP 2**	The critical access hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area and locked when necessary to prevent diversion in accordance with law and regulation. Note 1: Scheduled medications include those listed in Schedules II–V of the Comprehensive Drug Abuse Prevention and Control Act of 1970. Note 2: This element of performance is also applicable to sample medications. Note 3: Only authorized staff have access to locked areas.
§482.25(b)(2)(iii)	**TAG: A-0504**	**MM.13.01.01**	**The critical access hospital safely stores medications.**
(iii) Only authorized personnel may have access to locked areas.		**EP 2**	The critical access hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area and locked when necessary to prevent diversion in accordance with law and regulation. Note 1: Scheduled medications include those listed in Schedules II–V of the Comprehensive Drug Abuse Prevention and Control Act of 1970. Note 2: This element of performance is also applicable to sample medications. Note 3: Only authorized staff have access to locked areas.
§482.25(b)(3)	**TAG: A-0505**	**MM.13.01.01**	**The critical access hospital safely stores medications.**
(3) Outdated, mislabeled, or otherwise unusable drugs and biologicals must not be available for patient use.		**EP 4**	The critical access hospital removes all expired, damaged, mislabeled, contaminated, or otherwise unusable medications and stores them separately from medications available for patient use. Note: This element of performance is also applicable to sample medications.
§482.25(b)(4)	**TAG: A-0506**	**MM.13.01.01**	**The critical access hospital safely stores medications.**
(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.		**EP 5**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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.

CFR Number §482.25(b)(5)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.25(b)(5)	**TAG: A-0507**	**MM.14.01.01**	**Medication orders are clear and accurate.**
(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.		**EP 3**	The critical access 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 includes 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 or number of doses are automatically stopped after a reasonable time that is predetermined by the medical staff.
§482.25(b)(6)	**TAG: A-0508**	**MM.17.01.01**	**The critical access hospital responds to actual or potential adverse drug events, significant adverse drug reactions, and medication errors.**
(6) Drug administration errors, adverse drug reactions, and incompatibilities must be immediately reported to the attending physician and, if appropriate, to the hospital's quality assessment and performance improvement program.		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: Medication administration errors, adverse drug reactions, and medication incompatibilities, as defined by the critical access hospital, are immediately reported to the attending physician or licensed practitioner and, as appropriate, to the hospitalwide quality assessment and performance improvement program.
		EP 3	The critical access hospital has a method (such as using established benchmarks for the size and scope of services provided by the critical access 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.
§482.25(b)(7)	**TAG: A-0509**	**MM.13.01.01**	**The critical access hospital safely stores medications.**
(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.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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)	**TAG: A-0510**	**MM.11.01.03**	**The pharmacy is a resource for medication related information.**
(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.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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)	**TAG: A-0511**	**MM.12.01.01**	**The critical access hospital selects and procures medications.**
(9) A formulary system must be established by the medical staff to assure quality pharmaceuticals at reasonable costs.		**EP 1**	The critical access hospital maintains a formulary that includes 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.

CFR Number §482.26	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.26	**TAG: A-0528**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§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.		**EP 1**	The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: • Outpatient • Emergency • Medical records • Diagnostic and therapeutic radiology • Nuclear medicine • Surgical • Anesthesia • Laboratory • Respiratory • Dietetic • Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital.
		NPG.12.01.01	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
		EP 1	Leaders provide for an adequate number and mix of qualified individuals to support safe, quality care, treatment, and services. Note 1: The number and mix of individuals is appropriate to the scope and complexity of the services offered. Services may include but are not limited to the following: • Rehabilitation services • Emergency services • Outpatient services • Respiratory services • Pharmaceutical services, including emergency pharmaceutical services • Diagnostic and therapeutic radiology services Note 2: Emergency services staff are qualified in emergency care. Note 3: For rehabilitation and psychiatric distinct part units in critical access hospitals: As of the first day of the first cost reporting period for which all other exclusion requirements are met, the unit is fully equipped and staffed and is capable of providing hospital inpatient psychiatric or rehabilitation care regardless of whether there are any inpatients in the unit on that date.

CFR Number §482.26(a)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.26(a)	**TAG: A-0529**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§482.26(a) Standard: Radiologic Services The hospital must maintain, or have available, radiologic services according to the needs of the patients.		**EP 1**	The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: • Outpatient • Emergency • Medical records • Diagnostic and therapeutic radiology • Nuclear medicine • Surgical • Anesthesia • Laboratory • Respiratory • Dietetic • Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital.
		NPG.12.01.01	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
		EP 1	Leaders provide for an adequate number and mix of qualified individuals to support safe, quality care, treatment, and services. Note 1: The number and mix of individuals is appropriate to the scope and complexity of the services offered. Services may include but are not limited to the following: • Rehabilitation services • Emergency services • Outpatient services • Respiratory services • Pharmaceutical services, including emergency pharmaceutical services • Diagnostic and therapeutic radiology services Note 2: Emergency services staff are qualified in emergency care. Note 3: For rehabilitation and psychiatric distinct part units in critical access hospitals: As of the first day of the first cost reporting period for which all other exclusion requirements are met, the unit is fully equipped and staffed and is capable of providing hospital inpatient psychiatric or rehabilitation care regardless of whether there are any inpatients in the unit on that date.

CFR Number §482.26(b)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.26(b)	**TAG: A-0535**	**PE.02.01.01**	**The critical access hospital manages risks related to hazardous materials and waste.**
§482.26(b) Standard: Safety for Patients and Personnel The radiologic services, particularly ionizing radiology procedures, must be free from hazards for patients and personnel.		**EP 4**	The critical access hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials. The policies and procedures address the following: • Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors • Disposal of hazardous medications • Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding • Periodic inspection of radiology equipment and prompt correction of hazards found during inspection • Precautions to follow and personal protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers and MRIs). Note 2: Hazardous gases and vapors include but are not limited to ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9)
§482.26(b)(1)	**TAG: A-0536**	**PE.02.01.01**	**The critical access hospital manages risks related to hazardous materials and waste.**
(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.		**EP 4**	The critical access hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials. The policies and procedures address the following: • Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors • Disposal of hazardous medications • Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding • Periodic inspection of radiology equipment and prompt correction of hazards found during inspection • Precautions to follow and personal protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers and MRIs). Note 2: Hazardous gases and vapors include but are not limited to ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9)
§482.26(b)(2)	**TAG: A-0537**	**PE.02.01.01**	**The critical access hospital manages risks related to hazardous materials and waste.**
(2) Periodic inspection of equipment must be made and hazards identified must be promptly corrected.		**EP 4**	The critical access hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials. The policies and procedures address the following: • Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors • Disposal of hazardous medications • Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding • Periodic inspection of radiology equipment and prompt correction of hazards found during inspection • Precautions to follow and personal protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers and MRIs). Note 2: Hazardous gases and vapors include but are not limited to ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9)
§482.26(b)(3)	**TAG: A-0538**	**PE.02.01.01**	**The critical access hospital manages risks related to hazardous materials and waste.**
(3) Radiation workers must be checked periodically, by the use of exposure meters or badge tests, for amount of radiation exposure.		**EP 5**	Radiation workers are checked periodically, using exposure meters or badge tests, for the amount of radiation exposure.

CFR Number §482.26(b)(4)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.26(b)(4)	**TAG: A-0539**	**PC.12.01.01**	**The critical access hospital provides care, treatment, and services as ordered or prescribed and in accordance with law and regulation.**
(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.		**EP 1**	Prior to providing care, treatment, and services, the critical access hospital obtains or renews orders (verbal or written) from a physician or other licensed practitioner in accordance with professional standards of practice; law and regulation; critical access hospital policies; and medical staff bylaws, rules, and regulations. Note 1: This includes but is not limited to respiratory services, radiology services, rehabilitation services, nuclear medicine services, and dietetic services, if provided. Note 2: Patient diets, including therapeutic diets, are ordered by the physician or other licensed practitioner responsible for the patient's care or by a qualified dietitian or qualified nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals. The requirement of 42 CFR 483.25(i) is met for inpatients receiving care at a skilled nursing facility subsequent to critical access hospital care.
§482.26(c)	**TAG: A-0546**		
§482.26(c) Standard: Personnel			
§482.26(c)(1)	**TAG: A-0546**	**MS.17.01.03**	**The critical access hospital collects information regarding each physician's or other licensed practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.**
(1) 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.		**EP 5**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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.
§482.26(c)(2)	**TAG: A-0547**	**MS.16.01.01**	**The organized medical staff oversees the quality of patient care, treatment, and services provided by physicians and other licensed practitioners privileged through the medical staff process.**
(2) Only personnel designated as qualified by the medical staff may use the radiologic equipment and administer procedures.		**EP 11**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The medical staff determines the qualifications of the radiology staff who use equipment and administer procedures. Note: Technologists who perform diagnostic computed tomography exams will, at a minimum, meet the requirements specified at NPG.13.01.01, EP 1.

CFR Number §482.26(d)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.26(d)	**TAG: A-0553**	**RC.12.01.01**	**The medical record contains information that reflects the patient's care, treatment, and services.**
§482.26(d) Standard: Records Records of radiologic services must be maintained.		**EP 2**	The medical record contains the following clinical information: • Admitting diagnosis • Any emergency care, treatment, and services provided to the patient before their arrival • Any allergies to food and medications • Any findings of assessments and reassessments • Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient • Treatment goals, plan of care, and revisions to the plan of care • Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia • All practitioners' orders • Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition • Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the critical access hospital defines in policy the urgent/ emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. • Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) • Records of radiology and nuclear medicine services, including signed interpretation reports • All care, treatment, and services provided to the patient • Patient's response to care, treatment, and services • Medical history and physical examination, including any conclusions or impressions drawn from the information • Discharge plan and discharge planning evaluation • Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge • Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis.

CFR Number §482.26(d)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.26(d)(1) **TAG: A-0553**		**RC.12.01.01**	**The medical record contains information that reflects the patient's care, treatment, and services.**
(1) The radiologist or other practitioner who performs radiology services must sign reports of his or her interpretations.		**EP 2**	The medical record contains the following clinical information: • Admitting diagnosis • Any emergency care, treatment, and services provided to the patient before their arrival • Any allergies to food and medications • Any findings of assessments and reassessments • Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient • Treatment goals, plan of care, and revisions to the plan of care • Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia • All practitioners' orders • Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition • Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the critical access hospital defines in policy the urgent/ emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. • Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) • Records of radiology and nuclear medicine services, including signed interpretation reports • All care, treatment, and services provided to the patient • Patient's response to care, treatment, and services • Medical history and physical examination, including any conclusions or impressions drawn from the information • Discharge plan and discharge planning evaluation • Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge • Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis.
§482.26(d)(2) **TAG: A-0553**		**RC.11.03.01**	**The critical access hospital retains its medical records.**
(2) The hospital must maintain the following for at least 5 years:		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The retention time of the original or legally reproduced medical record is determined by its use and critical access hospital policy, in accordance with law and regulation. Note: 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) **TAG: A-0553**		**RC.11.03.01**	**The critical access hospital retains its medical records.**
(i) Copies of reports and printouts		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The retention time of the original or legally reproduced medical record is determined by its use and critical access hospital policy, in accordance with law and regulation. Note: 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.

CFR Number §482.26(d)(2)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.26(d)(2)(ii)	**TAG: A-0553**	**RC.11.03.01**	**The critical access hospital retains its medical records.**
(ii) Films, scans, and other image records, as appropriate.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The retention time of the original or legally reproduced medical record is determined by its use and critical access hospital policy, in accordance with law and regulation. Note: 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.
§482.27	**TAG: A-0576**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§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.		**EP 1**	The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: • Outpatient • Emergency • Medical records • Diagnostic and therapeutic radiology • Nuclear medicine • Surgical • Anesthesia • Laboratory • Respiratory • Dietetic • Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital.
		EP 12	The critical access hospital provides the following basic laboratory services essential to the immediate diagnosis and treatment of the patient: • Chemical examination of urine by the stick method, the tablet method, or both (including urine ketones) • Hemoglobin or hematocrit tests • Blood glucose tests • Examination of stool specimens for occult blood • Pregnancy tests • Primary culturing for transmittal to a certified laboratory Note 1: The laboratory meets the standards imposed under section 353 of the Public Health Service Act (42 U.S.C. 263a). (Refer to the laboratory requirements specified in 42 CFR 493) Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has laboratory services available, either directly or through a contractual agreement with a Clinical Laboratory Improvement Amendments (CLIA)–certified laboratory that meets the requirements of 42 CFR 493.

CFR Number §482.27(a)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.27(a)	**TAG: A-0582**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§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.		**EP 1**	The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: • Outpatient • Emergency • Medical records • Diagnostic and therapeutic radiology • Nuclear medicine • Surgical • Anesthesia • Laboratory • Respiratory • Dietetic • Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital.
		EP 12	The critical access hospital provides the following basic laboratory services essential to the immediate diagnosis and treatment of the patient: • Chemical examination of urine by the stick method, the tablet method, or both (including urine ketones) • Hemoglobin or hematocrit tests • Blood glucose tests • Examination of stool specimens for occult blood • Pregnancy tests • Primary culturing for transmittal to a certified laboratory Note 1: The laboratory meets the standards imposed under section 353 of the Public Health Service Act (42 U.S.C. 263a). (Refer to the laboratory requirements specified in 42 CFR 493) Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has laboratory services available, either directly or through a contractual agreement with a Clinical Laboratory Improvement Amendments (CLIA)–certified laboratory that meets the requirements of 42 CFR 493.
§482.27(a)(1)	**TAG: A-0583**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(1) Emergency laboratory services must be available 24 hours a day.		**EP 13**	For rehabilitation and psychiatric distinct part units in critical access hospitals: Emergency laboratory services are available 24 hours a day, 7 days a week.
§482.27(a)(2)	**TAG: A-0584**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(2) A written description of services provided must be available to the medical staff.		**EP 14**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital maintains a written description of the scope of laboratory services provided that is available to the medical staff.
§482.27(a)(3)	**TAG: A-0585**	**PC.13.01.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The laboratory has written policies and procedures for the handling of tissue specimens removed during a surgical procedure.**
(3) The laboratory must make provision for proper receipt and reporting of tissue specimens.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The laboratory develops and implements written policies and procedures for collecting, preserving, transporting, receiving, and reporting examination results for tissue specimens.

CFR Number §482.27(a)(4)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.27(a)(4) **TAG: A-0586**		**PC.13.01.05**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The laboratory has written policies and procedures for the handling of tissue specimens removed during a surgical procedure.**
(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.		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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) **TAG: A-0592**			
§482.27(b) Standard: Potentially Infectious Blood and Blood Components			
§482.27(b)(1) **TAG: A-0592**			
(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) **TAG: A-0592**		**PC.15.01.01**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital safely provides blood and blood components.**
(i) Who tested negative at the time of donation but tests reactive for evidence of HIV infection on a later donation;		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital develops and implements written policies and 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)(ii) **TAG: A-0592**		**PC.15.01.01**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital safely provides blood and blood components.**
(ii) Who tests positive on the supplemental (additional, more specific) test or other follow-up testing required by FDA; and		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital develops and implements written policies and 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) **TAG: A-0592**		**PC.15.01.01**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital safely provides blood and blood components.**
(iii) For whom the timing of seroconversion cannot be precisely estimated.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital develops and implements written policies and 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) **TAG: A-0592**		**PC.15.01.01**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital safely provides blood and blood components.**
(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.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital develops and implements written policies and 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.

CFR Number §482.27(b)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.27(b)(3)	**TAG: A-0592**	**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
(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 --		**EP 5**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access 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 critical access hospital within the specified timeframes under the following circumstances: • Within 3 calendar days if the blood collecting establishment supplied blood and blood components collected from a donor who tested negative at the time of donation but tests reactive for evidence of human immunodeficiency virus (HIV) or hepatitis C virus (HCV) infection on a later donation or who is determined to be at increased risk for transmitting HIV or HCV infection • Within 45 days of the test for the results of the supplemental (additional, more specific) test for HIV or HCV or other follow-up testing required by the US Food and Drug Administration • Within 3 calendar days after the blood collecting establishment supplied blood and blood components collected from an infectious donor, whenever records are available
§482.27(b)(3)(i)	**TAG: A-0592**	**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
(i) Within 3 calendar days if the blood collecting establishment supplied blood and blood components collected from a donor who tested negative at the time of donation but tests reactive for evidence of HIV or HCV infection on a later donation or who is determined to be at increased risk for transmitting HIV or HCV infection;		**EP 5**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access 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 critical access hospital within the specified timeframes under the following circumstances: • Within 3 calendar days if the blood collecting establishment supplied blood and blood components collected from a donor who tested negative at the time of donation but tests reactive for evidence of human immunodeficiency virus (HIV) or hepatitis C virus (HCV) infection on a later donation or who is determined to be at increased risk for transmitting HIV or HCV infection • Within 45 days of the test for the results of the supplemental (additional, more specific) test for HIV or HCV or other follow-up testing required by the US Food and Drug Administration • Within 3 calendar days after the blood collecting establishment supplied blood and blood components collected from an infectious donor, whenever records are available
§482.27(b)(3)(ii)	**TAG: A-0592**	**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
(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;		**EP 5**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access 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 critical access 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

CFR Number §482.27(b)(3)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.27(b)(3)(iii) **TAG: A-0592**		**LD.13.03.03**	**Care, treatment, and services provided through contractual agreement are provided safely and effectively.**
(iii) Within 3 calendar days after the blood collecting establishment supplied blood and blood components collected from an infectious donor, whenever records are available.		**EP 5**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access 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 critical access hospital within the specified timeframes under the following circumstances: • Within 3 calendar days if the blood collecting establishment supplied blood and blood components collected from a donor who tested negative at the time of donation but tests reactive for evidence of human immunodeficiency virus (HIV) or hepatitis C virus (HCV) infection on a later donation or who is determined to be at increased risk for transmitting HIV or HCV infection • Within 45 days of the test for the results of the supplemental (additional, more specific) test for HIV or HCV or other follow-up testing required by the US Food and Drug Administration • Within 3 calendar days after the blood collecting establishment supplied blood and blood components collected from an infectious donor, whenever records are available
§482.27(b)(4) **TAG: A-0592**		**PC.15.01.01**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital safely provides blood and blood components.**
(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.		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access hospital receives notification of blood that is reactive to the human immunodeficiency virus (HIV) or hepatitis C virus (HCV) screening test, the critical access 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) **TAG: A-0592**		**PC.15.01.01**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital safely provides blood and blood components.**
(i) If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is negative, absent other informative test results, the hospital may release the blood and blood components from quarantine.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access hospital receives notification that the result of the supplemental (additional, more specific) test for potentially infectious blood or blood components or other follow-up testing required by the US Food and Drug Administration is negative and there are no other informative test results, the critical access hospital may release the blood and blood components from quarantine.
§482.27(b)(4)(ii) **TAG: A-0592**			
(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) **TAG: A-0592**		**PC.15.01.01**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital safely provides blood and blood components.**
(A) Dispose of the blood and blood components; and		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access 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 critical access 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)

CFR Number §482.27(b)(4)(ii)(B)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.27(b)(4)(ii)(B) **TAG: A-0592**		**PC.15.01.01**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital safely provides blood and blood components.**
(B) Notify the transfusion recipients as set forth in paragraph (b)(6) of this section.		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access 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 critical access 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) **TAG: A-0592**		**PC.15.01.01**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital safely provides blood and blood components.**
(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).		**EP 5**	For rehabilitation or psychiatric distinct part units in critical access hospitals: If the critical access 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 critical access hospital destroys or labels prior collections of blood or blood components held in quarantine, consistent with FDA requirements 21 CFR 610.46(b)(2) and 610.47(b)(2).
§482.27(b)(5) **TAG: A-0592**			
(5) Recordkeeping by the hospital. The hospital must maintain --			
§482.27(b)(5)(i) **TAG: A-0592**		**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
(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		**EP 7**	For rehabilitation and psychiatric distinct part units: The critical access 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 critical access hospital ceases operation for any reason
§482.27(b)(5)(ii) **TAG: A-0592**		**LD.13.01.01**	**The critical access hospital complies with law and regulation.**
(ii) A fully funded plan to transfer these records to another hospital or other entity if such hospital ceases operation for any reason.		**EP 7**	For rehabilitation and psychiatric distinct part units: The critical access 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 critical access hospital ceases operation for any reason
§482.27(b)(6) **TAG: A-0592**			
(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:			

CFR Number §482.27(b)(6)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.27(b)(6)(i) **TAG: A-0592**		**PC.15.01.01**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital safely provides blood and blood components.**
(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 be a need for HIV or HCV testing and counseling.		**EP 6**	For rehabilitation and psychiatric distinct part units in critical access hospitals: When potentially human immunodeficiency virus (HIV) or hepatitis C virus (HCV) infectious blood or blood components are administered (either directly through the critical access hospital's own blood collecting establishment or under an agreement) or released to another entity or individual, the critical access hospital takes the following actions: • 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)(ii) **TAG: A-0592**		**PC.15.01.01**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital safely provides blood and blood components.**
(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.		**EP 6**	For rehabilitation and psychiatric distinct part units in critical access hospitals: When potentially human immunodeficiency virus (HIV) or hepatitis C virus (HCV) infectious blood or blood components are administered (either directly through the critical access hospital's own blood collecting establishment or under an agreement) or released to another entity or individual, the critical access hospital takes the following actions: • 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) **TAG: A-0592**		**PC.15.01.01**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital safely provides blood and blood components.**
(iii) Document in the patient's medical record the notification or attempts to give the required notification.		**EP 6**	For rehabilitation and psychiatric distinct part units in critical access hospitals: When potentially human immunodeficiency virus (HIV) or hepatitis C virus (HCV) infectious blood or blood components are administered (either directly through the critical access hospital's own blood collecting establishment or under an agreement) or released to another entity or individual, the critical access hospital takes the following actions: • 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

CFR Number §482.27(b)(7)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.27(b)(7) **TAG: A-0592**		**PC.15.01.01**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital safely provides blood and blood components.**
(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—		**EP 7**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access hospital receives notification that it received potentially human immunodeficiency virus (HIV) or hepatitis C virus (HCV) infectious blood and blood components, the critical access 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 critical access hospital is unable to locate the patient and documents in the patient's medical record the extenuating circumstances beyond the critical access 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)(i) **TAG: A-0592**		**PC.15.01.01**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital safely provides blood and blood components.**
(i) The patient is located and notified; or		**EP 7**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access hospital receives notification that it received potentially human immunodeficiency virus (HIV) or hepatitis C virus (HCV) infectious blood and blood components, the critical access 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 critical access hospital is unable to locate the patient and documents in the patient's medical record the extenuating circumstances beyond the critical access 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) **TAG: A-0592**		**PC.15.01.01**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital safely provides blood and blood components.**
(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.		**EP 7**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access hospital receives notification that it received potentially human immunodeficiency virus (HIV) or hepatitis C virus (HCV) infectious blood and blood components, the critical access 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 critical access hospital is unable to locate the patient and documents in the patient's medical record the extenuating circumstances beyond the critical access 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)(8) **TAG: A-0592**			
(8) Content of notification. The notification must include the following information:			

CFR Number §482.27(b)(8)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.27(b)(8)(i) **TAG: A-0592**		**PC.15.01.01**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital safely provides blood and blood components.**
(i) A basic explanation of the need for HIV or HCV testing and counseling.		**EP 8**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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) **TAG: A-0592**		**PC.15.01.01**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital safely provides blood and blood components.**
(ii) Enough oral or written information so that an informed decision can be made about whether to obtain HIV or HCV testing and counseling.		**EP 8**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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)(iii) **TAG: A-0592**		**PC.15.01.01**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital safely provides blood and blood components.**
(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.		**EP 8**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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)(9) **TAG: A-0592**		**PC.15.01.01**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital safely provides blood and blood components.**
(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.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital develops and implements written policies and 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) **TAG: A-0592**		**PC.15.01.01**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital safely provides blood and blood components.**
(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.		**EP 9**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If a patient has received an infectious blood or blood component, the critical access 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

CFR Number §482.27(c)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.27(c)	**TAG: A-0593**		
§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)	**TAG: A-0593**	**PC.15.01.01**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital safely provides blood and blood components.**
(1) Appropriate testing and quarantining of infectious blood and blood components.		**EP 10**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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)	**TAG: A-0593**	**PC.15.01.01**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital safely provides blood and blood components.**
(2) Notification and counseling of recipients that may have received infectious blood and blood components.		**EP 10**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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.
§482.28	**TAG: A-0618**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§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.		**EP 1**	The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: • Outpatient • Emergency • Medical records • Diagnostic and therapeutic radiology • Nuclear medicine • Surgical • Anesthesia • Laboratory • Respiratory • Dietetic • Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital.

CFR Number §482.28	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		NPG.12.01.01	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
		EP 7	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has dietetic services that are directed and adequately staffed by qualified personnel. Note: For critical access hospitals that provide dietetic services through contracted services, the contracted service has a dietician who serves the critical access hospital full-time, part-time, or on a consultant basis and acts as a liaison to critical access hospital medical staff for recommendations on dietetic policies that affect patient care, treatment, and services.
§482.28(a) **TAG: A-0619** §482.28(a) Standard: Organization			
§482.28(a)(1) **TAG: A-0620** (1) The hospital must have a full-time employee who–			
§482.28(a)(1)(i) **TAG: A-0620** (i) Serves as director of the food and dietetic services;		**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
		EP 8	The critical access 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) **TAG: A-0620** (ii) Is responsible for daily management of the dietary services; and		**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
		EP 8	The critical access 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)(iii) **TAG: A-0620** (iii) Is qualified by experience or training.		**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
		EP 8	The critical access 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)(2) **TAG: A-0621** (2) There must be a qualified dietitian, full-time, part-time or on a consultant basis.		**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
		EP 9	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has a qualified dietitian on a full-time, part-time, or consultative basis.
§482.28(a)(3) **TAG: A-0622** (3) There must be administrative and technical personnel competent in their respective duties.		**HR.11.01.01**	**The critical access hospital has the necessary staff to support the care, treatment, and services it provides.**
		EP 1	The critical access hospital's food and dietetic services administrative and technical staff are competent to perform their responsibilities.
§482.28(b) **TAG: A-0629** §482.28(b) Standard: Diets Menus must meet the needs of the patients.		**PC.12.01.09**	**The critical access hospital makes food and nutrition products available to its patients.**
		EP 1	The nutritional needs of the individual patient are met in accordance with clinical practice guidelines and recognized dietary practices. Note 1: Diet menus meet the needs of the patients. Note 2: For swing beds in critical access hospitals: The critical access hospital meets the assisted nutrition and hydration requirement at 42 CFR 483.25(g) with respect to inpatients receiving posthospital skilled nursing facility care.

CFR Number §482.28(b)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.28(b)(1)	**TAG: A-0629**	**PC.12.01.09**	**The critical access hospital makes food and nutrition products available to its patients.**
(1) Individual patient nutritional needs must be met in accordance with recognized dietary practices.		**EP 1**	The nutritional needs of the individual patient are met in accordance with clinical practice guidelines and recognized dietary practices. Note 1: Diet menus meet the needs of the patients. Note 2: For swing beds in critical access hospitals: The critical access hospital meets the assisted nutrition and hydration requirement at 42 CFR 483.25(g) with respect to inpatients receiving posthospital skilled nursing facility care.
§482.28(b)(2)	**TAG: A-0630**	**PC.12.01.01**	**The critical access hospital provides care, treatment, and services as ordered or prescribed and in accordance with law and regulation.**
(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.		**EP 1**	Prior to providing care, treatment, and services, the critical access hospital obtains or renews orders (verbal or written) from a physician or other licensed practitioner in accordance with professional standards of practice; law and regulation; critical access hospital policies; and medical staff bylaws, rules, and regulations. Note 1: This includes but is not limited to respiratory services, radiology services, rehabilitation services, nuclear medicine services, and dietetic services, if provided. Note 2: Patient diets, including therapeutic diets, are ordered by the physician or other licensed practitioner responsible for the patient's care or by a qualified dietitian or qualified nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals. The requirement of 42 CFR 483.25(i) is met for inpatients receiving care at a skilled nursing facility subsequent to critical access hospital care.
§482.28(b)(3)	**TAG: A-0631**	**PC.12.01.09**	**The critical access hospital makes food and nutrition products available to its patients.**
(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.		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The dietician 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	**TAG: A-0652**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
§482.30 Condition of Participation: Utilization Review The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has a utilization review plan that provides for review of services provided by the critical access hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note: The critical access hospital does not need to have a utilization review plan if either a quality improvement organization (QIO) has assumed binding review for the critical access 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 critical access hospitals in that state to meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245.
§482.30(a)	**TAG: A-0653**		
§482.30(a) Standard: Applicability The provisions of this section apply except in either of the following circumstances:			

CFR Number §482.30(a)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.30(a)(1) TAG: A-0653		**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(1) A Utilization and Quality Control Quality Improvement Organization (QIO) has assumed binding review for the hospital.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has a utilization review plan that provides for review of services provided by the critical access hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note: The critical access hospital does not need to have a utilization review plan if either a quality improvement organization (QIO) has assumed binding review for the critical access 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 critical access hospitals in that state to meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245.
§482.30(a)(2) TAG: A-0653		**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(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.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has a utilization review plan that provides for review of services provided by the critical access hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note: The critical access hospital does not need to have a utilization review plan if either a quality improvement organization (QIO) has assumed binding review for the critical access 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 critical access hospitals in that state to meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245.
§482.30(b) TAG: A-0654		**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
§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).		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 critical access hospital or who was professionally involved in the care of the patient whose case is being reviewed. (See also MS.16.01.03, EP 5)
§482.30(b)(1) TAG: A-0654			
(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) TAG: A-0654		**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(i) A staff committee of the institution;		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has a utilization review committee that is either a staff committee or a group outside the critical access 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 critical access hospital, it is impracticable to have a properly functioning staff committee, the utilization review committee is established by a group outside the critical access hospital, as specified in 42 CFR 482.30(b)(1)(ii).

CFR Number §482.30(b)(1)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.30(b)(1)(ii)	**TAG: A-0654**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(ii) A group outside the institution--		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has a utilization review committee that is either a staff committee or a group outside the critical access 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 critical access hospital, it is impracticable to have a properly functioning staff committee, the utilization review committee is established by a group outside the critical access hospital, as specified in 42 CFR 482.30(b)(1)(ii).
§482.30(b)(1)(ii)(A)	**TAG: A-0654**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(A) Established by the local medical society and some or all of the hospitals in the locality; or		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has a utilization review committee that is either a staff committee or a group outside the critical access 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 critical access hospital, it is impracticable to have a properly functioning staff committee, the utilization review committee is established by a group outside the critical access hospital, as specified in 42 CFR 482.30(b)(1)(ii).
§482.30(b)(1)(ii)(B)	**TAG: A-0654**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(B) Established in a manner approved by CMS.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has a utilization review committee that is either a staff committee or a group outside the critical access 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 critical access hospital, it is impracticable to have a properly functioning staff committee, the utilization review committee is established by a group outside the critical access hospital, as specified in 42 CFR 482.30(b)(1)(ii).
§482.30(b)(2)	**TAG: A-0654**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(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		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has a utilization review committee that is either a staff committee or a group outside the critical access 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 critical access hospital, it is impracticable to have a properly functioning staff committee, the utilization review committee is established by a group outside the critical access hospital, as specified in 42 CFR 482.30(b)(1)(ii).
§482.30(b)(3)	**TAG: A-0654**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(3) The committee or group's reviews may not be conducted by any individual who--		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 critical access hospital or who was professionally involved in the care of the patient whose case is being reviewed. (See also MS.16.01.03, EP 5)

CFR Number §482.30(b)(3)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.30(b)(3)(i)	**TAG: A-0654**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(i) Has a direct financial interest (for example, an ownership interest) in that hospital; or		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 critical access hospital or who was professionally involved in the care of the patient whose case is being reviewed. (See also MS.16.01.03, EP 5)
§482.30(b)(3)(ii)	**TAG: A-0654**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(ii) Was professionally involved in the care of the patient whose case is being reviewed.		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 critical access hospital or who was professionally involved in the care of the patient whose case is being reviewed. (See also MS.16.01.03, EP 5)
§482.30(c)	**TAG: A-0655**		
§482.30(c) Standard: Scope and Frequency of Review			
§482.30(c)(1)	**TAG: A-0655**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(1) The UR plan must provide for review for Medicare and Medicaid patients with respect to the medical necessity of--		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 critical access hospital • Duration of stays • Professional services provided, including drugs and biologicals Note 1: The critical access hospital may perform reviews of admissions before, during, or after hospital admission. Note 2: The critical access hospital may perform reviews on a sample basis, except for reviews of extended stay cases.
§482.30(c)(1)(i)	**TAG: A-0655**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(i) Admissions to the institution;		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 critical access hospital • Duration of stays • Professional services provided, including drugs and biologicals Note 1: The critical access hospital may perform reviews of admissions before, during, or after hospital admission. Note 2: The critical access hospital may perform reviews on a sample basis, except for reviews of extended stay cases.

CFR Number §482.30(c)(1)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.30(c)(1)(ii)	**TAG: A-0655**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(ii) The duration of stays; and		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 critical access hospital • Duration of stays • Professional services provided, including drugs and biologicals Note 1: The critical access hospital may perform reviews of admissions before, during, or after hospital admission. Note 2: The critical access hospital may perform reviews on a sample basis, except for reviews of extended stay cases.
§482.30(c)(1)(iii)	**TAG: A-0655**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(iii) Professional services furnished including drugs and biologicals.		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 critical access hospital • Duration of stays • Professional services provided, including drugs and biologicals Note 1: The critical access hospital may perform reviews of admissions before, during, or after hospital admission. Note 2: The critical access hospital may perform reviews on a sample basis, except for reviews of extended stay cases.
§482.30(c)(2)	**TAG: A-0655**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(2) Review of admissions may be performed before, at, or after hospital admission.		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 critical access hospital • Duration of stays • Professional services provided, including drugs and biologicals Note 1: The critical access hospital may perform reviews of admissions before, during, or after hospital admission. Note 2: The critical access hospital may perform reviews on a sample basis, except for reviews of extended stay cases.
§482.30(c)(3)	**TAG: A-0655**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(3) Except as specified in paragraph (e) of this section, reviews may be conducted on a sample basis.		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 critical access hospital • Duration of stays • Professional services provided, including drugs and biologicals Note 1: The critical access hospital may perform reviews of admissions before, during, or after hospital admission. Note 2: The critical access hospital may perform reviews on a sample basis, except for reviews of extended stay cases.
§482.30(c)(4)	**TAG: A-0655**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(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:		**EP 7**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access 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 critical access 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 critical access 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).

CFR Number §482.30(c)(4)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.30(c)(4)(i)	**TAG: A-0655**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(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		**EP 7**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access 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 critical access 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 critical access 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).
§482.30(c)(4)(ii)	**TAG: A-0655**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(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.		**EP 7**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access 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 critical access 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 critical access 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).
§482.30(d)	**TAG: A-0656**		
§482.30(d) Standard: Determination Regarding Admissions or Continued Stays			
§482.30(d)(1)	**TAG: A-0656**		
(1) The determination that an admission or continued stay is not medically necessary-			
§482.30(d)(1)(i)	**TAG: A-0656**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(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		**EP 6**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 and affords the practitioner(s) the opportunity to present their views.
§482.30(d)(1)(ii)	**TAG: A-0656**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(ii) Must be made by at least two members of the UR committee in all other cases.		**EP 6**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 and affords the practitioner(s) the opportunity to present their views.

CFR Number §482.30(d)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.30(d)(2)	**TAG: A-0656**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(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.		**EP 6**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 and affords the practitioner(s) the opportunity to present their views.
§482.30(d)(3)	**TAG: A-0656**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(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);		**EP 10**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the utilization review committee determines that admission to or continued stay in the critical access hospital is not medically necessary, the committee gives written notification to the critical access 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.
§482.30(e)	**TAG: A-0657**		
§482.30(e) Standard: Extended Stay Review			
§482.30(e)(1)	**TAG: A-0657**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(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--		**EP 8**	For rehabilitation and psychiatric distinct part units in critical access hospitals: In critical access 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.
§482.30(e)(1)(i)	**TAG: A-0657**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(i) Be the same for all cases; or		**EP 8**	For rehabilitation and psychiatric distinct part units in critical access hospitals: In critical access 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.
§482.30(e)(1)(ii)	**TAG: A-0657**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(ii) Differ for different classes of cases.		**EP 8**	For rehabilitation and psychiatric distinct part units in critical access hospitals: In critical access 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.
§482.30(e)(2)	**TAG: A-0657**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(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.		**EP 9**	For rehabilitation and psychiatric distinct part units: In critical access 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 critical access 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.

CFR Number §482.30(e)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.30(e)(3)	**TAG: A-0657**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
(3) The UR committee must make the periodic review no later than 7 days after the day required in the UR plan.		**EP 9**	For rehabilitation and psychiatric distinct part units: In critical access 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 critical access 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.
§482.30(f)	**TAG: A-0658**	**LD.13.01.03**	**The critical access hospital reviews services for medical necessity.**
§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.		**EP 5**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital's utilization review committee reviews professional services provided to determine medical necessity and to promote the most efficient use of available health facilities and services.
§482.41	**TAG: A-0700**	**PE.01.01.01**	**The critical access hospital has a safe and adequate physical environment.**
§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.		**EP 1**	The critical access hospital's building is constructed, arranged, and maintained to allow safe access and to protect the safety and well-being of patients. Note 1: Diagnostic and therapeutic facilities are located in areas appropriate for the services provided. Note 2: When planning for new, altered, or renovated space, the critical access hospital uses state rules and regulations or the current Guidelines for Design and Construction of Hospitals published by the Facility Guidelines Institute. If the state rules and regulations or the Guidelines do not address the design needs of the critical access hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria.
		EP 2	The critical access hospital has adequate space and facilities for the services it provides, including facilities for the diagnosis and treatment of patients and for any special services offered to meet the needs of the community served. Note: The extent and complexity of facilities is determined by the services offered.
§482.41(a)	**TAG: A-0701**	**PE.01.01.01**	**The critical access hospital has a safe and adequate physical environment.**
§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.		**EP 1**	The critical access hospital's building is constructed, arranged, and maintained to allow safe access and to protect the safety and well-being of patients. Note 1: Diagnostic and therapeutic facilities are located in areas appropriate for the services provided. Note 2: When planning for new, altered, or renovated space, the critical access hospital uses state rules and regulations or the current Guidelines for Design and Construction of Hospitals published by the Facility Guidelines Institute. If the state rules and regulations or the Guidelines do not address the design needs of the critical access hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria.
		EP 2	The critical access hospital has adequate space and facilities for the services it provides, including facilities for the diagnosis and treatment of patients and for any special services offered to meet the needs of the community served. Note: The extent and complexity of facilities is determined by the services offered.
		EP 3	The critical access hospital's premises are clean and orderly. Note: Clean and orderly means an uncluttered physical environment where patients and staff can function. This includes but is not limited to storing equipment and supplies in their proper spaces, attending to spills, and keeping areas neat.

CFR Number §482.41(a)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.41(a)(1)	**TAG: A-0702**	**PE.04.01.03**	**The critical access hospital manages utility systems.**
(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.		**EP 1**	The critical access hospital has emergency power and lighting in the following areas, at a minimum: • Operating rooms • Recovery rooms • Intensive care • Emergency rooms • Stairwells Battery lamps and flashlights are available in all other areas not serviced by the emergency power supply source.
§482.41(a)(2)	**TAG: A-0703**	**PE.04.01.03**	**The critical access hospital manages utility systems.**
(2) There must be facilities for emergency gas and water supply.		**EP 2**	The critical access hospital has a system to provide emergency gas and water supply. Note 1: The system includes making arrangements with local utility companies and others for the provision of emergency sources of water and gas. Note 2: Emergency gas includes fuels such as propane, natural gas, fuel oil, or liquefied natural gas, as well as any gases the critical access hospital uses in the care of patients, such as oxygen, nitrogen, or nitrous oxide.
§482.41(b)	**TAG: A-0709**	**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
§482.41(b) Standard: Life Safety from Fire The hospital must ensure that the life safety from fire requirements are met.		**EP 3**	The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§482.41(b)(1)	**TAG: A-0710**		
(1) Except as otherwise provided in this section—			

CFR Number §482.41(b)(1)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.41(b)(1)(i)	**TAG: A-0710**	**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(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.		**EP 3**	The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§482.41(b)(1)(ii)	**TAG: A-0710**	**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(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.		**EP 6**	Regardless of the provisions of the Life Safety Code, corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited on these doors.
§482.41(b)(2)	**TAG: A-0710**	**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a hospital, but only if the waiver will not adversely affect the health and safety of the patients.		**EP 3**	The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.

CFR Number §482.41(b)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.41(b)(3)	**TAG: A-0710**	**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(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.		**EP 3**	The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§482.41(b)(4)	**TAG: A-0713**	**PE.02.01.01**	**The critical access hospital manages risks related to hazardous materials and waste.**
(4) The hospital must have procedures for the proper routine storage and prompt disposal of trash.		**EP 6**	The critical access hospital has procedures for the proper routine storage and prompt disposal of trash and regulated medical waste.
§482.41(b)(5)	**TAG: A-0714**	**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(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.		**EP 4**	The critical access hospital has written fire control plans that include provisions for prompt reporting of fires; extinguishing fires; protection of patients, staff, and guests; evacuation; and cooperation with firefighting authorities.
§482.41(b)(6)	**TAG: A-0715**	**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(6) The hospital must maintain written evidence of regular inspection and approval by State or local fire control agencies.		**EP 5**	The critical access hospital maintains written evidence of regular inspection and approval by state or local fire control agencies.
§482.41(b)(7)	**TAG: A-0716**	**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(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;		**EP 7**	When the critical access hospital installs alcohol-based hand rub dispensers, it installs the dispensers in a manner that protects against inappropriate access.
§482.41(b)(8)	**TAG: A-0717**		
(8) When a sprinkler system is shut down for more than 10 hours, the hospital must:			
§482.41(b)(8)(i)	**TAG: A-0717**	**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(i) Evacuate the building or portion of the building affected by the system outage until the system is back in service, or		**EP 8**	When a sprinkler system is shut down for more than 10 hours, the critical access hospital either evacuates the building or portion of the building affected by the system outage until the system is back in service, or the critical access hospital establishes a fire watch until the system is back in service.

CFR Number §482.41(b)(8)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.41(b)(8)(ii)	**TAG: A-0717**	**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(ii) Establish a fire watch until the system is back in service.		**EP 8**	When a sprinkler system is shut down for more than 10 hours, the critical access hospital either evacuates the building or portion of the building affected by the system outage until the system is back in service, or the critical access hospital establishes a fire watch until the system is back in service.
§482.41(b)(9)	**TAG: A-0718**	**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(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.		**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)(i)	**TAG: A-0718**	**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(i) The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours.		**EP 9**	Buildings have an outside window or outside door in every sleeping room. For any building constructed after July 5, 2016, the sill height does not exceed 36 inches above the floor. Note 1: Windows in atrium walls are considered outside windows for the purposes of this requirement. Note 2: The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours. Note 3: The sill height in special nursing care areas of new occupancies does not exceed 60 inches.
§482.41(b)(9)(ii)	**TAG: A-0718**	**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(ii) The sill height in special nursing care areas of new occupancies must not exceed 60 inches		**EP 9**	Buildings have an outside window or outside door in every sleeping room. For any building constructed after July 5, 2016, the sill height does not exceed 36 inches above the floor. Note 1: Windows in atrium walls are considered outside windows for the purposes of this requirement. Note 2: The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours. Note 3: The sill height in special nursing care areas of new occupancies does not exceed 60 inches.
§482.41(c)	**TAG: A-0720**	**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(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).		**EP 1**	The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.

CFR Number §482.41(c)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.41(c)(1)	**TAG: A-0720**	**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to a hospital.		**EP 1**	The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§482.41(c)(2)	**TAG: A-0720**	**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(2) If application of the Health Care Facilities Code required under paragraph (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.		**EP 1**	The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§482.41(d)	**TAG: A-0722**	**PE.01.01.01**	**The critical access hospital has a safe and adequate physical environment.**
§482.41(d) Standard: Facilities The hospital must maintain adequate facilities for its services.		**EP 1**	The critical access hospital's building is constructed, arranged, and maintained to allow safe access and to protect the safety and well-being of patients. Note 1: Diagnostic and therapeutic facilities are located in areas appropriate for the services provided. Note 2: When planning for new, altered, or renovated space, the critical access hospital uses state rules and regulations or the current Guidelines for Design and Construction of Hospitals published by the Facility Guidelines Institute. If the state rules and regulations or the Guidelines do not address the design needs of the critical access hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria.
		EP 2	The critical access hospital has adequate space and facilities for the services it provides, including facilities for the diagnosis and treatment of patients and for any special services offered to meet the needs of the community served. Note: The extent and complexity of facilities is determined by the services offered.
§482.41(d)(1)	**TAG: A-0723**	**PE.01.01.01**	**The critical access hospital has a safe and adequate physical environment.**
(1) Diagnostic and therapeutic facilities must be located for the safety of patients.		**EP 1**	The critical access hospital's building is constructed, arranged, and maintained to allow safe access and to protect the safety and well-being of patients. Note 1: Diagnostic and therapeutic facilities are located in areas appropriate for the services provided. Note 2: When planning for new, altered, or renovated space, the critical access hospital uses state rules and regulations or the current Guidelines for Design and Construction of Hospitals published by the Facility Guidelines Institute. If the state rules and regulations or the Guidelines do not address the design needs of the critical access hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria.
§482.41(d)(2)	**TAG: A-0724**	**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.		**EP 2**	The critical access hospital maintains essential mechanical, electrical, and patient care equipment in safe operating condition.
		EP 5	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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.

CFR Number §482.41(d)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		PE.04.01.05	**The critical access hospital has a water management program that addresses Legionella and other waterborne pathogens. Note: The water management program is in accordance with law and regulation.**
		EP 1	The water management program has an individual or a team responsible for the oversight and implementation of the program, including but not limited to development, management, and maintenance activities.
		EP 2	The individual or team responsible for the water management program develops the following: • A basic diagram that maps all water supply sources, treatment systems, processing steps, control measures, and end-use points Note: An example would be a flow chart with symbols showing sinks, showers, water fountains, ice machines, and so forth. • A water risk management plan based on the diagram that includes an evaluation of the physical and chemical conditions of each step of the water flow diagram to identify any areas where potentially hazardous conditions may occur (these conditions are most likely to occur in areas with slow or stagnant water) Note: Refer to the Centers for Disease Control and Prevention's "Water Infection Control Risk Assessment (WICRA) for Healthcare Settings" tool as an example for conducting a water-related risk assessment. • A plan for addressing the use of water in areas of buildings where water may have been stagnant for a period of time (for example, unoccupied or temporarily closed areas) • An evaluation of the patient populations served to identify patients who are immunocompromised • Monitoring protocols and acceptable ranges for control measures Note: Critical access hospitals should consider incorporating basic practices for water monitoring within their water management programs that include monitoring of water temperature, residual disinfectant, and pH. In addition, protocols should include specificity around the parameters measured, locations where measurements are made, and appropriate corrective actions taken when parameters are out of range. (See also IC.04.01.01, EP 2)
		EP 3	The individual or team responsible for the water management program manages the following: • Documenting results of all monitoring activities • Corrective actions and procedures to follow if a test result outside of acceptable limits is obtained, including when a probable or confirmed waterborne pathogen(s) indicates action is necessary • Documenting corrective actions taken when control limits are not maintained Note: See PE.07.01.01, EP 1 for the process of monitoring, reporting, and investigating utility system issues.
		EP 4	The individual or team responsible for the water management program reviews the program annually and when the following occurs: • Changes have been made to the water system that would add additional risk. • New equipment or an at-risk water system(s) has been added that could generate aerosols or be a potential source for Legionella. This includes the commissioning of a new wing or building. Note 1: Joint Commission and the Centers for Medicare & Medicaid Services (CMS) do not require culturing for Legionella or other waterborne pathogens. Testing protocols are at the discretion of the critical access hospital unless required by law or regulation. Note 2: Refer to ASHRAE Standard 188-2018 "Legionellosis: Risk Management for Building Water Systems" and the Centers for Disease Control and Prevention Toolkit "Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings" for guidance on creating a water management plan. For additional guidance, consult ANSI/ASHRAE Guideline 12-2020 "Managing the Risk of Legionellosis Associated with Building Water Systems."
§482.41(d)(3) TAG: A-0725		**PE.01.01.01**	**The critical access hospital has a safe and adequate physical environment.**
(3) The extent and complexity of facilities must be determined by the services offered.		**EP 2**	The critical access hospital has adequate space and facilities for the services it provides, including facilities for the diagnosis and treatment of patients and for any special services offered to meet the needs of the community served. Note: The extent and complexity of facilities is determined by the services offered.

CFR Number §482.41(d)(4)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.41(d)(4)	**TAG: A-0726**	**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(4) There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas.		**EP 3**	The critical access hospital has proper ventilation, lighting, and temperature control in all pharmaceutical, patient care, and food preparation areas.
§482.41(e)	**TAG: A-0730**		
(e) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C.552(a) and 1 CFR part 51. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.			
§482.41(e)(1)	**TAG: A-0730**		
(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.			
§482.41(e)(1)(i)	**TAG: A-0730**	**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(i) NFPA 99, Standards for Health Care Facilities Code of the National Fire Protection Association 99, 2012 edition, issued August 11, 2011.		**EP 1**	The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§482.41(e)(1)(ii)	**TAG: A-0730**	**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(ii) TIA 12–2 to NFPA 99, issued August 11, 2011.		**EP 1**	The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§482.41(e)(1)(iii)	**TAG: A-0730**	**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(iii) TIA 12–3 to NFPA 99, issued August 9, 2012.		**EP 1**	The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.

CFR Number §482.41(e)(1)(iv)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.41(e)(1)(iv)	**TAG: A-0730**	**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(iv) TIA 12–4 to NFPA 99, issued March 7, 2013.		**EP 1**	The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§482.41(e)(1)(v)	**TAG: A-0730**	**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(v) TIA 12–5 to NFPA 99, issued August 1, 2013.		**EP 1**	The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§482.41(e)(1)(vi)	**TAG: A-0730**	**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(vi) TIA 12–6 to NFPA 99, issued March 3, 2014.		**EP 1**	The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§482.41(e)(1)(vii)	**TAG: A-0730**	**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011;		**EP 3**	The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.

CFR Number §482.41(e)(1)(viii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.41(e)(1)(viii) **TAG: A-0730**		**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(viii) TIA 12–1 to NFPA 101, issued August 11, 2011.		**EP 3**	The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§482.41(e)(1)(ix) **TAG: A-0730**		**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(ix) TIA 12–2 to NFPA 101, issued October 30, 2012.		**EP 3**	The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.

CFR Number §482.41(e)(1)(x)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.41(e)(1)(x) TAG: A-0730		**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(x) TIA 12–3 to NFPA 101, issued October 22, 2013.		**EP 3**	The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§482.41(e)(1)(xi) TAG: A-0730		**PE.03.01.01**	**The critical access hospital designs and manages the physical environment to comply with the Life Safety Code.**
(xi) TIA 12–4 to NFPA 101, issued October 22, 2013.		**EP 3**	The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.

CFR Number §482.42	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.42	**TAG: A-0747**	**IC.04.01.01**	**The critical access hospital has a hospitalwide infection prevention and control program for the surveillance, prevention, and control of health care–associated infections (HAIs) and other infectious diseases.**
§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.		**EP 2**	The infection preventionist(s) or infection control professional(s) is responsible for the following: • Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines • Documentation of the infection prevention and control program and its surveillance, prevention, and control activities • Competency-based training and education of critical access hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the critical access hospital, on infection prevention and control guidelines, policies and procedures and their application • Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures • Communication and collaboration with all components of the critical access hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program • Communication and collaboration with the critical access hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.11.04.01 EP 1). (See also PE.04.01.05, EP 2)
		EP 3	The critical access hospital's infection prevention and control program has written policies and procedures to guide its activities and methods for preventing and controlling the transmission of infections within the critical access hospital and between the critical access hospital and other institutions and settings. The policies and procedures are in accordance with the following hierarchy of references: a. Applicable law and regulation. b. Manufacturers' instructions for use. c. Nationally recognized evidence-based guidelines and standards of practice, including the Centers for Disease Control and Prevention's (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings or, in the absence of such guidelines, expert consensus or best practices. The guidelines are documented within the policies and procedures. Note 1: Relevant federal, state, and local law and regulations include but are not limited to the Centers for Medicare & Medicaid Services' Conditions of Participation, Food and Drug Administration's regulations for reprocessing single-use medical devices; Occupational Safety and Health Administration's Bloodborne Pathogens Standard 29 CFR 1910.1030, Personal Protective Equipment Standard 29 CFR 1910.132, and Respiratory Protection Standard 29 CFR 1910.134; health care worker vaccination laws; state and local public health authorities' requirements for reporting of communicable diseases and outbreaks; and state and local regulatory requirements for biohazardous or regulated medical waste generators. Note 2: For full details on the CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, refer to https://www.cdc.gov/infection-control/hcp/disinfection-sterilization/introduction-methods-definition-of-terms.html. Note 3: The critical access hospital determines which evidence-based guidelines, expert recommendations, best practices, or a combination thereof it adopts in its policies and procedures.
		EP 5	The infection prevention and control program reflects the scope and complexity of the critical access hospital services provided by addressing all locations, patient populations, and staff. (See also LD.11.01.01, EP 10)

CFR Number §482.42	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		IC.05.01.01	**The critical access hospital's governing body, or responsible individual, is accountable for the implementation, performance, and sustainability of the infection prevention and control program.**
		EP 1	The critical access hospital's governing body, or responsible individual, is responsible for the implementation, performance, and sustainability of the infection prevention and control program and provides resources to support and track the implementation, success, and sustainability of the program's activities. Note: To make certain that systems are in place and operational to support the program, the governing body, or responsible individual, provides access to information technology; laboratory services; equipment and supplies; local, state, and federal public health authorities' advisories and alerts, such as the CDC's Health Alert Network (HAN); FDA alerts; manufacturers' instructions for use; and guidelines used to inform policies.
		EP 2	The critical access hospital's governing body, or responsible individual, ensures that the problems identified by the infection prevention and control program are addressed in collaboration with critical access hospital quality assessment and performance improvement leaders and other leaders (for example, the medical director, nurse executive, and administrative leaders).
		IC.06.01.01	**The critical access hospital implements its infection prevention and control program through surveillance, prevention, and control activities.**
		EP 3	The critical access hospital implements activities for the surveillance, prevention, and control of health care–associated infections and other infectious diseases, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and addresses any infection control issues identified by public health authorities that could impact the critical access hospital. (See also NPG.05.03.01, EP 1)
		MM.18.01.01	**The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.**
		EP 1	The antibiotic stewardship program reflects the scope and complexity of the critical access hospital services provided.
		EP 3	The leader(s) of the antibiotic stewardship program is responsible for the following: • Development and implementation a critical access hospitalwide antibiotic stewardship program, based on nationally recognized guidelines, to monitor and improve the use of antibiotics. • All documentation, written or electronic, of antibiotic stewardship program activities. • Communication and collaboration with medical staff, nursing, and pharmacy leadership, as well as with the critical access hospital's infection prevention and control and QAPI programs, on antibiotic use issues. • Competency-based training and education of critical access hospital personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the critical access hospital, on the practical applications of antibiotic stewardship guidelines, policies, and procedures.
		PE.04.01.01	**The critical access hospital addresses building safety and facility management.**
		EP 1	The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§482.42(a)	**TAG: A-0748**		
(a) Standard: Infection prevention and control program organization and policies. The hospital must demonstrate that:			

CFR Number §482.42(a)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.42(a)(1)	**TAG: A-0748**	**HR.11.02.01**	**The critical access hospital defines and verifies staff qualifications.**
(1) An individual (or individuals), who is qualified through education, training, experience, or certification in infection prevention and control, is appointed by the governing body as the infection preventionist(s)/infection control professional(s) responsible for the infection prevention and control program and that the appointment is based on the recommendations of medical staff leadership and nursing leadership;		**EP 1**	The critical access hospital defines staff qualifications specific to their job responsibilities. Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control). Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists, as defined in 42 CFR 484, provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the critical access hospital. See Glossary for definitions of physical therapist, physical therapist assistant, occupational therapist, occupational therapy assistant, speech-language pathologist, and audiologist. Note 3: For rehabilitation and psychiatric distinct part units in critical access hospitals: If respiratory care services are provided, staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing.
		NPG.12.01.01	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
		EP 12	The critical access hospital's governing body, or responsible individual, based on the recommendation of the medical staff and nursing leaders, appoints an infection preventionist(s) or infection control professional(s) qualified through education, training, experience, or certification in infection prevention to be responsible for the infection prevention and control program.
§482.42(a)(2)	**TAG: A-0749**	**IC.04.01.01**	**The critical access hospital has a hospitalwide infection prevention and control program for the surveillance, prevention, and control of health care–associated infections (HAIs) and other infectious diseases.**
(2) The 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;		**EP 3**	The critical access hospital's infection prevention and control program has written policies and procedures to guide its activities and methods for preventing and controlling the transmission of infections within the critical access hospital and between the critical access hospital and other institutions and settings. The policies and procedures are in accordance with the following hierarchy of references: a. Applicable law and regulation. b. Manufacturers' instructions for use. c. Nationally recognized evidence-based guidelines and standards of practice, including the Centers for Disease Control and Prevention's (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings or, in the absence of such guidelines, expert consensus or best practices. The guidelines are documented within the policies and procedures. Note 1: Relevant federal, state, and local law and regulations include but are not limited to the Centers for Medicare & Medicaid Services' Conditions of Participation, Food and Drug Administration's regulations for reprocessing single-use medical devices; Occupational Safety and Health Administration's Bloodborne Pathogens Standard 29 CFR 1910.1030, Personal Protective Equipment Standard 29 CFR 1910.132, and Respiratory Protection Standard 29 CFR 1910.134; health care worker vaccination laws; state and local public health authorities' requirements for reporting of communicable diseases and outbreaks; and state and local regulatory requirements for biohazardous or regulated medical waste generators. Note 2: For full details on the CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, refer to https://www.cdc.gov/infection-control/hcp/disinfection-sterilization/introduction-methods-definition-of-terms.html. Note 3: The critical access hospital determines which evidence-based guidelines, expert recommendations, best practices, or a combination thereof it adopts in its policies and procedures.

CFR Number §482.42(a)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		EP 4	The critical access hospital's policies and procedures for cleaning, disinfection, and sterilization of reusable medical and surgical devices and equipment address the following: • Cleaning, disinfection, and sterilization of reusable medical and surgical devices in accordance with the Spaulding classification system and manufacturers' instructions • Use of disinfectants registered by the Environmental Protection Agency for noncritical devices and equipment according to the directions on the product labeling, including but not limited to indication, specified use dilution, contact time, and method of application • Use of FDA-approved liquid chemical sterilants for the processing of critical devices and high-level disinfectants for the processing of semicritical devices in accordance with FDA-cleared label and device manufacturers' instructions • Required documentation for device reprocessing cycles, including but not limited to sterilizer cycle logs, the frequency of chemical and biological testing, and the results of testing for appropriate concentration for chemicals used in high-level disinfection • Resolution of conflicts or discrepancies between a medical device manufacturer's instructions and manufacturers' instructions for automated high-level disinfection or sterilization equipment • Criteria and process for the use of immediate-use steam sterilization • Actions to take in the event of a reprocessing error or failure identified either prior to the release of the reprocessed item(s) or after the reprocessed item(s) was used or stored for later use Note 1: The Spaulding classification system classifies medical and surgical devices as critical, semicritical, or noncritical based on risk to the patient from contamination on a device and establishes the levels of germicidal activity (sterilization, high-level disinfection, intermediate-level disinfection, and low-level disinfection) to be used for the three classes of devices. Note 2: Depending on the nature of the incident, examples of actions may include quarantine of the sterilizer, recall of item(s), stakeholder notification, patient notification, surveillance, and follow-up.
§482.42(a)(3) TAG: A-0750		**IC.06.01.01**	**The critical access hospital implements its infection prevention and control program through surveillance, prevention, and control activities.**
(3) The infection prevention and control program includes surveillance, prevention, and control of HAIs, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and addresses any infection control issues identified by public health authorities; and		**EP 3**	The critical access hospital implements activities for the surveillance, prevention, and control of health care–associated infections and other infectious diseases, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and addresses any infection control issues identified by public health authorities that could impact the critical access hospital. (See also NPG.05.03.01, EP 1)
		EP 4	The critical access hospital implements its policies and procedures for infectious disease outbreaks, including the following: • Implementing infection prevention and control activities when an outbreak is first recognized by internal surveillance or public health authorities • Reporting an outbreak in accordance with state and local public health authorities' requirements • Investigating an outbreak • Communicating information necessary to prevent further transmission of the infection among patients, visitors, and staff, as appropriate
		EP 5	The critical access hospital implements policies and procedures to minimize the risk of communicable disease exposure and acquisition among its staff, in accordance with law and regulation. The policies and procedures address the following: • Screening and medical evaluations for infectious diseases • Immunizations • Staff education and training • Management of staff with potentially infectious exposures or communicable illnesses

CFR Number §482.42(a)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		PE.01.01.01	**The critical access hospital has a safe and adequate physical environment.**
		EP 1	The critical access hospital's building is constructed, arranged, and maintained to allow safe access and to protect the safety and well-being of patients. Note 1: Diagnostic and therapeutic facilities are located in areas appropriate for the services provided. Note 2: When planning for new, altered, or renovated space, the critical access hospital uses state rules and regulations or the current Guidelines for Design and Construction of Hospitals published by the Facility Guidelines Institute. If the state rules and regulations or the Guidelines do not address the design needs of the critical access hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria.
		PE.04.01.05	**The critical access hospital has a water management program that addresses Legionella and other waterborne pathogens. Note: The water management program is in accordance with law and regulation.**
		EP 1	The water management program has an individual or a team responsible for the oversight and implementation of the program, including but not limited to development, management, and maintenance activities.
		EP 2	The individual or team responsible for the water management program develops the following: • A basic diagram that maps all water supply sources, treatment systems, processing steps, control measures, and end-use points Note: An example would be a flow chart with symbols showing sinks, showers, water fountains, ice machines, and so forth. • A water risk management plan based on the diagram that includes an evaluation of the physical and chemical conditions of each step of the water flow diagram to identify any areas where potentially hazardous conditions may occur (these conditions are most likely to occur in areas with slow or stagnant water) Note: Refer to the Centers for Disease Control and Prevention's "Water Infection Control Risk Assessment (WICRA) for Healthcare Settings" tool as an example for conducting a water-related risk assessment. • A plan for addressing the use of water in areas of buildings where water may have been stagnant for a period of time (for example, unoccupied or temporarily closed areas) • An evaluation of the patient populations served to identify patients who are immunocompromised • Monitoring protocols and acceptable ranges for control measures Note: Critical access hospitals should consider incorporating basic practices for water monitoring within their water management programs that include monitoring of water temperature, residual disinfectant, and pH. In addition, protocols should include specificity around the parameters measured, locations where measurements are made, and appropriate corrective actions taken when parameters are out of range. (See also IC.04.01.01, EP 2)
§482.42(a)(4) **TAG: A-0751** (4) The infection prevention and control program reflects the scope and complexity of the hospital services provided.		**IC.04.01.01**	**The critical access hospital has a hospitalwide infection prevention and control program for the surveillance, prevention, and control of health care–associated infections (HAIs) and other infectious diseases.**
		EP 5	The infection prevention and control program reflects the scope and complexity of the critical access hospital services provided by addressing all locations, patient populations, and staff. (See also LD.11.01.01, EP 10)
§482.42(b) **TAG: A-0760** (b) Standard: Antibiotic stewardship program organization and policies. The hospital must demonstrate that:			
§482.42(b)(1) **TAG: A-0760** (1) An individual (or individuals), who is qualified through education, training, or experience in infectious diseases and/or antibiotic stewardship, is appointed by the governing body as the leader(s) of the antibiotic stewardship program and that the appointment is based on the recommendations of medical staff leadership and pharmacy leadership;		**MM.18.01.01**	**The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.**
		EP 2	The critical access hospital demonstrates that an individual (or individuals), who is qualified through education, training, or experience in infectious diseases and/or antibiotic stewardship, is appointed by the governing body, or responsible individual, as the leader(s) of the antibiotic stewardship program and that the appointment is based on the recommendations of medical staff leadership and pharmacy leadership.

CFR Number §482.42(b)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.42(b)(2)	**TAG: A-0761**		
(2) The hospital-wide antibiotic stewardship program:			
§482.42(b)(2)(i)	**TAG: A-0761**	**MM.18.01.01**	**The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.**
(i) Demonstrates coordination among all components of the 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;		**EP 5**	The critical access hospitalwide antibiotic stewardship program: • Demonstrates coordination among all components of the critical access hospital responsible for antibiotic use and resistance, including, but not limited to, the infection prevention and control program, the QAPI program, the medical staff, nursing services, and pharmacy services. • Documents the evidence-based use of antibiotics in all departments and services of the critical access hospital. • Documents any improvements, including sustained improvements, in proper antibiotic use.
§482.42(b)(2)(ii)	**TAG: A-0762**	**MM.18.01.01**	**The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.**
(ii) Documents the evidence-based use of antibiotics in all departments and services of the hospital; and		**EP 5**	The critical access hospitalwide antibiotic stewardship program: • Demonstrates coordination among all components of the critical access hospital responsible for antibiotic use and resistance, including, but not limited to, the infection prevention and control program, the QAPI program, the medical staff, nursing services, and pharmacy services. • Documents the evidence-based use of antibiotics in all departments and services of the critical access hospital. • Documents any improvements, including sustained improvements, in proper antibiotic use.
§482.42(b)(2)(iii)	**TAG: A-0763**	**MM.18.01.01**	**The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.**
(iii) Documents any improvements, including sustained improvements, in proper antibiotic use;		**EP 5**	The critical access hospitalwide antibiotic stewardship program: • Demonstrates coordination among all components of the critical access hospital responsible for antibiotic use and resistance, including, but not limited to, the infection prevention and control program, the QAPI program, the medical staff, nursing services, and pharmacy services. • Documents the evidence-based use of antibiotics in all departments and services of the critical access hospital. • Documents any improvements, including sustained improvements, in proper antibiotic use.
§482.42(b)(3)	**TAG: A-0764**	**MM.18.01.01**	**The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.**
(3) The antibiotic stewardship program adheres to nationally recognized guidelines, as well as best practices, for improving antibiotic use; and		**EP 6**	The antibiotic stewardship program adheres to nationally recognized guidelines, as well as best practices, for improving antibiotic use.
§482.42(b)(4)	**TAG: A-0765**	**MM.18.01.01**	**The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.**
(4) The antibiotic stewardship program reflects the scope and complexity of the hospital services provided.		**EP 1**	The antibiotic stewardship program reflects the scope and complexity of the critical access hospital services provided.
§482.42(c)	**TAG: A-0770**		
(c) Standard: Leadership responsibilities.			
§482.42(c)(1)	**TAG: A-0770**		
(1) The governing body must ensure all of the following:			

CFR Number §482.42(c)(1)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.42(c)(1)(i) **TAG: A-0770**		**IC.05.01.01**	**The critical access hospital's governing body, or responsible individual, is accountable for the implementation, performance, and sustainability of the infection prevention and control program.**
(i) Systems are in place and operational for the tracking of all infection surveillance, prevention, and control, and antibiotic use activities, in order to demonstrate the implementation, success, and sustainability of such activities.		**EP 1**	The critical access hospital's governing body, or responsible individual, is responsible for the implementation, performance, and sustainability of the infection prevention and control program and provides resources to support and track the implementation, success, and sustainability of the program's activities. Note: To make certain that systems are in place and operational to support the program, the governing body, or responsible individual, provides access to information technology; laboratory services; equipment and supplies; local, state, and federal public health authorities' advisories and alerts, such as the CDC's Health Alert Network (HAN); FDA alerts; manufacturers' instructions for use; and guidelines used to inform policies.
		MM.18.01.01	**The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.**
		EP 7	The governing body, or responsible individual, ensures that systems are in place and operational for the tracking of all antibiotic use activities in order to demonstrate the implementation, success, and sustainability of such activities.
§482.42(c)(1)(ii) **TAG: A-0771**		**IC.05.01.01**	**The critical access hospital's governing body, or responsible individual, is accountable for the implementation, performance, and sustainability of the infection prevention and control program.**
(ii) All HAIs and other infectious diseases identified by the infection prevention and control program as well as antibiotic use issues identified by the antibiotic stewardship program are addressed in collaboration with hospital QAPI leadership.		**EP 2**	The critical access hospital's governing body, or responsible individual, ensures that the problems identified by the infection prevention and control program are addressed in collaboration with critical access hospital quality assessment and performance improvement leaders and other leaders (for example, the medical director, nurse executive, and administrative leaders).
		MM.18.01.01	**The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.**
		EP 4	The governing body, or responsible individual, ensures all antibiotic use issues identified by the antibiotic stewardship program are addressed in collaboration with the critical access hospital's QAPI leadership.
§482.42(c)(2) **TAG: A-0772**			
(2) The infection preventionist(s)/infection control professional(s) is responsible for:			

CFR Number §482.42(c)(2)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.42(c)(2)(i) **TAG: A-0772**		**IC.04.01.01**	**The critical access hospital has a hospitalwide infection prevention and control program for the surveillance, prevention, and control of health care–associated infections (HAIs) and other infectious diseases.**
(i) The development and implementation of hospital-wide infection surveillance, prevention, and control policies and procedures that adhere to nationally recognized guidelines.		**EP 2**	The infection preventionist(s) or infection control professional(s) is responsible for the following: • Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines • Documentation of the infection prevention and control program and its surveillance, prevention, and control activities • Competency-based training and education of critical access hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the critical access hospital, on infection prevention and control guidelines, policies and procedures and their application • Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures • Communication and collaboration with all components of the critical access hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program • Communication and collaboration with the critical access hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.11.04.01 EP 1). (See also PE.04.01.05, EP 2)
§482.42(c)(2)(ii) **TAG: A-0773**		**IC.04.01.01**	**The critical access hospital has a hospitalwide infection prevention and control program for the surveillance, prevention, and control of health care–associated infections (HAIs) and other infectious diseases.**
(ii) All documentation, written or electronic, of the infection prevention and control program and its surveillance, prevention, and control activities.		**EP 2**	The infection preventionist(s) or infection control professional(s) is responsible for the following: • Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines • Documentation of the infection prevention and control program and its surveillance, prevention, and control activities • Competency-based training and education of critical access hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the critical access hospital, on infection prevention and control guidelines, policies and procedures and their application • Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures • Communication and collaboration with all components of the critical access hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program • Communication and collaboration with the critical access hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.11.04.01 EP 1). (See also PE.04.01.05, EP 2)

CFR Number §482.42(c)(2)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.42(c)(2)(iii) **TAG: A-0774**		**IC.04.01.01**	**The critical access hospital has a hospitalwide infection prevention and control program for the surveillance, prevention, and control of health care–associated infections (HAIs) and other infectious diseases.**
(iii) Communication and collaboration with the hospital's QAPI program on infection prevention and control issues.		**EP 2**	The infection preventionist(s) or infection control professional(s) is responsible for the following: • Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines • Documentation of the infection prevention and control program and its surveillance, prevention, and control activities • Competency-based training and education of critical access hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the critical access hospital, on infection prevention and control guidelines, policies and procedures and their application • Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures • Communication and collaboration with all components of the critical access hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program • Communication and collaboration with the critical access hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.11.04.01 EP 1). (See also PE.04.01.05, EP 2)
§482.42(c)(2)(iv) **TAG: A-0775**		**HR.11.03.01**	**The critical access hospital provides orientation, education, and training to their staff.**
(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.		**EP 1**	Staff participate in ongoing education and training to maintain or increase their competency and, as needed, when staff responsibilities change. Staff participation is documented.
		HR.11.04.01	**The critical access hospital evaluates staff competence and performance.**
		EP 1	Staff competence is initially assessed and documented as part of orientation and once every three years, or more frequently as required by critical access hospital policy or in accordance with law and regulation.

CFR Number §482.42(c)(2)(iv)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		IC.04.01.01	**The critical access hospital has a hospitalwide infection prevention and control program for the surveillance, prevention, and control of health care–associated infections (HAIs) and other infectious diseases.**
		EP 2	The infection preventionist(s) or infection control professional(s) is responsible for the following: • Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines • Documentation of the infection prevention and control program and its surveillance, prevention, and control activities • Competency-based training and education of critical access hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the critical access hospital, on infection prevention and control guidelines, policies and procedures and their application • Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures • Communication and collaboration with all components of the critical access hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program • Communication and collaboration with the critical access hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.11.04.01 EP 1). (See also PE.04.01.05, EP 2)
§482.42(c)(2)(v) TAG: A-0776 (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**	**The critical access hospital has a hospitalwide infection prevention and control program for the surveillance, prevention, and control of health care–associated infections (HAIs) and other infectious diseases.**
		EP 2	The infection preventionist(s) or infection control professional(s) is responsible for the following: • Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines • Documentation of the infection prevention and control program and its surveillance, prevention, and control activities • Competency-based training and education of critical access hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the critical access hospital, on infection prevention and control guidelines, policies and procedures and their application • Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures • Communication and collaboration with all components of the critical access hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program • Communication and collaboration with the critical access hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.11.04.01 EP 1). (See also PE.04.01.05, EP 2)

CFR Number §482.42(c)(2)(vi)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.42(c)(2)(vi) **TAG: A-0777**		**IC.04.01.01**	**The critical access hospital has a hospitalwide infection prevention and control program for the surveillance, prevention, and control of health care–associated infections (HAIs) and other infectious diseases.**
(vi) Communication and collaboration with the antibiotic stewardship program.		**EP 2**	The infection preventionist(s) or infection control professional(s) is responsible for the following: • Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines • Documentation of the infection prevention and control program and its surveillance, prevention, and control activities • Competency-based training and education of critical access hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the critical access hospital, on infection prevention and control guidelines, policies and procedures and their application • Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures • Communication and collaboration with all components of the critical access hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program • Communication and collaboration with the critical access hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.11.04.01 EP 1). (See also PE.04.01.05, EP 2)
§482.42(c)(3) **TAG: A-0778**			
(3) The leader(s) of the antibiotic stewardship program is responsible for:			
§482.42(c)(3)(i) **TAG: A-0778**		**MM.18.01.01**	**The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.**
(i) The development and implementation of a hospital-wide antibiotic stewardship program, based on nationally recognized guidelines, to monitor and improve the use of antibiotics.		**EP 3**	The leader(s) of the antibiotic stewardship program is responsible for the following: • Development and implementation a critical access hospitalwide antibiotic stewardship program, based on nationally recognized guidelines, to monitor and improve the use of antibiotics. • All documentation, written or electronic, of antibiotic stewardship program activities. • Communication and collaboration with medical staff, nursing, and pharmacy leadership, as well as with the critical access hospital's infection prevention and control and QAPI programs, on antibiotic use issues. • Competency-based training and education of critical access hospital personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the critical access hospital, on the practical applications of antibiotic stewardship guidelines, policies, and procedures.
§482.42(c)(3)(ii) **TAG: A-0779**		**MM.18.01.01**	**The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.**
(ii) All documentation, written or electronic, of antibiotic stewardship program activities.		**EP 3**	The leader(s) of the antibiotic stewardship program is responsible for the following: • Development and implementation a critical access hospitalwide antibiotic stewardship program, based on nationally recognized guidelines, to monitor and improve the use of antibiotics. • All documentation, written or electronic, of antibiotic stewardship program activities. • Communication and collaboration with medical staff, nursing, and pharmacy leadership, as well as with the critical access hospital's infection prevention and control and QAPI programs, on antibiotic use issues. • Competency-based training and education of critical access hospital personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the critical access hospital, on the practical applications of antibiotic stewardship guidelines, policies, and procedures.

CFR Number §482.42(c)(3)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.42(c)(3)(iii) **TAG: A-0780**		**MM.18.01.01**	**The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.**
(iii) Communication and collaboration with medical staff, nursing, and pharmacy leadership, as well as with the hospital's infection prevention and control and QAPI programs, on antibiotic use issues.		**EP 3**	The leader(s) of the antibiotic stewardship program is responsible for the following: • Development and implementation a critical access hospitalwide antibiotic stewardship program, based on nationally recognized guidelines, to monitor and improve the use of antibiotics. • All documentation, written or electronic, of antibiotic stewardship program activities. • Communication and collaboration with medical staff, nursing, and pharmacy leadership, as well as with the critical access hospital's infection prevention and control and QAPI programs, on antibiotic use issues. • Competency-based training and education of critical access hospital personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the critical access hospital, on the practical applications of antibiotic stewardship guidelines, policies, and procedures.
§482.42(c)(3)(iv) **TAG: A-0781**		**MM.18.01.01**	**The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.**
(iv) Competency-based training and education of 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.		**EP 3**	The leader(s) of the antibiotic stewardship program is responsible for the following: • Development and implementation a critical access hospitalwide antibiotic stewardship program, based on nationally recognized guidelines, to monitor and improve the use of antibiotics. • All documentation, written or electronic, of antibiotic stewardship program activities. • Communication and collaboration with medical staff, nursing, and pharmacy leadership, as well as with the critical access hospital's infection prevention and control and QAPI programs, on antibiotic use issues. • Competency-based training and education of critical access hospital personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the critical access hospital, on the practical applications of antibiotic stewardship guidelines, policies, and procedures.
§482.42(d) **TAG: A-0785**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(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 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:		**EP 10**	If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency hospitals, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member facilities after determining that such a decision is in accordance with applicable law and regulation. Each separately certified critical access hospital subject to the system governing body demonstrates that the unified and integrated infection prevention and control program and the antibiotic stewardship program do the following: • Account for each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered • Establish and implement policies and procedures to make certain that the needs and concerns of each separately certified critical access hospital, regardless of practice or location, are given due consideration • Have mechanisms in place to ensure that issues localized to particular critical access hospitals are duly considered and addressed • Designate a qualified individual(s) at the critical access hospital with expertise in infection prevention and control and in antibiotic stewardship as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to critical access hospital staff Note: The system governing body is responsible and accountable for making certain that each of its separately certified critical access hospitals meet all of the requirements at 42 CFR 485.640(g). (See also IC.04.01.01, EP 5)

CFR Number §482.42(d)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.42(d)(1)	**TAG: A-0786**	**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(1) The unified and integrated infection prevention and control and antibiotic stewardship programs are established in a manner that takes into account each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital;		**EP 10**	If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency hospitals, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member facilities after determining that such a decision is in accordance with applicable law and regulation. Each separately certified critical access hospital subject to the system governing body demonstrates that the unified and integrated infection prevention and control program and the antibiotic stewardship program do the following: • Account for each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered • Establish and implement policies and procedures to make certain that the needs and concerns of each separately certified critical access hospital, regardless of practice or location, are given due consideration • Have mechanisms in place to ensure that issues localized to particular critical access hospitals are duly considered and addressed • Designate a qualified individual(s) at the critical access hospital with expertise in infection prevention and control and in antibiotic stewardship as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to critical access hospital staff Note: The system governing body is responsible and accountable for making certain that each of its separately certified critical access hospitals meet all of the requirements at 42 CFR 485.640(g). (See also IC.04.01.01, EP 5)

CFR Number §482.42(d)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.42(d)(2) **TAG: A-0787**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(2) The unified and integrated infection prevention and control and antibiotic stewardship programs establish and implement policies and procedures to ensure that the needs and concerns of each of its separately certified hospitals, regardless of practice or location, are given due consideration;		**EP 10**	If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency hospitals, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member facilities after determining that such a decision is in accordance with applicable law and regulation. Each separately certified critical access hospital subject to the system governing body demonstrates that the unified and integrated infection prevention and control program and the antibiotic stewardship program do the following: • Account for each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered • Establish and implement policies and procedures to make certain that the needs and concerns of each separately certified critical access hospital, regardless of practice or location, are given due consideration • Have mechanisms in place to ensure that issues localized to particular critical access hospitals are duly considered and addressed • Designate a qualified individual(s) at the critical access hospital with expertise in infection prevention and control and in antibiotic stewardship as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to critical access hospital staff Note: The system governing body is responsible and accountable for making certain that each of its separately certified critical access hospitals meet all of the requirements at 42 CFR 485.640(g). (See also IC.04.01.01, EP 5)

CFR Number §482.42(d)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.42(d)(3) **TAG: A-0788**		**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(3) The unified and integrated infection prevention and control and antibiotic stewardship programs have mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed; and		**EP 10**	If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency hospitals, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member facilities after determining that such a decision is in accordance with applicable law and regulation. Each separately certified critical access hospital subject to the system governing body demonstrates that the unified and integrated infection prevention and control program and the antibiotic stewardship program do the following: • Account for each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered • Establish and implement policies and procedures to make certain that the needs and concerns of each separately certified critical access hospital, regardless of practice or location, are given due consideration • Have mechanisms in place to ensure that issues localized to particular critical access hospitals are duly considered and addressed • Designate a qualified individual(s) at the critical access hospital with expertise in infection prevention and control and in antibiotic stewardship as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to critical access hospital staff Note: The system governing body is responsible and accountable for making certain that each of its separately certified critical access hospitals meet all of the requirements at 42 CFR 485.640(g). (See also IC.04.01.01, EP 5)

CFR Number §482.42(d)(4)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.42(d)(4)	**TAG: A-0789**	**LD.11.01.01**	**The governing body is ultimately accountable for the safety and quality of care, treatment, and services.**
(4) A qualified individual (or individuals) with expertise in infection prevention and control and in antibiotic stewardship has been designated at the 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.		**EP 10**	If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency hospitals, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member facilities after determining that such a decision is in accordance with applicable law and regulation. Each separately certified critical access hospital subject to the system governing body demonstrates that the unified and integrated infection prevention and control program and the antibiotic stewardship program do the following: • Account for each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered • Establish and implement policies and procedures to make certain that the needs and concerns of each separately certified critical access hospital, regardless of practice or location, are given due consideration • Have mechanisms in place to ensure that issues localized to particular critical access hospitals are duly considered and addressed • Designate a qualified individual(s) at the critical access hospital with expertise in infection prevention and control and in antibiotic stewardship as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to critical access hospital staff Note: The system governing body is responsible and accountable for making certain that each of its separately certified critical access hospitals meet all of the requirements at 42 CFR 485.640(g). (See also IC.04.01.01, EP 5)
§482.43	**TAG: A-0799**	**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
§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.		**EP 1**	The critical access hospital has an effective discharge planning process that focuses on, and is consistent with, the patient's goals and treatment preferences; makes certain there is an effective transition of the patient from the critical access hospital to postdischarge care; and reduces the factors leading to preventable critical access hospital and hospital readmissions. Note: The critical access hospital's discharge planning process requires regular reevaluation of the patient's condition to identify changes that require modification of the discharge plan. The discharge plan is updated as needed to reflect these changes.
		EP 4	The patient, the patient's caregiver(s) or support person(s), physicians, other licensed practitioners, clinical psychologists, and staff who are involved in the patient's care, treatment, and services participate in planning the patient's discharge or transfer. The patient and their caregiver(s) or support person(s) are included as active partners when planning for postdischarge care. Note 1: For rehabilitation and psychiatric distinct part units in critical access hospitals: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (refer to the Glossary). Note 2: For psychiatric distinct part units in critical access hospitals: Social service staff responsibilities include but are not limited to participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the critical access hospital. Note 3: For swing beds in critical access hospitals: The critical access hospital notifies the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and reasons for the move. The notice is in writing, in a language and manner they understand, and includes the items described in 42 CFR 483.15(c)(5). The critical access hospital also provides sufficient preparation and orientation to residents to make sure that transfer or discharge from the critical access hospital is safe and orderly. The critical access hospital sends a copy of the notice to a representative of the office of the state's long-term care ombudsman.

CFR Number §482.43(a)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.43(a)	**TAG: A-0800**	**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
§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.		**EP 2**	The critical access hospital begins the discharge planning process early in the patient's episode of care, treatment, and services.
		EP 5	The critical access hospital performs a discharge planning evaluation and creates a discharge plan for those patients it identifies at an early stage of hospitalization are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning or at the request of the patient, patient's representative, or the patient's physician. Note 1: The discharge planning evaluation is completed in a timely manner so that appropriate arrangements for post–hospital care are made before discharge and unnecessary delays in discharge are avoided. Note 2: The discharge planning evaluation is performed and subsequent discharge plan is created by, or under the supervision of, a registered nurse, social worker, or other qualified person.
§482.43(a)(1)	**TAG: A-0805**	**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(1) Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge.		**EP 5**	The critical access hospital performs a discharge planning evaluation and creates a discharge plan for those patients it identifies at an early stage of hospitalization are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning or at the request of the patient, patient's representative, or the patient's physician. Note 1: The discharge planning evaluation is completed in a timely manner so that appropriate arrangements for post–hospital care are made before discharge and unnecessary delays in discharge are avoided. Note 2: The discharge planning evaluation is performed and subsequent discharge plan is created by, or under the supervision of, a registered nurse, social worker, or other qualified person.
§482.43(a)(2)	**TAG: A-0807**	**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(2) A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-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.		**EP 3**	As part of the discharge planning evaluation, the critical access hospital evaluates the patient's need for appropriate post–critical access hospital services, including but not limited to hospice care services, extended care services, home health services, and non–health care services and community-based care providers. The critical access hospital also evaluates the availability of the appropriate services and the patient's access to those services as part of the discharge planning evaluation.
§482.43(a)(3)	**TAG: A-0808**	**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(3) The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative).		**EP 6**	The critical access hospital discusses the results of the discharge planning evaluation with the patient or their representative, including any reevaluations performed and any arrangements made.

CFR Number §482.43(a)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		RC.12.01.01	**The medical record contains information that reflects the patient's care, treatment, and services.**
		EP 2	The medical record contains the following clinical information: • Admitting diagnosis • Any emergency care, treatment, and services provided to the patient before their arrival • Any allergies to food and medications • Any findings of assessments and reassessments • Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient • Treatment goals, plan of care, and revisions to the plan of care • Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia • All practitioners' orders • Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition • Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the critical access hospital defines in policy the urgent/ emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. • Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) • Records of radiology and nuclear medicine services, including signed interpretation reports • All care, treatment, and services provided to the patient • Patient's response to care, treatment, and services • Medical history and physical examination, including any conclusions or impressions drawn from the information • Discharge plan and discharge planning evaluation • Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge • Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis.
§482.43(a)(4) **TAG: A-0801**		**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(4) Upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient.		**EP 5**	The critical access hospital performs a discharge planning evaluation and creates a discharge plan for those patients it identifies at an early stage of hospitalization are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning or at the request of the patient, patient's representative, or the patient's physician. Note 1: The discharge planning evaluation is completed in a timely manner so that appropriate arrangements for post–hospital care are made before discharge and unnecessary delays in discharge are avoided. Note 2: The discharge planning evaluation is performed and subsequent discharge plan is created by, or under the supervision of, a registered nurse, social worker, or other qualified person.
§482.43(a)(5) **TAG: A-0809**		**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(5) Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of, a registered nurse, social worker, or other appropriately qualified personnel.		**EP 5**	The critical access hospital performs a discharge planning evaluation and creates a discharge plan for those patients it identifies at an early stage of hospitalization are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning or at the request of the patient, patient's representative, or the patient's physician. Note 1: The discharge planning evaluation is completed in a timely manner so that appropriate arrangements for post–hospital care are made before discharge and unnecessary delays in discharge are avoided. Note 2: The discharge planning evaluation is performed and subsequent discharge plan is created by, or under the supervision of, a registered nurse, social worker, or other qualified person.

CFR Number §482.43(a)(6)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.43(a)(6)	**TAG: A-0802**	**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(6) The hospital's discharge planning process must require regular re-evaluation of the patient's condition to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.		**EP 1**	The critical access hospital has an effective discharge planning process that focuses on, and is consistent with, the patient's goals and treatment preferences; makes certain there is an effective transition of the patient from the critical access hospital to postdischarge care; and reduces the factors leading to preventable critical access hospital and hospital readmissions. Note: The critical access hospital's discharge planning process requires regular reevaluation of the patient's condition to identify changes that require modification of the discharge plan. The discharge plan is updated as needed to reflect these changes.
§482.43(a)(7)	**TAG: A-0803**	**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(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.		**EP 14**	The critical access hospital assesses its discharge planning process on a regular basis, as defined by the critical access hospital. The assessment includes an ongoing, periodic review of a representative sample of discharge plans, including plans for patients who were readmitted within 30 days of a previous admission, to make certain that the plans are responsive to patient postdischarge needs.
§482.43(a)(8)	**TAG: A-0804**	**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(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.		**EP 7**	The critical access hospital assists the patient, their family, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes but is not limited to home health agency, skilled nursing facility, inpatient rehabilitation facility, and long-term care hospital data on quality measures and resource-use measures. The critical access hospital makes certain that the post–acute care data on quality measures and resource-use measures is relevant and applicable to the patient's goals of care and treatment preferences.
§482.43(b)	**TAG: A-0813**	**PC.14.02.03**	**When a patient is discharged or transferred, the critical access hospital gives information about the care, treatment, and services provided to the patient to other service providers who will provide the patient with care, treatment, or services.**
§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.		**EP 1**	The critical access hospital provides or transmits necessary medical information when discharging, transferring, or referring the patient to post–acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners who are responsible for the patient's follow-up or ancillary care. Necessary medical information includes, at a minimum, the following: • Current course of illness and treatment • Postdischarge goals of care • Treatment preferences at the time of discharge Note: For swing beds in critical access hospitals: The information sent to the receiving provider also includes the following: • Contact information of the physician or other licensed practitioner responsible for the care of the resident • Resident representative information, including contact information • Advance directive information • All special instructions or precautions for ongoing care, when appropriate • Comprehensive care plan goals • All other necessary information, including a copy of the residents discharge summary, consistent with 42 CFR 483.21(c)(2), and any other documentation, as applicable, to support a safe and effective transition of care

CFR Number §482.43(c)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.43(c)		**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
§482.43(c) Standard: Transfer protocols. Effective July 1, 2025, the hospital must have written policies and procedures for transferring patients under its care (inclusive of inpatient services) to the appropriate level of care (including to another hospital) as needed to meet the needs of the patient. The hospital must also provide annual training to relevant staff regarding the hospital policies and procedures for transferring patients under its care.		**EP 15**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has written policies and procedures for transferring patients under its care (inclusive of inpatient services) to the appropriate level of care (including to another hospital) as needed to meet the needs of the patient. The critical access hospital also provides annual training to relevant staff regarding the critical access hospital policies and procedures for transferring patients under its care.
§482.43(d) **TAG: A-0814**			
§482.43(d) 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(d)(1) **TAG: A-0815**		**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(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.		**EP 8**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access 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 critical access 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(d)(1)(i) **TAG: A-0815**		**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(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.		**EP 8**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access 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 critical access 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(d)(1)(ii) **TAG: A-0815**		**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(ii) For patients enrolled in managed care organizations, the hospital must make the patient aware of the need to verify with their managed care organization which practitioners, providers or certified suppliers are in the managed care organization's network. If the hospital has information on which practitioners, providers or certified supplies are in the network of the patient's managed care organization, it must share this with the patient or the patient's representative.		**EP 9**	For rehabilitation and psychiatric distinct part units in critical access hospitals: For patients enrolled in managed care organizations, the critical access 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 critical access 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.

CFR Number §482.43(d)(1)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.43(d)(1)(iii) **TAG: A-0815**		**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(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.		**EP 8**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access 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 critical access 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(d)(2) **TAG: A-0816**		**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(2) The hospital, as part of the discharge planning process, must inform the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of post-discharge services and must, when possible, respect the patient's or the patient's representative's goals of care and treatment preferences, as well as other preferences they express. The hospital must not specify or otherwise limit the qualified providers or suppliers that are available to the patient.		**EP 10**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 critical access hospital does not limit the qualified providers or suppliers that are available to the patient.
§482.43(d)(3) **TAG: A-0817**		**PC.14.01.01**	**The critical access hospital follows its process for discharging or transferring patients.**
(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.		**EP 11**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The discharge plan identifies any home health agency or skilled nursing facility in which the critical access hospital has a disclosable financial interest and any home health agency or skilled nursing facility that has a disclosable financial interest in a critical access 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 **TAG: A-0884**			
§482.45 Condition of Participation: Organ, Tissue and Eye Procurement			
§482.45(a) **TAG: A-0885**			
§482.45(a) Standard: Organ Procurement Responsibilities The hospital must have and implement written protocols that:			

CFR Number §482.45(a)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.45(a)(1)	**TAG: A-0886**	**TS.11.01.01**	**The critical access hospital, with the medical staff's participation, develops and implements written policies and procedures for donating and procuring organs, tissues, and eyes.**
(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 consultation with the tissue and eye banks identified by the hospital for this purpose;		**EP 1**	The critical access hospital develops and implements written policies and procedures for organ procurement responsibilities that include the following: • A written agreement with an organ procurement organization (OPO) that requires the critical access hospital to notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the critical access hospital, and that includes the OPO's responsibility to determine medical suitability for organ donation • A written agreement with at least one tissue bank and at least one eye bank to cooperate in retrieving, processing, preserving, storing, and distributing tissues and eyes to make certain that all usable tissues and eyes are obtained from potential donors, to the extent that the agreement does not interfere with organ procurement • Designation of an individual, who is an organ procurement representative, an organizational representative of a tissue or eye bank, or a designated requestor, to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes • Procedures for informing the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes, in collaboration with the designated OPO • Education and training of staff in the use of discretion and sensitivity to the circumstances, views, and beliefs of the family when discussing potential organ, tissue, or eye donations Note 1: The critical access hospital has an agreement with an OPO designated under 42 CFR part 486. Note 2: The requirements for a written agreement with at least one tissue bank and at least one eye bank may be satisfied through a single agreement with an OPO that provides services for organ, tissue, and eye, or by a separate agreement with another tissue and/or eye bank outside the OPO, chosen by the critical access hospital. Note 3: A designated requestor is an individual who has completed a course offered or approved by the OPO. This course is designed in conjunction with the tissue and eye bank community to provide a methodology for approaching potential donor families and requesting organ and tissue donation. Note 4: The term "organ" means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs). Note 5: For additional information about criteria for the determination of brain death, see the American Academy of Neurology guidelines available at https://n.neurology.org/content/early/2023/09/13/WNL.0000000000207740, the American Academy of Pediatrics guidelines available at https://www.aan.com/Guidelines/Home/GuidelineDetail/1085, and the interactive tool that can be used alongside the new guidance to help walk clinicians through the BD/DNC evaluation process at https://www.aan.com/Guidelines/BDDNC.

CFR Number §482.45(a)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.45(a)(2) TAG: A-0887		**TS.11.01.01**	**The critical access hospital, with the medical staff's participation, develops and implements written policies and procedures for donating and procuring organs, tissues, and eyes.**
(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;		**EP 1**	The critical access hospital develops and implements written policies and procedures for organ procurement responsibilities that include the following: • A written agreement with an organ procurement organization (OPO) that requires the critical access hospital to notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the critical access hospital, and that includes the OPO's responsibility to determine medical suitability for organ donation • A written agreement with at least one tissue bank and at least one eye bank to cooperate in retrieving, processing, preserving, storing, and distributing tissues and eyes to make certain that all usable tissues and eyes are obtained from potential donors, to the extent that the agreement does not interfere with organ procurement • Designation of an individual, who is an organ procurement representative, an organizational representative of a tissue or eye bank, or a designated requestor, to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes • Procedures for informing the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes, in collaboration with the designated OPO • Education and training of staff in the use of discretion and sensitivity to the circumstances, views, and beliefs of the family when discussing potential organ, tissue, or eye donations Note 1: The critical access hospital has an agreement with an OPO designated under 42 CFR part 486. Note 2: The requirements for a written agreement with at least one tissue bank and at least one eye bank may be satisfied through a single agreement with an OPO that provides services for organ, tissue, and eye, or by a separate agreement with another tissue and/or eye bank outside the OPO, chosen by the critical access hospital. Note 3: A designated requestor is an individual who has completed a course offered or approved by the OPO. This course is designed in conjunction with the tissue and eye bank community to provide a methodology for approaching potential donor families and requesting organ and tissue donation. Note 4: The term "organ" means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs). Note 5: For additional information about criteria for the determination of brain death, see the American Academy of Neurology guidelines available at https://n.neurology.org/content/early/2023/09/13/WNL.0000000000207740, the American Academy of Pediatrics guidelines available at https://www.aan.com/Guidelines/Home/GuidelineDetail/1085, and the interactive tool that can be used alongside the new guidance to help walk clinicians through the BD/DNC evaluation process at https://www.aan.com/Guidelines/BDDNC.

CFR Number §482.45(a)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.45(a)(3)	**TAG: A-0888, A-0889**	**TS.11.01.01**	**The critical access hospital, with the medical staff's participation, develops and implements written policies and procedures for donating and procuring organs, tissues, and eyes.**
(3) Ensure, in collaboration with the designated OPO, that the family of each potential donor is informed of its options to donate organs, tissues, or eyes, or to decline to donate. The individual designated by the hospital to initiate the request to the family must be an organ procurement representative or a designated requestor. A designated requestor is an individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ or tissue donation;		**EP 1**	The critical access hospital develops and implements written policies and procedures for organ procurement responsibilities that include the following: • A written agreement with an organ procurement organization (OPO) that requires the critical access hospital to notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the critical access hospital, and that includes the OPO's responsibility to determine medical suitability for organ donation • A written agreement with at least one tissue bank and at least one eye bank to cooperate in retrieving, processing, preserving, storing, and distributing tissues and eyes to make certain that all usable tissues and eyes are obtained from potential donors, to the extent that the agreement does not interfere with organ procurement • Designation of an individual, who is an organ procurement representative, an organizational representative of a tissue or eye bank, or a designated requestor, to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes • Procedures for informing the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes, in collaboration with the designated OPO • Education and training of staff in the use of discretion and sensitivity to the circumstances, views, and beliefs of the family when discussing potential organ, tissue, or eye donations Note 1: The critical access hospital has an agreement with an OPO designated under 42 CFR part 486. Note 2: The requirements for a written agreement with at least one tissue bank and at least one eye bank may be satisfied through a single agreement with an OPO that provides services for organ, tissue, and eye, or by a separate agreement with another tissue and/or eye bank outside the OPO, chosen by the critical access hospital. Note 3: A designated requestor is an individual who has completed a course offered or approved by the OPO. This course is designed in conjunction with the tissue and eye bank community to provide a methodology for approaching potential donor families and requesting organ and tissue donation. Note 4: The term "organ" means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs). Note 5: For additional information about criteria for the determination of brain death, see the American Academy of Neurology guidelines available at https://n.neurology.org/content/early/2023/09/13/WNL.0000000000207740, the American Academy of Pediatrics guidelines available at https://www.aan.com/Guidelines/Home/GuidelineDetail/1085, and the interactive tool that can be used alongside the new guidance to help walk clinicians through the BD/DNC evaluation process at https://www.aan.com/Guidelines/BDDNC.

CFR Number §482.45(a)(4)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.45(a)(4)	**TAG: A-0890**	**TS.11.01.01**	**The critical access hospital, with the medical staff's participation, develops and implements written policies and procedures for donating and procuring organs, tissues, and eyes.**
(4) Encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of the families of potential donors;		**EP 1**	The critical access hospital develops and implements written policies and procedures for organ procurement responsibilities that include the following: • A written agreement with an organ procurement organization (OPO) that requires the critical access hospital to notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the critical access hospital, and that includes the OPO's responsibility to determine medical suitability for organ donation • A written agreement with at least one tissue bank and at least one eye bank to cooperate in retrieving, processing, preserving, storing, and distributing tissues and eyes to make certain that all usable tissues and eyes are obtained from potential donors, to the extent that the agreement does not interfere with organ procurement • Designation of an individual, who is an organ procurement representative, an organizational representative of a tissue or eye bank, or a designated requestor, to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes • Procedures for informing the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes, in collaboration with the designated OPO • Education and training of staff in the use of discretion and sensitivity to the circumstances, views, and beliefs of the family when discussing potential organ, tissue, or eye donations Note 1: The critical access hospital has an agreement with an OPO designated under 42 CFR part 486. Note 2: The requirements for a written agreement with at least one tissue bank and at least one eye bank may be satisfied through a single agreement with an OPO that provides services for organ, tissue, and eye, or by a separate agreement with another tissue and/or eye bank outside the OPO, chosen by the critical access hospital. Note 3: A designated requestor is an individual who has completed a course offered or approved by the OPO. This course is designed in conjunction with the tissue and eye bank community to provide a methodology for approaching potential donor families and requesting organ and tissue donation. Note 4: The term "organ" means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs). Note 5: For additional information about criteria for the determination of brain death, see the American Academy of Neurology guidelines available at https://n.neurology.org/content/early/2023/09/13/WNL.0000000000207740, the American Academy of Pediatrics guidelines available at https://www.aan.com/Guidelines/Home/GuidelineDetail/1085, and the interactive tool that can be used alongside the new guidance to help walk clinicians through the BD/DNC evaluation process at https://www.aan.com/Guidelines/BDDNC.
§482.45(a)(5)	**TAG: A-0891, A-0892, A-0893**	**TS.11.01.01**	**The critical access hospital, with the medical staff's participation, develops and implements written policies and procedures for donating and procuring organs, tissues, and eyes.**
(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.		**EP 2**	The critical access hospital develops and implements policies and procedures for working with the organ procurement organization (OPO) and tissue and eye banks to do the following: • Review death records in order to improve identification of potential donors • Maintain potential donors while the necessary testing and placement of potential donated organs, tissues, and eyes takes place in order to maximize the viability of donor organs for transplant • Educate staff about issues surrounding donation
§482.45(b)	**TAG: A-0899**		
§482.45(b) Standard: Organ Transplantation Responsibilities			

CFR Number §482.45(b)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.45(b)(1)	**TAG: A-0899**	**TS.12.01.01**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital complies with organ transplantation responsibilities.**
(1) A hospital in which organ transplants are performed must be a member of the Organ Procurement and Transplantation Network (OPTN) established and operated in accordance with section 372 of the Public Health Service (PHS) Act (42 U.S.C. 274) and abide by its rules. The term “rules of the OPTN” means those rules provided for in regulations issued by the Secretary in accordance with section 372 of the PHS Act which are enforceable under 42 CFR 121.10. No hospital is considered to be out of compliance with section 1138(a)(1)(B) of the Act, or with the requirements of this paragraph, unless the Secretary has given the OPTN formal notice that he or she approves the decision to exclude the hospital from the OPTN and has notified the hospital in writing.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital performing organ transplants belongs to and abides by the rules of the Organ Procurement and Transplantation Network (OPTN) established under section 372 of the Public Health Service (PHS) Act. Note: The term “rules of the OPTN” means those rules provided for in regulations issued by the Secretary of the US Department of Health & Human Services in accordance with section 372 of the PHS Act which are enforceable under 42 CFR 121.10. No hospital is considered to be out of compliance with section 1138(a)(1)(B) of the Act, or with the requirements of this element of performance, unless the Secretary has given the OPTN formal notice that the Secretary approves the decision to exclude the critical access hospital from the OPTN and has notified the critical access hospital in writing.
§482.45(b)(2)	**TAG: A-0899**	**TS.11.01.01**	**The critical access hospital, with the medical staff's participation, develops and implements written policies and procedures for donating and procuring organs, tissues, and eyes.**
(2) For purposes of these standards, the term “organ” means a human kidney, liver, heart, lung, or pancreas.		**EP 1**	The critical access hospital develops and implements written policies and procedures for organ procurement responsibilities that include the following: • A written agreement with an organ procurement organization (OPO) that requires the critical access hospital to notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the critical access hospital, and that includes the OPO’s responsibility to determine medical suitability for organ donation • A written agreement with at least one tissue bank and at least one eye bank to cooperate in retrieving, processing, preserving, storing, and distributing tissues and eyes to make certain that all usable tissues and eyes are obtained from potential donors, to the extent that the agreement does not interfere with organ procurement • Designation of an individual, who is an organ procurement representative, an organizational representative of a tissue or eye bank, or a designated requestor, to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes • Procedures for informing the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes, in collaboration with the designated OPO • Education and training of staff in the use of discretion and sensitivity to the circumstances, views, and beliefs of the family when discussing potential organ, tissue, or eye donations Note 1: The critical access hospital has an agreement with an OPO designated under 42 CFR part 486. Note 2: The requirements for a written agreement with at least one tissue bank and at least one eye bank may be satisfied through a single agreement with an OPO that provides services for organ, tissue, and eye, or by a separate agreement with another tissue and/or eye bank outside the OPO, chosen by the critical access hospital. Note 3: A designated requestor is an individual who has completed a course offered or approved by the OPO. This course is designed in conjunction with the tissue and eye bank community to provide a methodology for approaching potential donor families and requesting organ and tissue donation. Note 4: The term “organ” means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs). Note 5: For additional information about criteria for the determination of brain death, see the American Academy of Neurology guidelines available at https://n.neurology.org/content/early/2023/09/13/WNL.0000000000207740, the American Academy of Pediatrics guidelines available at https://www.aan.com/Guidelines/Home/GuidelineDetail/1085, and the interactive tool that can be used alongside the new guidance to help walk clinicians through the BD/DNC evaluation process at https://www.aan.com/Guidelines/BDDNC.
			CAMH glossary definition of organ: As defined by the Centers for Medicare & Medicaid Services in 42 CFR 482.45(b), organ means a human kidney, liver, heart, lung, or pancreas.

CFR Number §482.45(b)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.45(b)(3)	**TAG: A-0899**	**TS.12.01.01**	**For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital complies with organ transplantation responsibilities.**
(3) If a hospital performs any type of transplants, it must provide organ transplant related data, as requested by the OPTN, the Scientific Registry, and the OPOs. The hospital must also provide such data directly to the Department when requested by the Secretary.		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If requested, the critical access hospital provides all data related to organ transplant to the Organ Procurement and Transplantation Network (OPTN), the Scientific Registry of Transplant Recipients, the critical access hospital's designated organ procurement organization (OPO), and, when requested by the Office of the Secretary, directly to the US Department of Health & Human Services.
§482.51	**TAG: A-0940**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§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.		**EP 1**	The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: • Outpatient • Emergency • Medical records • Diagnostic and therapeutic radiology • Nuclear medicine • Surgical • Anesthesia • Laboratory • Respiratory • Dietetic • Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital.
		EP 10	If the critical access hospital provides outpatient surgical services, the services are consistent with the quality of inpatient surgical care.

CFR Number §482.51(a)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.51(a) **TAG: A-0941**		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§482.51(a) Standard: Organization and Staffing The organization of the surgical services must be appropriate to the scope of the services offered.		**EP 1**	The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: • Outpatient • Emergency • Medical records • Diagnostic and therapeutic radiology • Nuclear medicine • Surgical • Anesthesia • Laboratory • Respiratory • Dietetic • Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital.
		EP 11	For rehabilitation and psychiatric distinct part units in critical access hospitals: The surgical services are consistent with the resources available.
§482.51(a)(1) **TAG: A-0942**		**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(1) The operating rooms must be supervised by an experienced registered nurse or a doctor of medicine or osteopathy.		**EP 13**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The surgical services include but are not limited to the following staff: • An experienced registered nurse or doctor of medicine or osteopathy who supervises the operating rooms • Licensed practical nurses (LPNs) and surgical technologists (operating room technicians) who serve as scrub nurses, if under the supervision of a registered nurse • Qualified registered nurses who perform circulating duties in the operating room Note: In accordance with applicable state laws and approved medical staff policies and procedures, LPNs and surgical technologists may assist in circulatory duties under the supervision of a qualified registered nurse who is immediately available to respond to emergencies.
§482.51(a)(2) **TAG: A-0943**		**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(2) Licensed practical nurses (LPNs) and surgical technologists (operating room technicians) may serve as "scrub nurses" under the supervision of a registered nurse.		**EP 13**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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.

CFR Number §482.51(a)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.51(a)(3)	**TAG: A-0944**	**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(3) 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.		**EP 13**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The surgical services include but are not limited to the following staff: • An experienced registered nurse or doctor of medicine or osteopathy who supervises the operating rooms • Licensed practical nurses (LPNs) and surgical technologists (operating room technicians) who serve as scrub nurses, if under the supervision of a registered nurse • Qualified registered nurses who perform circulating duties in the operating room Note: In accordance with applicable state laws and approved medical staff policies and procedures, LPNs and surgical technologists may assist in circulatory duties under the supervision of a qualified registered nurse who is immediately available to respond to emergencies.
§482.51(a)(4)	**TAG: A-0945**	**MS.17.02.01**	**The decision to grant or deny a privilege(s) and/or to renew an existing privilege(s) is an objective, evidence-based process.**
(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.		**EP 6**	The critical access hospital designates the practitioners who are allowed to perform surgery, in accordance with appropriate policies and procedures, and with scope of practice laws and regulations. Surgery is performed only by the following: • A doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Social Security Act • A doctor of dental surgery or dental medicine • A doctor of podiatric medicine
		EP 7	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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	**The organized medical staff reviews and analyzes all relevant information regarding each requesting physician's or other licensed practitioner's current licensure status, training, experience, current competence, and ability to perform the requested privilege.**
		EP 1	Decisions on membership and granting of privileges include criteria that are directly related to the quality of health care, treatment, and services.

CFR Number §482.51(b)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.51(b) **TAG: A-0951**		**LD.13.01.09**	**The critical access hospital has policies and procedures that guide and support patient care, treatment, and services.**
§482.51(b) Standard: Delivery of Service Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.		**EP 6**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital develops and implements surgical care policies and procedures that maintain high standards for medical practice and patient care.
		LD.13.03.01	**The critical access hospital provides services that meet patient needs.**
		EP 1	The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: • Outpatient • Emergency • Medical records • Diagnostic and therapeutic radiology • Nuclear medicine • Surgical • Anesthesia • Laboratory • Respiratory • Dietetic • Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital.
		EP 11	For rehabilitation and psychiatric distinct part units in critical access hospitals: The surgical services are consistent with the resources available.
§482.51(b)(1) **TAG: A-0952**			
(1) Prior to surgery or a procedure requiring anesthesia services and except in the case of emergencies:			
§482.51(b)(1)(i) **TAG: A-0952**		**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(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.		**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 rehabilitation and psychiatric distinct part units in critical access hospitals: 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/.

CFR Number §482.51(b)(1)(ii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.51(b)(1)(ii)	**TAG: A-0953**	**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(ii) An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration when the medical history and physical examination are completed within 30 days before admission or registration, and except as provided under paragraph (b)(1)(iii) of this section.		**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 rehabilitation and psychiatric distinct part units in critical access hospitals: 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), refer to https://www.ecfr.gov/.
§482.51(b)(1)(iii)	**TAG: A-0954**	**PC.11.02.01**	**The critical access hospital assesses and reassesses the patient and the patient's condition according to defined time frames.**
(iii) An assessment of the patient must be completed and documented after registration (in lieu of the requirements of paragraphs (b)(1)(i) and (ii) of this section) when the patient is receiving specific outpatient surgical or procedural services and when the medical staff has chosen to develop and maintain a policy that identifies, in accordance with the requirements at § 482.22(c)(5)(v), specific patients as not requiring a comprehensive medical history and physical examination, or any update to it, prior to specific outpatient surgical or procedural services.		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: When the medical staff allows an assessment (in lieu of a comprehensive medical history and physical examination) for patients receiving specific outpatient surgical or procedural services, the patient assessment is completed and documented after registration but prior to the surgery or procedure requiring anesthesia services. Note: For further regulatory guidance at 42 CFR 482.24(c)(4)(i)(A) and (B), 482.51(b)(1)(i) and (ii), and 482.22(c)(5)(v), refer to https://www.ecfr.gov/.
§482.51(b)(2)	**TAG: A-0955**	**RC.12.01.01**	**The medical record contains information that reflects the patient's care, treatment, and services.**
(2) A properly executed informed consent form for the operation must be in the patient's chart before surgery, except in emergencies.		**EP 3**	The medical record contains any informed consent, when required by critical access hospital policy or federal or state law or regulation. Note: The properly executed informed consent is placed in the patient's medical record prior to surgery, except in emergencies. A properly executed informed consent contains documentation of a patient's mutual understanding of and agreement for care, treatment, and services through written signature; electronic signature; or, when a patient is unable to provide a signature, documentation of the verbal agreement by the patient or surrogate decision-maker.
§482.51(b)(3)	**TAG: A-0956**	**PC.12.01.05**	**Resuscitative services are available throughout the critical access hospital.**
(3) The following equipment must be available to the operating room suites: call-in system, cardiac monitor, resuscitator, defibrillator, aspirator, and tracheotomy set.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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)	**TAG: A-0957**	**PC.13.01.03**	**The critical access hospital provides the patient with care before and after operative or other high-risk procedures.**
(4) There must be adequate provisions for immediate post-operative care.		**EP 5**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has adequate provisions for immediate postoperative care.

CFR Number §482.51(b)(5)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.51(b)(5)	**TAG: A-0958**	**RC.12.01.03**	**The patient's medical record contains documentation on any operative or other high-risk procedures and the use of moderate or deep sedation or anesthesia.**
(5) The operating room register must be complete and up-to-date.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has a complete and up-to-date operating room register or equivalent record that includes the following: • Patient's name • Patient's critical access 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)	**TAG: A-0959**	**RC.12.01.03**	**The patient's medical record contains documentation on any operative or other high-risk procedures and the use of moderate or deep sedation or anesthesia.**
(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.		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: An operative report is written or dictated immediately following surgery and signed by the surgeon. The report includes the following: • Name and hospital identification number of the patient • Date and times of the surgery • Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues) • Preoperative and postoperative diagnosis • Name of the specific surgical procedure(s) performed • Type of anesthesia administered • Complications, if any • Description of techniques, findings, and tissues removed or altered • Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any • Any estimated blood loss Note 1: The exception to this requirement occurs when an operative or other high-risk procedure progress note is written immediately after the procedure, in which case the full report can be written or dictated within a time frame defined by the critical access 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.
§482.52	**TAG: A-1000**	**LD.13.01.07**	**The critical access hospital effectively manages its programs, services, sites, or departments.**
§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.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access hospital. Note 2: For respiratory care services, the director may serve on either a full-time or part-time basis.

CFR Number §482.52	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		LD.13.03.01	**The critical access hospital provides services that meet patient needs.**
		EP 1	The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: • Outpatient • Emergency • Medical records • Diagnostic and therapeutic radiology • Nuclear medicine • Surgical • Anesthesia • Laboratory • Respiratory • Dietetic • Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital.
§482.52(a) **TAG: A-1001**		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§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 --		**EP 1**	The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: • Outpatient • Emergency • Medical records • Diagnostic and therapeutic radiology • Nuclear medicine • Surgical • Anesthesia • Laboratory • Respiratory • Dietetic • Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital.

CFR Number §482.52(a)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.52(a)(1)	**TAG: A-1001**	**PC.13.01.01**	**The critical access hospital plans operative or other high-risk procedures. Note: Equipment identified in the elements of performance is available to the operating room suites.**
(1) A qualified anesthesiologist;		**EP 1**	Anesthesia is administered only by the following individuals: • A qualified anesthesiologist • A doctor of medicine or osteopathy other than an anesthesiologist, including an osteopathic practitioner recognized under section 1101(a)(7) of the Social Security Act • A doctor of dental surgery or dental medicine, who is qualified to administer anesthesia under state law • A doctor of podiatric medicine, who is qualified to administer anesthesia under state law • A certified registered nurse anesthetist (CRNA), as defined in 42 CFR 410.69(b) of this chapter, supervised by the operating practitioner, except as provided in 42 CFR 485.639(e) regarding the state exemption for this supervision • An anesthesiologist's assistant, as defined in 42 CFR 410.69(b), supervised by an anesthesiologist • A supervised trainee in an approved educational program Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law, or if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission. Note 2: See Glossary for the definition of certified registered nurse anesthetist (CRNA) and anesthesiologist assistant. Note 3: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's boards of medicine and nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state boards of medicine and nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission. Note 4: Only the above individuals can administer deep sedation/analgesia.

CFR Number §482.52(a)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.52(a)(2) TAG: A-1001		PC.13.01.01	**The critical access hospital plans operative or other high-risk procedures. Note: Equipment identified in the elements of performance is available to the operating room suites.**
(2) A doctor of medicine or osteopathy (other than an anesthesiologist);		**EP 1**	Anesthesia is administered only by the following individuals: • A qualified anesthesiologist • A doctor of medicine or osteopathy other than an anesthesiologist, including an osteopathic practitioner recognized under section 1101(a)(7) of the Social Security Act • A doctor of dental surgery or dental medicine, who is qualified to administer anesthesia under state law • A doctor of podiatric medicine, who is qualified to administer anesthesia under state law • A certified registered nurse anesthetist (CRNA), as defined in 42 CFR 410.69(b) of this chapter, supervised by the operating practitioner, except as provided in 42 CFR 485.639(e) regarding the state exemption for this supervision • An anesthesiologist's assistant, as defined in 42 CFR 410.69(b), supervised by an anesthesiologist • A supervised trainee in an approved educational program Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law, or if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission. Note 2: See Glossary for the definition of certified registered nurse anesthetist (CRNA) and anesthesiologist assistant. Note 3: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's boards of medicine and nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state boards of medicine and nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission. Note 4: Only the above individuals can administer deep sedation/analgesia.

CFR Number §482.52(a)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.52(a)(3) TAG: A-1001		PC.13.01.01	**The critical access hospital plans operative or other high-risk procedures. Note: Equipment identified in the elements of performance is available to the operating room suites.**
(3) A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law;		**EP 1**	Anesthesia is administered only by the following individuals: • A qualified anesthesiologist • A doctor of medicine or osteopathy other than an anesthesiologist, including an osteopathic practitioner recognized under section 1101(a)(7) of the Social Security Act • A doctor of dental surgery or dental medicine, who is qualified to administer anesthesia under state law • A doctor of podiatric medicine, who is qualified to administer anesthesia under state law • A certified registered nurse anesthetist (CRNA), as defined in 42 CFR 410.69(b) of this chapter, supervised by the operating practitioner, except as provided in 42 CFR 485.639(e) regarding the state exemption for this supervision • An anesthesiologist's assistant, as defined in 42 CFR 410.69(b), supervised by an anesthesiologist • A supervised trainee in an approved educational program Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law, or if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission. Note 2: See Glossary for the definition of certified registered nurse anesthetist (CRNA) and anesthesiologist assistant. Note 3: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's boards of medicine and nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state boards of medicine and nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission. Note 4: Only the above individuals can administer deep sedation/analgesia.

CFR Number §482.52(a)(4)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.52(a)(4)	**TAG: A-1001**	**PC.13.01.01**	**The critical access hospital plans operative or other high-risk procedures. Note: Equipment identified in the elements of performance is available to the operating room suites.**
(4) A certified registered nurse anesthetist (CRNA), as defined in §410.69(b) of this chapter, who, unless exempted in accordance with paragraph (c) of this section, is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed; or		**EP 1**	Anesthesia is administered only by the following individuals: • A qualified anesthesiologist • A doctor of medicine or osteopathy other than an anesthesiologist, including an osteopathic practitioner recognized under section 1101(a)(7) of the Social Security Act • A doctor of dental surgery or dental medicine, who is qualified to administer anesthesia under state law • A doctor of podiatric medicine, who is qualified to administer anesthesia under state law • A certified registered nurse anesthetist (CRNA), as defined in 42 CFR 410.69(b) of this chapter, supervised by the operating practitioner, except as provided in 42 CFR 485.639(e) regarding the state exemption for this supervision • An anesthesiologist's assistant, as defined in 42 CFR 410.69(b), supervised by an anesthesiologist • A supervised trainee in an approved educational program Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law, or if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission. Note 2: See Glossary for the definition of certified registered nurse anesthetist (CRNA) and anesthesiologist assistant. Note 3: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's boards of medicine and nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state boards of medicine and nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission. Note 4: Only the above individuals can administer deep sedation/analgesia.

CFR Number §482.52(a)(5)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.52(a)(5) **TAG: A-1001**		**PC.13.01.01**	**The critical access hospital plans operative or other high-risk procedures. Note: Equipment identified in the elements of performance is available to the operating room suites.**
(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.		**EP 1**	Anesthesia is administered only by the following individuals: • A qualified anesthesiologist • A doctor of medicine or osteopathy other than an anesthesiologist, including an osteopathic practitioner recognized under section 1101(a)(7) of the Social Security Act • A doctor of dental surgery or dental medicine, who is qualified to administer anesthesia under state law • A doctor of podiatric medicine, who is qualified to administer anesthesia under state law • A certified registered nurse anesthetist (CRNA), as defined in 42 CFR 410.69(b) of this chapter, supervised by the operating practitioner, except as provided in 42 CFR 485.639(e) regarding the state exemption for this supervision • An anesthesiologist's assistant, as defined in 42 CFR 410.69(b), supervised by an anesthesiologist • A supervised trainee in an approved educational program Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law, or if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission. Note 2: See Glossary for the definition of certified registered nurse anesthetist (CRNA) and anesthesiologist assistant. Note 3: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's boards of medicine and nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state boards of medicine and nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission. Note 4: Only the above individuals can administer deep sedation/analgesia.

CFR Number §482.52(b)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.52(b) TAG: A-1002		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§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:		**EP 1**	The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: • Outpatient • Emergency • Medical records • Diagnostic and therapeutic radiology • Nuclear medicine • Surgical • Anesthesia • Laboratory • Respiratory • Dietetic • Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital.
		PC.13.01.03	**The critical access hospital provides the patient with care before and after operative or other high-risk procedures.**
		EP 2	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 critical access hospital policies and procedures that have been approved by the medical staff and reflect current standards of anesthesia care.
§482.52(b)(1) TAG: A-1003		**PC.13.01.03**	**The critical access hospital provides the patient with care before and after operative or other high-risk procedures.**
(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.		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 critical access hospital policies and procedures that have been approved by the medical staff and reflect current standards of anesthesia care.

CFR Number §482.52(b)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.52(b)(2) **TAG: A-1004**		**PC.13.01.03**	**The critical access hospital provides the patient with care before and after operative or other high-risk procedures.**
(2) An intraoperative anesthesia record.		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 critical access hospital policies and procedures that have been approved by the medical staff and reflect current standards of anesthesia care.
§482.52(b)(3) **TAG: A-1005**		**PC.13.01.03**	**The critical access hospital provides the patient with care before and after operative or other high-risk procedures.**
(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.		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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 critical access hospital policies and procedures that have been approved by the medical staff and reflect current standards of anesthesia care.
§482.52(c) **TAG: A-1001**			
§482.52(c) Standard: State Exemption			

CFR Number §482.52(c)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.52(c)(1) TAG: A-1001		PC.13.01.01	**The critical access hospital plans operative or other high-risk procedures. Note: Equipment identified in the elements of performance is available to the operating room suites.**
(1) A 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.		**EP 1**	Anesthesia is administered only by the following individuals: • A qualified anesthesiologist • A doctor of medicine or osteopathy other than an anesthesiologist, including an osteopathic practitioner recognized under section 1101(a)(7) of the Social Security Act • A doctor of dental surgery or dental medicine, who is qualified to administer anesthesia under state law • A doctor of podiatric medicine, who is qualified to administer anesthesia under state law • A certified registered nurse anesthetist (CRNA), as defined in 42 CFR 410.69(b) of this chapter, supervised by the operating practitioner, except as provided in 42 CFR 485.639(e) regarding the state exemption for this supervision • An anesthesiologist's assistant, as defined in 42 CFR 410.69(b), supervised by an anesthesiologist • A supervised trainee in an approved educational program Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law, or if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission. Note 2: See Glossary for the definition of certified registered nurse anesthetist (CRNA) and anesthesiologist assistant. Note 3: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's boards of medicine and nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state boards of medicine and nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission. Note 4: Only the above individuals can administer deep sedation/analgesia.

CFR Number §482.52(c)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.52(c)(2) TAG: A-1001		PC.13.01.01	**The critical access hospital plans operative or other high-risk procedures. Note: Equipment identified in the elements of performance is available to the operating room suites.**
(2) The request for exemption and recognition of State laws, and the withdrawal of the request may be submitted at any time, and are effective upon submission.		**EP 1**	Anesthesia is administered only by the following individuals: • A qualified anesthesiologist • A doctor of medicine or osteopathy other than an anesthesiologist, including an osteopathic practitioner recognized under section 1101(a)(7) of the Social Security Act • A doctor of dental surgery or dental medicine, who is qualified to administer anesthesia under state law • A doctor of podiatric medicine, who is qualified to administer anesthesia under state law • A certified registered nurse anesthetist (CRNA), as defined in 42 CFR 410.69(b) of this chapter, supervised by the operating practitioner, except as provided in 42 CFR 485.639(e) regarding the state exemption for this supervision • An anesthesiologist's assistant, as defined in 42 CFR 410.69(b), supervised by an anesthesiologist • A supervised trainee in an approved educational program Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law, or if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission. Note 2: See Glossary for the definition of certified registered nurse anesthetist (CRNA) and anesthesiologist assistant. Note 3: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's boards of medicine and nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state boards of medicine and nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission. Note 4: Only the above individuals can administer deep sedation/analgesia.

CFR Number §482.53	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.53	**TAG: A-1025, A-1026**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§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.		**EP 1**	The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: • Outpatient • Emergency • Medical records • Diagnostic and therapeutic radiology • Nuclear medicine • Surgical • Anesthesia • Laboratory • Respiratory • Dietetic • Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital.
§482.53(a)	**TAG: A-1027**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§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.		**EP 1**	The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: • Outpatient • Emergency • Medical records • Diagnostic and therapeutic radiology • Nuclear medicine • Surgical • Anesthesia • Laboratory • Respiratory • Dietetic • Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital.
§482.53(a)(1)	**TAG: A-1027**	**LD.13.01.07**	**The critical access hospital effectively manages its programs, services, sites, or departments.**
(1) There must be a director who is a doctor of medicine or osteopathy qualified in nuclear medicine.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access hospital. Note 2: For respiratory care services, the director may serve on either a full-time or part-time basis.

CFR Number §482.53(a)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.53(a)(2)	**TAG: A-1027**	**MS.16.01.01**	**The organized medical staff oversees the quality of patient care, treatment, and services provided by physicians and other licensed practitioners privileged through the medical staff process.**
(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.		**EP 12**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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)	**TAG: A-1035**	**PE.02.01.01**	**The critical access hospital manages risks related to hazardous materials and waste.**
§482.53(b) Standard: Delivery of Service Radioactive materials must be prepared, labeled, used, transported, stored, and disposed of in accordance with acceptable standards of practice.		**EP 4**	The critical access hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials. The policies and procedures address the following: • Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors • Disposal of hazardous medications • Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding • Periodic inspection of radiology equipment and prompt correction of hazards found during inspection • Precautions to follow and personal protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers and MRIs). Note 2: Hazardous gases and vapors include but are not limited to ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9)
§482.53(b)(1)	**TAG: A-1036**	**MM.15.01.01**	**The critical access hospital safely prepares medications.**
(1) In-house preparation of radiopharmaceuticals is by, or under the supervision of, an appropriately trained registered pharmacist or a doctor of medicine or osteopathy.		**EP 7**	For rehabilitation and psychiatric distinct part units in critical access hospitals: An appropriately trained registered pharmacist or doctor of medicine or osteopathy performs or supervises in-house preparation of radiopharmaceuticals.
§482.53(b)(2)	**TAG: A-1037**	**PE.02.01.01**	**The critical access hospital manages risks related to hazardous materials and waste.**
(2) There is proper storage and disposal of radioactive material.		**EP 4**	The critical access hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials. The policies and procedures address the following: • Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors • Disposal of hazardous medications • Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding • Periodic inspection of radiology equipment and prompt correction of hazards found during inspection • Precautions to follow and personal protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers and MRIs). Note 2: Hazardous gases and vapors include but are not limited to ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9)
§482.53(b)(3)	**TAG: A-1038**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(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.		**EP 9**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access hospital provides nuclear medicine services, and nuclear medicine staff perform laboratory tests, the services meet the applicable requirements for laboratory services specified in 42 CRF 482.27.

CFR Number §482.53(c)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.53(c)	**TAG: A-1044**	**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
§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--		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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)	**TAG: A-1044**	**PE.04.01.01**	**The critical access hospital addresses building safety and facility management.**
(1) Maintained in safe operating condition; and		**EP 4**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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)(2)	**TAG: A-1044**	**PE.05.01.01**	**The critical access hospital manages imaging safety risks.**
(2) Inspected, tested and calibrated at least annually by qualified personnel.		**EP 1**	At least annually, a diagnostic medical physicist or nuclear medicine physicist inspects, tests, and calibrates all nuclear medicine (NM) imaging equipment. The results, along with recommendations for correcting any problems identified, are documented. These activities are conducted for all of the image types produced clinically by each NM scanner (for example, planar and/or tomographic) and include the use of phantoms to assess the following imaging metrics: • Image uniformity/system uniformity • High-contrast resolution/system spatial resolution • Sensitivity • 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)	**TAG: A-1051**	**RC.11.01.01**	**The critical access hospital maintains complete and accurate medical records for each individual patient.**
§482.53(d) Standard: Records The hospital must maintain signed and dated reports of nuclear medicine interpretations, consultations, and procedures.		**EP 4**	The critical access hospital develops and implements policies and procedures for accurate, legible, complete, signed, dated, and timed medical record entries that are authenticated by the person responsible for providing or evaluating the service provided. Medical records are promptly completed, systematically organized, and readily accessible.

CFR Number §482.53(d)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		RC.12.01.01	**The medical record contains information that reflects the patient's care, treatment, and services.**
		EP 2	The medical record contains the following clinical information: • Admitting diagnosis • Any emergency care, treatment, and services provided to the patient before their arrival • Any allergies to food and medications • Any findings of assessments and reassessments • Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient • Treatment goals, plan of care, and revisions to the plan of care • Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia • All practitioners' orders • Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition • Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the critical access hospital defines in policy the urgent/ emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. • Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) • Records of radiology and nuclear medicine services, including signed interpretation reports • All care, treatment, and services provided to the patient • Patient's response to care, treatment, and services • Medical history and physical examination, including any conclusions or impressions drawn from the information • Discharge plan and discharge planning evaluation • Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge • Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis.
§482.53(d)(1) TAG: A-1051		**RC.11.03.01**	**The critical access hospital retains its medical records.**
(1) The hospital must maintain copies of nuclear medicine reports for at least 5 years.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The retention time of the original or legally reproduced medical record is determined by its use and critical access hospital policy, in accordance with law and regulation. Note: 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) TAG: A-1051		**RC.11.01.01**	**The critical access hospital maintains complete and accurate medical records for each individual patient.**
(2) The practitioner approved by the medical staff to interpret diagnostic procedures must sign and date the interpretation of these tests.		**EP 4**	The critical access hospital develops and implements policies and procedures for accurate, legible, complete, signed, dated, and timed medical record entries that are authenticated by the person responsible for providing or evaluating the service provided. Medical records are promptly completed, systematically organized, and readily accessible.
§482.53(d)(3) TAG: A-1054		**MM.13.01.01**	**The critical access hospital safely stores medications.**
(3) The hospital must maintain records of the receipt and distribution of radio pharmaceuticals.		**EP 6**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital maintains records of the receipt and distribution of radiopharmaceuticals.

CFR Number §482.53(d)(4)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.53(d)(4)	**TAG: A-1055**	**PC.12.01.01**	**The critical access hospital provides care, treatment, and services as ordered or prescribed and in accordance with law and regulation.**
(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.		**EP 1**	Prior to providing care, treatment, and services, the critical access hospital obtains or renews orders (verbal or written) from a physician or other licensed practitioner in accordance with professional standards of practice; law and regulation; critical access hospital policies; and medical staff bylaws, rules, and regulations. Note 1: This includes but is not limited to respiratory services, radiology services, rehabilitation services, nuclear medicine services, and dietetic services, if provided. Note 2: Patient diets, including therapeutic diets, are ordered by the physician or other licensed practitioner responsible for the patient's care or by a qualified dietitian or qualified nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals. The requirement of 42 CFR 483.25(i) is met for inpatients receiving care at a skilled nursing facility subsequent to critical access hospital care.
§482.54	**TAG: A-1076, A-1081**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§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.		**EP 1**	The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: • Outpatient • Emergency • Medical records • Diagnostic and therapeutic radiology • Nuclear medicine • Surgical • Anesthesia • Laboratory • Respiratory • Dietetic • Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital.
§482.54(a)	**TAG: A-1077**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§482.54(a) Standard: Organization Outpatient services must be appropriately organized and integrated with inpatient services.		**EP 5**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access hospital provides outpatient services, the services are integrated with inpatient services.
§482.54(b)	**TAG: A-1079**		
§482.54(b) Standard: Personnel The hospital must -			
§482.54(b)(1)	**TAG: A-1079**	**LD.13.01.07**	**The critical access hospital effectively manages its programs, services, sites, or departments.**
(1) Assign one or more individuals to be responsible for outpatient services.		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital assigns one or more individuals who are responsible for outpatient services.

CFR Number §482.54(b)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.54(b)(2)	**TAG: A-1079**	**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(2) Have appropriate professional and nonprofessional personnel available at each location where outpatient services are offered, based on the scope and complexity of outpatient services.		**EP 1**	Leaders provide for an adequate number and mix of qualified individuals to support safe, quality care, treatment, and services. Note 1: The number and mix of individuals is appropriate to the scope and complexity of the services offered. Services may include but are not limited to the following: • Rehabilitation services • Emergency services • Outpatient services • Respiratory services • Pharmaceutical services, including emergency pharmaceutical services • Diagnostic and therapeutic radiology services Note 2: Emergency services staff are qualified in emergency care. Note 3: For rehabilitation and psychiatric distinct part units in critical access hospitals: As of the first day of the first cost reporting period for which all other exclusion requirements are met, the unit is fully equipped and staffed and is capable of providing hospital inpatient psychiatric or rehabilitation care regardless of whether there are any inpatients in the unit on that date.
§482.54(c)	**TAG: A-1080**		
(c) Standard: Orders for outpatient services. Outpatient services must be ordered by a practitioner who meets the following conditions:			
§482.54(c)(1)	**TAG: A-1080**	**PC.12.01.01**	**The critical access hospital provides care, treatment, and services as ordered or prescribed and in accordance with law and regulation.**
(1) Is responsible for the care of the patient.		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access hospital's medical staff or have been granted privileges, as well as practitioners not appointed to the medical staff who satisfy the above criteria.
§482.54(c)(2)	**TAG: A-1080**	**PC.12.01.01**	**The critical access hospital provides care, treatment, and services as ordered or prescribed and in accordance with law and regulation.**
(2) Is licensed in the State where he or she provides care to the patient.		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access hospital's medical staff or have been granted privileges, as well as practitioners not appointed to the medical staff who satisfy the above criteria.

CFR Number §482.54(c)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.54(c)(3) **TAG: A-1080**		**PC.12.01.01**	**The critical access hospital provides care, treatment, and services as ordered or prescribed and in accordance with law and regulation.**
(3) Is acting within his or her scope of practice under State law.		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access hospital's medical staff or have been granted privileges, as well as practitioners not appointed to the medical staff who satisfy the above criteria.
§482.54(c)(4) **TAG: A-1080**		**PC.12.01.01**	**The critical access hospital provides care, treatment, and services as ordered or prescribed and in accordance with law and regulation.**
(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:		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access hospital's medical staff or have been granted privileges, as well as practitioners not appointed to the medical staff who satisfy the above criteria.
§482.54(c)(4)(i) **TAG: A-1080**		**PC.12.01.01**	**The critical access hospital provides care, treatment, and services as ordered or prescribed and in accordance with law and regulation.**
(i) All practitioners who are appointed to the hospital's medical staff and who have been granted privileges to order the applicable outpatient services.		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access hospital's medical staff or have been granted privileges, as well as practitioners not appointed to the medical staff who satisfy the above criteria.
§482.54(c)(4)(ii) **TAG: A-1080**		**PC.12.01.01**	**The critical access hospital provides care, treatment, and services as ordered or prescribed and in accordance with law and regulation.**
(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.		**EP 2**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access hospital's medical staff or have been granted privileges, as well as practitioners not appointed to the medical staff who satisfy the above criteria.

CFR Number §482.55	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.55	**TAG: A-1100**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§482.55 Condition of Participation: Emergency Services The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice.		**EP 1**	The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: • Outpatient • Emergency • Medical records • Diagnostic and therapeutic radiology • Nuclear medicine • Surgical • Anesthesia • Laboratory • Respiratory • Dietetic • Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital.
		EP 7	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access hospital provides emergency services, the services are under the direction of a qualified member of the medical staff and are integrated with other departments of the critical access hospital.
§482.55(a)	**TAG: A-1101**		
§482.55(a) Standard: Organization and Direction. If emergency services are provided at the hospital --			
§482.55(a)(1)	**TAG: A-1102**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(1) The services must be organized under the direction of a qualified member of the medical staff;		**EP 1**	The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: • Outpatient • Emergency • Medical records • Diagnostic and therapeutic radiology • Nuclear medicine • Surgical • Anesthesia • Laboratory • Respiratory • Dietetic • Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital.

CFR Number §482.55(a)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
		EP 7	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access hospital provides emergency services, the services are under the direction of a qualified member of the medical staff and are integrated with other departments of the critical access hospital.
§482.55(a)(2)	**TAG: A-1103**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(2) The services must be integrated with other departments of the hospital;		**EP 1**	The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: • Outpatient • Emergency • Medical records • Diagnostic and therapeutic radiology • Nuclear medicine • Surgical • Anesthesia • Laboratory • Respiratory • Dietetic • Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital.
		EP 7	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access hospital provides emergency services, the services are under the direction of a qualified member of the medical staff and are integrated with other departments of the critical access hospital.
§482.55(a)(3)	**TAG: A-1104**	**MS.16.01.01**	**The organized medical staff oversees the quality of patient care, treatment, and services provided by physicians and other licensed practitioners privileged through the medical staff process.**
(3) The policies and procedures governing medical care provided in the emergency service or department are established by and are a continuing responsibility of the medical staff.		**EP 9**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access hospital provides emergency services, the policies and procedures governing emergency medical care are established by and are a continuing responsibility of the medical staff.
§482.55(b)	**TAG: A-1110**		
§482.55(b) Standard: Personnel			
§482.55(b)(1)	**TAG: A-1111**	**LD.13.01.07**	**The critical access hospital effectively manages its programs, services, sites, or departments.**
(1) The emergency services must be supervised by a qualified member of the medical staff.		**EP 1**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital's emergency services are supervised by a qualified member of the medical staff.

CFR Number §482.55(b)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.55(b)(2) TAG: A-1112		**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(2) There must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility.		**EP 1**	Leaders provide for an adequate number and mix of qualified individuals to support safe, quality care, treatment, and services. Note 1: The number and mix of individuals is appropriate to the scope and complexity of the services offered. Services may include but are not limited to the following: • Rehabilitation services • Emergency services • Outpatient services • Respiratory services • Pharmaceutical services, including emergency pharmaceutical services • Diagnostic and therapeutic radiology services Note 2: Emergency services staff are qualified in emergency care. Note 3: For rehabilitation and psychiatric distinct part units in critical access hospitals: As of the first day of the first cost reporting period for which all other exclusion requirements are met, the unit is fully equipped and staffed and is capable of providing hospital inpatient psychiatric or rehabilitation care regardless of whether there are any inpatients in the unit on that date.
§482.55(c)		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§482.55(c) Standard: Emergency services readiness. Effective July 1, 2025, in accordance with the complexity and scope of services offered, there must be adequate provisions and protocols to meet the emergency needs of patients.		**EP 20**	In accordance with the complexity and scope of services offered, the critical access hospital has adequate provisions (as required under 42 CFR 485.618 (b) and (c)) and protocols to meet the emergency needs of patients. Note: For 485.618(b) and (c), refer to https://www.ecfr.gov/current/title-42/section-485.618.
§482.55(c)(1)		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(1) Protocols. Protocols must be consistent with nationally recognized and evidence-based guidelines for the care of patients with emergency conditions, including but not limited to patients with obstetrical emergencies, complications, and immediate postdelivery care.		**EP 21**	In accordance with the complexity and scope of services offered, the critical access hospital protocols are consistent with nationally recognized and evidence-based guidelines for the care of patients with emergency conditions, including but not limited to patients with obstetrical emergencies, complications, and immediate postdelivery care.
§482.55(c)(2)		**PC.12.01.07**	**The critical access hospital recognizes and responds to changes in a patient's condition. Note: Critical access hospitals are not required to create rapid response teams or medical emergency teams in order to meet this standard. The existence of these types of teams does not mean that all of the elements of performance are automatically achieved.**
(2) Provisions. Provisions include equipment, supplies, and medication used in treating emergency cases. Such provisions must be kept at the hospital and be readily available for treating emergency cases to meet the needs of patients. The available provisions must include the following:		**EP 1**	The critical access hospital maintains equipment, supplies, and drugs and biologicals commonly used in life-saving procedures. These items are kept at the critical access hospital and are available for treating emergency cases. Note 1: The drugs and biologicals commonly used in life-saving procedures include but are not limited to analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids, antiarrythmics, cardiac glycosides, antihypertensives, diuretics, and electrolytes and replacement solutions. Note 2: Equipment and supplies commonly used life-saving procedures include but are not limited to airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters.

CFR Number §482.55(c)(2)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.55(c)(2)(i)		**PC.12.01.07**	**The critical access hospital recognizes and responds to changes in a patient's condition. Note: Critical access hospitals are not required to create rapid response teams or medical emergency teams in order to meet this standard. The existence of these types of teams does not mean that all of the elements of performance are automatically achieved.**
(i) Drugs, blood and blood products, and biologicals commonly used in lifesaving procedures;		**EP 1**	The critical access hospital maintains equipment, supplies, and drugs and biologicals commonly used in life-saving procedures. These items are kept at the critical access hospital and are available for treating emergency cases. Note 1: The drugs and biologicals commonly used in life-saving procedures include but are not limited to analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids, antiarrythmics, cardiac glycosides, antihypertensives, diuretics, and electrolytes and replacement solutions. Note 2: Equipment and supplies commonly used life-saving procedures include but are not limited to airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters.
§482.55(c)(2)(ii)		**PC.12.01.07**	**The critical access hospital recognizes and responds to changes in a patient's condition. Note: Critical access hospitals are not required to create rapid response teams or medical emergency teams in order to meet this standard. The existence of these types of teams does not mean that all of the elements of performance are automatically achieved.**
(ii) Equipment and supplies commonly used in life-saving procedures; and		**EP 1**	The critical access hospital maintains equipment, supplies, and drugs and biologicals commonly used in life-saving procedures. These items are kept at the critical access hospital and are available for treating emergency cases. Note 1: The drugs and biologicals commonly used in life-saving procedures include but are not limited to analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids, antiarrythmics, cardiac glycosides, antihypertensives, diuretics, and electrolytes and replacement solutions. Note 2: Equipment and supplies commonly used life-saving procedures include but are not limited to airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters.
§482.55(c)(2)(iii)		**PC.12.01.07**	**The critical access hospital recognizes and responds to changes in a patient's condition. Note: Critical access hospitals are not required to create rapid response teams or medical emergency teams in order to meet this standard. The existence of these types of teams does not mean that all of the elements of performance are automatically achieved.**
(iii) Each emergency services treatment area must have a call-in-system for each patient.		**EP 1**	The critical access hospital maintains equipment, supplies, and drugs and biologicals commonly used in life-saving procedures. These items are kept at the critical access hospital and are available for treating emergency cases. Note 1: The drugs and biologicals commonly used in life-saving procedures include but are not limited to analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids, antiarrythmics, cardiac glycosides, antihypertensives, diuretics, and electrolytes and replacement solutions. Note 2: Equipment and supplies commonly used life-saving procedures include but are not limited to airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters.
§482.55(c)(3)		**HR.11.03.01**	**The critical access hospital provides orientation, education, and training to their staff.**
(3) Staff training. Applicable staff, as identified by the hospital, must be trained annually on the protocols and provisions implemented pursuant to this section.		**EP 2**	Applicable staff, as identified by the critical access hospital, are trained annually on the protocols and provisions implemented for emergency services readiness pursuant to 42 CFR 485.618(e). Note 1: For 485.618(e), refer to https://www.ecfr.gov/current/title-42/part-485/section-485.618#p-485.618(e). Note 2: The critical access hospital must document in staff personnel records that the annual training was successfully completed.

CFR Number §482.55(c)(3)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.55(c)(3)(i)		**HR.11.03.01**	**The critical access hospital provides orientation, education, and training to their staff.**
(i) The governing body must identify and document which staff must complete such training.		**EP 3**	The governing body identifies and documents which staff must complete the annual emergency services readiness training.
§482.55(c)(3)(ii)		**HR.11.03.01**	**The critical access hospital provides orientation, education, and training to their staff.**
(ii) The hospital must document in the staff personnel records that the training was successfully completed.		**EP 2**	Applicable staff, as identified by the critical access hospital, are trained annually on the protocols and provisions implemented for emergency services readiness pursuant to 42 CFR 485.618(e). Note 1: For 485.618(e), refer to https://www.ecfr.gov/current/title-42/part-485/section-485.618#p-485.618(e). Note 2: The critical access hospital must document in staff personnel records that the annual training was successfully completed.
§482.55(c)(3)(iii)		**HR.11.03.01**	**The critical access hospital provides orientation, education, and training to their staff.**
(iii) The hospital must be able to demonstrate staff knowledge on the topics implemented pursuant to this section.		**EP 4**	The critical access hospital is able to demonstrate staff knowledge of emergency services readiness protocols and provisions training.
§482.55(c)(3)(iv)		**HR.11.03.01**	**The critical access hospital provides orientation, education, and training to their staff.**
(iv) The hospital must use findings from its QAPI program, as required at § 482.21, to inform staff training needs and any additions, revisions, or updates to training topics on an ongoing basis.		**EP 5**	The critical access hospital uses findings from its quality assessment and performance improvement (QAPI) program, as required at 42 CFR 485.641, to inform staff training needs and any additions, revisions, or updates to training topics on an ongoing basis. Note: For 485.641, refer to https://www.ecfr.gov/current/title-42/section-485.641.
§482.56	**TAG: A-1123**	**PC.12.01.01**	**The critical access hospital provides care, treatment, and services as ordered or prescribed and in accordance with law and regulation.**
§482.56 Condition of Participation: Rehabilitation Services If the hospital provides rehabilitation, physical therapy, occupational therapy, audiology, or speech pathology services, the services must be organized and staffed to ensure the health and safety of patients.		**EP 4**	If the critical access hospital provides rehabilitation, physical therapy, occupational therapy, speech-language pathology, or audiology services, the services are organized and provided in accordance with national accepted standards of practice. Note: For rehabilitation distinct part units in critical access hospitals: The critical access hospital provides rehabilitation nursing, physical therapy, and occupational therapy, and, as needed, speech-language pathology, social services, psychological services (including neuropsychological services), and orthotic and prosthetic services by qualified staff in accordance with national accepted standards of practice.
§482.56(a)	**TAG: A-1124**	**PC.12.01.01**	**The critical access hospital provides care, treatment, and services as ordered or prescribed and in accordance with law and regulation.**
§482.56(a) Standard: Organization and Staffing The organization of the service must be appropriate to the scope of the services offered.		**EP 4**	If the critical access hospital provides rehabilitation, physical therapy, occupational therapy, speech-language pathology, or audiology services, the services are organized and provided in accordance with national accepted standards of practice. Note: For rehabilitation distinct part units in critical access hospitals: The critical access hospital provides rehabilitation nursing, physical therapy, and occupational therapy, and, as needed, speech-language pathology, social services, psychological services (including neuropsychological services), and orthotic and prosthetic services by qualified staff in accordance with national accepted standards of practice.
§482.56(a)(1)	**TAG: A-1125**	**HR.11.02.01**	**The critical access hospital defines and verifies staff qualifications.**
(1) The director of the services must have the necessary knowledge, experience, and capabilities to properly supervise and administer the services.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: The director of rehabilitation services has the knowledge, experience, and capabilities to supervise and administer the services.

CFR Number §482.56(a)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.56(a)(2) TAG: A-1126		**HR.11.02.01**	**The critical access hospital defines and verifies staff qualifications.**
(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.		**EP 1**	The critical access hospital defines staff qualifications specific to their job responsibilities. Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control). Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists, as defined in 42 CFR 484, provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the critical access hospital. See Glossary for definitions of physical therapist, physical therapist assistant, occupational therapist, occupational therapy assistant, speech-language pathologist, and audiologist. Note 3: For rehabilitation and psychiatric distinct part units in critical access hospitals: If respiratory care services are provided, staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing.
§482.56(b) TAG: A-1132		**PC.12.01.01**	**The critical access hospital provides care, treatment, and services as ordered or prescribed and in accordance with law and regulation.**
§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.		**EP 1**	Prior to providing care, treatment, and services, the critical access hospital obtains or renews orders (verbal or written) from a physician or other licensed practitioner in accordance with professional standards of practice; law and regulation; critical access hospital policies; and medical staff bylaws, rules, and regulations. Note 1: This includes but is not limited to respiratory services, radiology services, rehabilitation services, nuclear medicine services, and dietetic services, if provided. Note 2: Patient diets, including therapeutic diets, are ordered by the physician or other licensed practitioner responsible for the patient's care or by a qualified dietitian or qualified nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals. The requirement of 42 CFR 483.25(i) is met for inpatients receiving care at a skilled nursing facility subsequent to critical access hospital care.

CFR Number §482.56(b)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.56(b)(1)	**TAG: A-1133**	**RC.12.01.01**	**The medical record contains information that reflects the patient's care, treatment, and services.**
(1) All rehabilitation services orders must be documented in the patient's medical record in accordance with the requirements at §482.24.		**EP 2**	The medical record contains the following clinical information: • Admitting diagnosis • Any emergency care, treatment, and services provided to the patient before their arrival • Any allergies to food and medications • Any findings of assessments and reassessments • Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient • Treatment goals, plan of care, and revisions to the plan of care • Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia • All practitioners' orders • Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition • Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the critical access hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. • Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) • Records of radiology and nuclear medicine services, including signed interpretation reports • All care, treatment, and services provided to the patient • Patient's response to care, treatment, and services • Medical history and physical examination, including any conclusions or impressions drawn from the information • Discharge plan and discharge planning evaluation • Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge • Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis.
§482.56(b)(2)	**TAG: A-1134**	**PC.12.01.01**	**The critical access hospital provides care, treatment, and services as ordered or prescribed and in accordance with law and regulation.**
(2)The provision of care and the personnel qualifications must be in accordance with national acceptable standards of practice and must also meet the requirements of §409.17 of this chapter.		**EP 4**	If the critical access hospital provides rehabilitation, physical therapy, occupational therapy, speech-language pathology, or audiology services, the services are organized and provided in accordance with national accepted standards of practice. Note: For rehabilitation distinct part units in critical access hospitals: The critical access hospital provides rehabilitation nursing, physical therapy, and occupational therapy, and, as needed, speech-language pathology, social services, psychological services (including neuropsychological services), and orthotic and prosthetic services by qualified staff in accordance with national accepted standards of practice.

CFR Number §482.57	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.57	**TAG: A-1151**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§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.		**EP 1**	The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: • Outpatient • Emergency • Medical records • Diagnostic and therapeutic radiology • Nuclear medicine • Surgical • Anesthesia • Laboratory • Respiratory • Dietetic • Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital.
§482.57(a)	**TAG: A-1152**	**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§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.		**EP 1**	The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: • Outpatient • Emergency • Medical records • Diagnostic and therapeutic radiology • Nuclear medicine • Surgical • Anesthesia • Laboratory • Respiratory • Dietetic • Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital.
§482.57(a)(1)	**TAG: A-1153**	**LD.13.01.07**	**The critical access hospital effectively manages its programs, services, sites, or departments.**
(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.		**EP 3**	For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access hospital. Note 2: For respiratory care services, the director may serve on either a full-time or part-time basis.

CFR Number §482.57(a)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.57(a)(2) **TAG: A-1154**		**NPG.12.01.01**	**The critical access hospital's leadership team ensures that there is qualified ancillary staff required to meet the needs of the population served and determine how they function within the organization.**
(2) There must be adequate numbers of respiratory therapists, respiratory therapy technicians, and other personnel who meet the qualifications specified by the medical staff, consistent with State law.		**EP 1**	Leaders provide for an adequate number and mix of qualified individuals to support safe, quality care, treatment, and services. Note 1: The number and mix of individuals is appropriate to the scope and complexity of the services offered. Services may include but are not limited to the following: • Rehabilitation services • Emergency services • Outpatient services • Respiratory services • Pharmaceutical services, including emergency pharmaceutical services • Diagnostic and therapeutic radiology services Note 2: Emergency services staff are qualified in emergency care. Note 3: For rehabilitation and psychiatric distinct part units in critical access hospitals: As of the first day of the first cost reporting period for which all other exclusion requirements are met, the unit is fully equipped and staffed and is capable of providing hospital inpatient psychiatric or rehabilitation care regardless of whether there are any inpatients in the unit on that date.
§482.57(b) **TAG: A-1160**		**LD.13.01.09**	**The critical access hospital has policies and procedures that guide and support patient care, treatment, and services.**
§482.57(b) Standard: Delivery of Services Services must be delivered in accordance with medical staff directives.		**EP 7**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If respiratory care services are provided, services are delivered in accordance with policies and procedures approved by the medical staff.
§482.57(b)(1) **TAG: A-1161**		**HR.11.02.01**	**The critical access hospital defines and verifies staff qualifications.**
(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.		**EP 1**	The critical access hospital defines staff qualifications specific to their job responsibilities. Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control). Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists, as defined in 42 CFR 484, provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the critical access hospital. See Glossary for definitions of physical therapist, physical therapist assistant, occupational therapist, occupational therapy assistant, speech-language pathologist, and audiologist. Note 3: For rehabilitation and psychiatric distinct part units in critical access hospitals: If respiratory care services are provided, staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing.
§482.57(b)(2) **TAG: A-1162**		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(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.		**EP 15**	For rehabilitation and psychiatric distinct part units in critical access hospitals: If the critical access 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.

CFR Number §482.57(b)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.57(b)(3)	**TAG: A-1163**	**PC.12.01.01**	**The critical access hospital provides care, treatment, and services as ordered or prescribed and in accordance with law and regulation.**
(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.		**EP 1**	Prior to providing care, treatment, and services, the critical access hospital obtains or renews orders (verbal or written) from a physician or other licensed practitioner in accordance with professional standards of practice; law and regulation; critical access hospital policies; and medical staff bylaws, rules, and regulations. Note 1: This includes but is not limited to respiratory services, radiology services, rehabilitation services, nuclear medicine services, and dietetic services, if provided. Note 2: Patient diets, including therapeutic diets, are ordered by the physician or other licensed practitioner responsible for the patient's care or by a qualified dietitian or qualified nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals. The requirement of 42 CFR 483.25(i) is met for inpatients receiving care at a skilled nursing facility subsequent to critical access hospital care.
§482.57(b)(4)	**TAG: A-1164**	**RC.12.01.01**	**The medical record contains information that reflects the patient's care, treatment, and services.**
(4) All respiratory care services orders must be documented in the patient's medical record in accordance with the requirements at §482.24.		**EP 2**	The medical record contains the following clinical information: • Admitting diagnosis • Any emergency care, treatment, and services provided to the patient before their arrival • Any allergies to food and medications • Any findings of assessments and reassessments • Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient • Treatment goals, plan of care, and revisions to the plan of care • Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia • All practitioners' orders • Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition • Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the critical access hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. • Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) • Records of radiology and nuclear medicine services, including signed interpretation reports • All care, treatment, and services provided to the patient • Patient's response to care, treatment, and services • Medical history and physical examination, including any conclusions or impressions drawn from the information • Discharge plan and discharge planning evaluation • Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge • Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis.

CFR Number §482.58	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.58	**TAG: A-1500**		
§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)	**TAG: A-1501**		
(a) Eligibility. A hospital must meet the following eligibility requirements:			
§482.58(a)(1)	**TAG: A-1501**		
(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)	**TAG: A-1501**		
(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)	**TAG: A-1501**		
(3) The hospital does not have in effect a 24-hour nursing waiver granted under §488.54(c) of this chapter.			
§482.58(a)(4)	**TAG: A-1501**		
(4) The hospital has not had a swing-bed approval terminated within the two years previous to application.			
§482.58(b)	**TAG: A-1562**	For section 482.58(b) of this crosswalk, see 485.645 in the Critical Access Hospital Crosswalk.	
(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)	**TAG: A-1562**		
(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.			
§482.58(b)(2)	**TAG: A-1564**		
(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)).			

CFR Number §482.58(b)(3)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.58(b)(3) **TAG: A-1566**			
(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)).			
§482.58(b)(4) **TAG: A-1567**			
(4) Social services (§483.40(d) of this chapter).			
§482.58(b)(5) **TAG: A-1569**			
(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)]			
§482.58(b)(6) **TAG: A-1574**			
(6) Specialized rehabilitative services (§483.65).			
§482.58(b)(7) **TAG: A-1573**			
(7) Dental services (§483.55(a)(2), (3), (4), and (5) and (b) of this chapter).			
§483.5 **TAG: A-1564**		The glossary includes this Medicare definition.	
§483.5 Definitions. Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.			
§483.10			
§483.10 Resident rights.			
§483.10(b)(7) **TAG: A-1562**		For section 483.10 of this crosswalk, see 483.10 in the Critical Access Hospital Crosswalk.	
(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law			
§483.10(b)(7)(i) **TAG: A-1562**			
(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.			
§483.10(b)(7)(ii) **TAG: A-1562**			
(ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative.			

CFR Number §483.10(b)(7)(iii)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.10(b)(7)(iii) **TAG: A-1562**			
(iii) To the extent practicable, the resident must be 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:			
§483.10(c)(1) **TAG: A-1562**			
(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.			
§483.10(c)(2)			
(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:			
§483.10(c)(2)(iii) **TAG: A-1562**			
(iii) The right to be informed, in advance, of changes to the plan of care.			
§483.10(c)(6) **TAG: A-1562**			
(6) The right to request, refuse, and/ or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.			
§483.10(d) **TAG: A-1562**			
(d) Choice of attending physician. The resident has the right to choose his or her attending physician.			
§483.10(d)(1) **TAG: A-1562**			
(1) The physician must be licensed to practice, and			
§483.10(d)(2) **TAG: A-1562**			
(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.			
§483.10(d)(3) **TAG: A-1562**			
(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.			

CFR Number §483.10(d)(4)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.10(d)(4) **TAG: A-1562**			
(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.			
§483.10(d)(5) **TAG: A-1562**			
(5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.			
§483.10(e)			
(e) Respect and dignity. The resident has a right to be treated with respect and dignity, including:			
§483.10(e)(2) **TAG: A-1562**			
(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.			
§483.10(e)(4) **TAG: A-1562**			
(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.			
§483.10(f)(4)(ii) **TAG: A-1562**			
(ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time;			
§483.10(f)(4)(iii) **TAG: A-1562**			
(iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time;			
§483.10(g)(8) **TAG: A-1562**			
(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:			
§483.10(g)(8)(i) **TAG: A-1562**			
(i) Privacy of such communications consistent with this section; and			
§483.10(g)(8)(ii) **TAG: A-1562**			
(ii) Access to stationery, postage, and writing implements at the resident's own expense.			

CFR Number §483.10(g)(17)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.10(g)(17) **TAG: A-1562**			
(17) The facility must—			
§483.10(g)(17)(i) **TAG: A-1562**			
(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of—			
§483.10(g)(17)(i)(A) **TAG: A-1562**			
(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;			
§483.10(g)(17)(i)(B) **TAG: A-1562**			
(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			
§483.10(g)(17)(ii) **TAG: A-1562**			
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in § 483.10(g)(17)(i)(A) and (B) of this section.			
§483.10(g)(18) **TAG: A-1562**			
(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.			
§483.10(h) **TAG: A-1562**			
(h) Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical 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.			
§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.			
§483.10(h)(3)			
(3) The resident has a right to secure and confidential personal and medical records.			

CFR Number §483.10(h)(3)(i)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§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.			
§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.			
§483.12(a)			
(a) The facility must—			
§483.12(a)(1)	**TAG: A-1566**	For section 483.12 of this crosswalk, see 483.12 in the Critical Access Hospital Crosswalk.	
(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;			
§483.12(a)(2)	**TAG: A-1566**		
(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.			
§483.12(a)(3)			
(3) Not employ or otherwise engage individuals who—			
§483.12(a)(3)(i)	**TAG: A-1566**		
(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;			
§483.12(a)(3)(ii)	**TAG: A-1566**		
(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			
§483.12(a)(4)	**TAG: A-1566**		
(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.			
§483.12(b)			
(b) The facility must develop and implement written policies and procedures that:			
§483.12(b)(1)	**TAG: A-1566**		
(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,			

CFR Number §483.12(b)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.12(b)(2)	**TAG: A-1566**		
(2) Establish policies and procedures to investigate any such allegations, and			
§483.12(c)	**TAG: A-1566**		
(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:			
§483.12(c)(1)	**TAG: A-1566**		
(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.			
§483.12(c)(2)	**TAG: A-1566**		
(2) Have evidence that all alleged violations are thoroughly investigated.			
§483.12(c)(3)	**TAG: A-1566**		
(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.			
§483.12(c)(4)	**TAG: A-1566**		
(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.			
§483.15(c)			
(c) Transfer and discharge—			
§483.15(c)(1)	**TAG: A-1564**	For section 483.15 of this crosswalk, see 483.15 in the Critical Access Hospital Crosswalk.	
(1) Facility requirements—			
§483.15(c)(1)(i)	**TAG: A-1564**		
(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—			
§483.15(c)(1)(i)(A)	**TAG: A-1564**		
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;			

CFR Number §483.15(c)(1)(i)(B)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.15(c)(1)(i)(B) **TAG: A-1564**			
(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;			
§483.15(c)(1)(i)(C) **TAG: A-1564**			
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;			
§483.15(c)(1)(i)(D) **TAG: A-1564**			
(D) The health of individuals in the facility would otherwise be endangered;			
§483.15(c)(1)(i)(E) **TAG: A-1564**			
(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			
§483.15(c)(1)(i)(F) **TAG: A-1564**			
(F) The facility ceases to operate.			
§483.15(c)(1)(ii) **TAG: A-1564**			
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.			
§483.15(c)(2)			
(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.			
§483.15(c)(2)(i) **TAG: A-1564**			
(i) Documentation in the resident's medical record must include:			
§483.15(c)(2)(i)(A) **TAG: A-1564**			
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.			

CFR Number §483.15(c)(2)(i)(B)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.15(c)(2)(i)(B)	**TAG: A-1564**		
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).			
§483.15(c)(2)(ii)	**TAG: A-1564**		
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by—			
§483.15(c)(2)(ii)(A)	**TAG: A-1564**		
(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and			
§483.15(c)(2)(ii)(B)	**TAG: A-1564**		
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.			
§483.15(c)(3)	**TAG: A-1564**		
(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must—			
§483.15(c)(3)(i)	**TAG: A-1564**		
(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.			
§483.15(c)(3)(ii)	**TAG: A-1564**		
(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			
§483.15(c)(3)(iii)	**TAG: A-1564**		
(iii) Include in the notice the items described in paragraph (c)(5) of this section.			
§483.15(c)(4)	**TAG: A-1564**		
(4) Timing of the notice.			
§483.15(c)(4)(i)	**TAG: A-1564**		
(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.			
§483.15(c)(4)(ii)	**TAG: A-1564**		
(ii) Notice must be made as soon as practicable before transfer or discharge when—			

CFR Number §483.15(c)(4)(ii)(A)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.15(c)(4)(ii)(A) **TAG: A-1564**			
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;			
§483.15(c)(4)(ii)(B) **TAG: A-1564**			
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;			
§483.15(c)(4)(ii)(C) **TAG: A-1564**			
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;			
§483.15(c)(4)(ii)(D) **TAG: A-1564**			
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or			
§483.15(c)(4)(ii)(E) **TAG: A-1564**			
(E) A resident has not resided in the facility for 30 days.			
§483.15(c)(5) **TAG: A-1564**			
(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) **TAG: A-1564**			
(i) The reason for transfer or discharge;			
§483.15(c)(5)(ii) **TAG: A-1564**			
(ii) The effective date of transfer or discharge;			
§483.15(c)(5)(iii) **TAG: A-1564**			
(iii) The location to which the resident is transferred or discharged;			
§483.15(c)(5)(iv) **TAG: A-1564**			
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;			
§483.15(c)(5)(v) **TAG: A-1564**			
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;			

CFR Number §483.15(c)(5)(vi)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.15(c)(5)(vi) **TAG: A-1564**			
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106–402, codified at 42 U.S.C. 15001 et seq.); and			
§483.15(c)(5)(vii) **TAG: A-1564**			
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.			
§483.15(c)(7) **TAG: A-1564**			
(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.			
§483.21(c)			
(c) Discharge planning—			
§483.21(c)(2) **TAG: A-1569**			
(2) Discharge summary. When the facility anticipates discharge a resident must have a discharge summary that includes, but is not limited to, the following:			
§483.21(c)(2)(i) **TAG: A-1569**			
(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.			
§483.21(c)(2)(ii) **TAG: A-1569**			
(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.			
§483.21(c)(2)(iii) **TAG: A-1569**			
(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).			

CFR Number §483.21(c)(2)(iv)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.21(c)(2)(iv) **TAG: A-1569**			
(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.			
§483.40(d) **TAG: A-1567**			
(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.			
§483.55 **TAG: A-1573**		For section 483.55 of this crosswalk, see 483.55 in the Critical Access Hospital Crosswalk.	
§483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care.			
§483.55(a) **TAG: A-1573**			
(a) Skilled nursing facilities. A facility			
§483.55(a)(2) **TAG: A-1573**			
(2) May charge a Medicare resident an additional amount for routine and emergency dental services;			
§483.55(a)(3) **TAG: A-1573**			
(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;			
§483.55(a)(4) **TAG: A-1573**			
(4) Must if necessary or if requested, assist the resident—			
§483.55(a)(4)(i) **TAG: A-1573**			
(i) In making appointments; and			
§483.55(a)(4)(ii) **TAG: A-1573**			
(ii) By arranging for transportation to and from the dental services location; and			
§483.55(a)(5) **TAG: A-1573**			
(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.			

CFR Number §483.55(b)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.55(b) **TAG: A-1573**			
(b) Nursing facilities. The facility			
§483.55(b)(1) **TAG: A-1573**			
(1) Must provide or obtain from an outside resource, in accordance with § 483.70(g) of this part, the following dental services to meet the needs of each resident:			
§483.55(b)(1)(i) **TAG: A-1573**			
(i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services;			
§483.55(b)(2) **TAG: A-1573**			
(2) Must, if necessary or if requested, assist the resident—			
§483.55(b)(2)(i) **TAG: A-1573**			
(i) In making appointments; and			
§483.55(b)(2)(ii) **TAG: A-1573**			
(ii) By arranging for transportation to and from the dental services locations;			
§483.55(b)(3) **TAG: A-1573**			
(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;			
§483.55(b)(4) **TAG: A-1573**			
(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			
§483.55(b)(5) **TAG: A-1573**			
(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.			
§483.65			
§483.65 Specialized rehabilitative services.			
§483.65(a) **TAG: A-1574**			
(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for a mental disorder and intellectual disability or services of a lesser intensity as set forth at § 483.120(c), are required in the resident's comprehensive plan of care, the facility must—			

CFR Number §483.65(a)(1)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§483.65(a)(1) **TAG: A-1574**			
(1) Provide the required services; or			
§483.65(a)(2) **TAG: A-1574**			
(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.			
§483.65(b) **TAG: A-1574**			
(b) Qualifications. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.			
§482.59		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
§482.59 Condition of participation: Obstetrical services. If the hospital offers obstetrical services, the services must be well organized and provided in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.		**EP 1**	The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: • Outpatient • Emergency • Medical records • Diagnostic and therapeutic radiology • Nuclear medicine • Surgical • Anesthesia • Laboratory • Respiratory • Dietetic • Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital.

CFR Number §482.59(a)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.59(a)		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(a) Standard: Organization and staffing. Effective January 1, 2026, the organization of the obstetrical services must be appropriate to the scope of the services offered. As applicable, the services must be integrated with other departments of the hospital.		**EP 1**	The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: • Outpatient • Emergency • Medical records • Diagnostic and therapeutic radiology • Nuclear medicine • Surgical • Anesthesia • Laboratory • Respiratory • Dietetic • Obstetrical Note: If obstetrical services are provided, they are in accordance with nationally recognized acceptable standards of practice for the health care (including physical and behavioral health) of pregnant, birthing, and postpartum patients. If outpatient obstetrical services are offered, the services are consistent in quality with inpatient care in accordance with the complexity of services offered. As applicable, the services must be integrated with other departments of the critical access hospital.
§482.59(a)(1)		**LD.13.01.07**	**The critical access hospital effectively manages its programs, services, sites, or departments.**
(1) Labor and delivery rooms/suites (including labor rooms, delivery rooms (including rooms for operative delivery), and post-partum/recovery rooms whether combined or separate) must be supervised by an experienced registered nurse, certified nurse midwife, nurse practitioner, physician assistant, or a doctor of medicine or osteopathy.		**EP 4**	If obstetrical services are provided, the critical access hospital labor and delivery rooms/suites (including labor rooms; delivery rooms, including rooms for operative delivery; and post-partum/recovery rooms whether combined or separate) are supervised by an experienced registered nurse, certified nurse midwife, nurse practitioner, physician assistant, or a doctor of medicine or a doctor of osteopathy (MD/DO).
§482.59(a)(2)		**MS.17.02.01**	**The decision to grant or deny a privilege(s) and/or to renew an existing privilege(s) is an objective, evidence-based process.**
(2) Obstetrical privileges must be delineated for all practitioners providing obstetrical care in accordance with the competencies of each practitioner in accordance with §482.22(c).		**EP 10**	If obstetrical services are provided, obstetrical privileges are delineated for all practitioners providing obstetrical care in accordance with the competencies of each practitioner, and consistent with credentialing agreements established under 42 CFR 485.616(b). For 485.616(b), refer to https://www.ecfr.gov/current/title-42/part-485/section-485.616#p-485.616(b).
§482.59(b)		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(b) Standard: Delivery of service. Effective January 1, 2026, Obstetrical services must be consistent with needs and resources of the facility. Policies governing obstetrical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care and safety.		**EP 23**	If obstetrical services are provided, obstetrical services are consistent with the needs and resources of the critical access hospital. Policies governing obstetrical care are designed to assure the achievement and maintenance of high standards of medical practice and patient care and safety.
§482.59(b)(1)		**PC.12.01.05**	**Resuscitative services are available throughout the critical access hospital.**
(1) The following equipment must be kept at the hospital and be readily available for treating obstetrical cases to meet the needs of patients in accordance with the scope, volume, and complexity of services offered: call-in-system, cardiac monitor, and fetal doppler or monitor.		**EP 2**	If obstetrical services are provided, the following equipment is kept at the critical access hospital and is readily available for treating obstetrical cases to meet the needs of patients in accordance with the scope, volume, and complexity of services offered: call-in-system, cardiac monitor, and fetal doppler or monitor.

CFR Number §482.59(b)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.59(b)(2)		**LD.13.03.01**	**The critical access hospital provides services that meet patient needs.**
(2) There must be adequate provisions and protocols, consistent with nationally recognized and evidence-based guidelines, for obstetrical emergencies, complications, immediate post-delivery care, and other patient health and safety events as identified as part of the QAPI program (§ 482.21). Provisions include equipment (in addition to the equipment required under paragraph (b)(1) of this section), supplies, and medication used in treating emergency cases. Such provisions must be kept in the hospital and be readily available for treating emergency cases.		**EP 24**	If obstetrical services are provided, the critical access hospital has adequate provisions and protocols, consistent with nationally recognized and evidence-based guidelines, for obstetrical emergencies, complications, immediate post-delivery care, and other patient health and safety events as identified as part of the quality assessment and performance improvement (QAPI) program (42 CFR 485.641). Provisions include equipment (in addition to the equipment required under 42 CFR 485.649 (b)(1)), supplies, and medication used in treating emergency cases. Such provisions are kept in the critical access hospital and are readily available for treating emergency cases. Note 1: For 485.641, refer to https://www.ecfr.gov/current/title-42/section-485.641. Note 2: For 485.649(b)(1), refer to https://www.ecfr.gov/current/title-42/part-485/section-485.649#p-485.649(b)(1).