The Joint Commission™

Disposition of Changes for the Hospital Program

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
APR.04.01.01, EP 2	The hospital selects and uses measures that reflect the following characteristics: Relevant to the hospital	Moved	APR.04.01.01, EP 1	The hospital selects and uses measures that reflect the following characteristics: Relevant to the hospital
APR.04.01.01, EP 3	The hospital selects and uses measures that reflect the following characteristics: Support strategic measurement goals	Moved	APR.04.01.01, EP 2	The hospital selects and uses measures that reflect the following characteristics: Support strategic measurement goals
APR.04.01.01, EP 4	The hospital selects and uses measures that reflect the following characteristics: Target high-volume, high-risk, problem-prone issues	Moved	APR.04.01.01, EP 3	The hospital selects and uses measures that reflect the following characteristics: Target high-volume, high-risk, problem-prone issues
APR.04.01.01, EP 5	The hospital selects and uses measures that reflect the following characteristics: Provide opportunities to improve the quality of care	Moved	APR.04.01.01, EP 4	The hospital selects and uses measures that reflect the following characteristics: Provide opportunities to improve the quality of care
APR.04.01.01, EP 11	The hospital selects chart-abstracted measures and/or electronic clinical quality measures (eCQMs) based on its patient population/services offered to meet current ORYX® requirements.	Moved	APR.04.01.01, EP 5	The hospital selects chart-abstracted measures and/or electronic clinical quality measures (eCQMs) based on its patient population/services offered to meet current ORYX® requirements.
APR.04.01.01, EP 12	The hospital selects performance measures within The Joint Commission's data submission application.	Moved	APR.04.01.01, EP 6	The hospital selects performance measures within The Joint Commission's data submission application.
APR.04.01.01, EP 17	The hospital discusses with the surveyor how the data are used to identify, prioritize, and monitor performance improvement activities.	Moved	APR.04.01.01, EP 7	The hospital discusses with the surveyor how the data are used to identify, prioritize, and monitor performance improvement activities.
APR.04.01.01, EP 18	The hospital uses each individual measure to identify patterns, trends, or variations for improvement opportunities before replacing it. (For example, chart-abstracted measures should begin the first quarter of the calendar year or first quarter following receipt of an accreditation decision letter and be used for the remainder of the calendar year before replacing any measures.)	Moved	APR.04.01.01, EP 8	The hospital uses each individual measure to identify patterns, trends, or variations for improvement opportunities before replacing it. (For example, chart-abstracted measures should begin the first quarter of the calendar year or first quarter following receipt of an accreditation decision letter and be used for the remainder of the calendar year before replacing any measures.)
APR.04.01.01, EP 19	Based on Joint Commission statistical analysis, the hospital continues to use a measure if the data suggest an unstable pattern of performance or otherwise identify an opportunity for improvement.	Moved	APR.04.01.01, EP 9	Based on Joint Commission statistical analysis, the hospital continues to use a measure if the data suggest an unstable pattern of performance or otherwise identify an opportunity for improvement.
APR.04.01.01, EP 20	The hospital selects a new measure if the data reflect stable and satisfactory performance.	Moved	APR.04.01.01, EP 10	The hospital selects a new measure if the data reflect stable and satisfactory performance.
APR.04.01.01, EP 21	The hospital notifies The Joint Commission of a change in its service line that results in specific measures no longer being applicable (for example, a hospital closes its obstetrical unit and can no longer report the Perinatal Care measures).	Moved	APR.04.01.01, EP 11	The hospital notifies The Joint Commission of a change in its service line that results in specific measures no longer being applicable (for example, a hospital closes its obstetrical unit and can no longer report the Perinatal Care measures).
APR.04.01.01, EP 22	The hospital's performance measure data are submitted to The Joint Commission in the timelines established and technical manner prescribed by The Joint Commission.	Moved	APR.04.01.01, EP 12	The hospital's performance measure data are submitted to The Joint Commission in the timelines established and technical manner prescribed by The Joint Commission.
APR.04.01.01, EP 23	The hospital resolves data quality issues for reported performance measures.	Moved	APR.04.01.01, EP 13	The hospital resolves data quality issues for reported performance measures.
APR.04.01.01, EP 24	For the most recent 12-month calendar reporting period, the hospital achieves and sustains an acceptable level of performance for each measure, as defined by Joint Commission statistical analysis, before it discontinues a measure's use in performance improvement activities.	Moved	APR.04.01.01, EP 14	For the most recent 12-month calendar reporting period, the hospital achieves and sustains an acceptable level of performance for each measure, as defined by Joint Commission statistical analysis, before it discontinues a measure's use in performance improvement activities.
EC.01.01.01, EP 1	Leaders identify an individual(s) to manage risk, coordinate risk reduction activities in the physical environment, collect deficiency information, and disseminate summaries of actions and results. Note: Deficiencies include injuries, problems, or use errors. CoPs: §482.41(c), §482.41(c)(1), §482.41(c)(2), §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.01.01.01, EP 3	The hospital has a library of information regarding inspection, testing, and maintenance of its equipment and systems.	Deleted EP - Replaced with more	N/A	N/A

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	Note: This library includes manuals, procedures provided by manufacturers, technical bulletins, and other information. CoPs: §482.41(d)(2)	direct EP(s) or moved to guidance within SPG		
EC.01.01.01, EP 4	The hospital has a written plan for managing the following: The environmental safety of patients and everyone else who enters the hospital's facilities. CoPs: §482.26(b), §482.41(a)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.01.01.01, EP 5	The hospital has a written plan for managing the following: The security of everyone who enters the hospital's facilities. CoPs: §482.13(c)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.01.01.01, EP 6	The hospital has a written plan for managing the following: Hazardous materials and waste. CoPs: §482.26(b), §482.41(a)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.01.01.01, EP 7	The hospital has a written plan for managing the following: Fire safety. CoPs: §482.41(a)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.01.01.01, EP 8	The hospital has a written plan for managing the following: Medical equipment. CoPs: §482.41(a), §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.01.01.01, EP 9	The hospital has a written plan for managing the following: Utility systems. Note: In circumstances where the program or service is located in a business occupancy not owned by the accredited organization, the plan may only need to address how routine service and maintenance for their utility systems are obtained. CoPs: §482.41(a), §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.01.01.01, EP 12	The hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. CoPs: §482.15(e)(1), §482.15(h)(1)(i), §482.15(h)(1)(ii), §482.15(h)(1)(iii), §482.15(h)(1)(iv), §482.15(h)(1)(v), §482.15(h)(1)(vi), §482.41(e)(1)(i), §482.41(e)(1)(ii), §482.41(e)(1)(iii), §482.41(e)(1)(iv), §482.41(e)(1)(v), §482.41(e)(1)(vi)	Moved and Revised	PE.04.01.01, EP 1	The hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity. CoPs: §482.15(e)(1), §482.15(h)(1)(i), §482.15(h)(1)(ii), §482.15(h)(1)(iii),

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				§482.15(h)(1)(iv), §482.15(h)(1)(v), §482.15(h)(1)(vi), §482.41(c), §482.41(c)(1), §482.41(c)(2), §482.41(e)(1)(i), §482.41(e)(1)(ii), §482.41(e)(1)(iii), §482.41(e)(1)(iv), §482.41(e)(1)(v), §482.41(e)(1)(vi), §482.42
EC.02.01.01, EP 1	The hospital implements its process to identify safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital's facilities. Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts. CoPs: §482.13(c)(2), §482.26(b), §482.41(a)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.01.01, EP 3	The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment. CoPs: §482.13(c)(2), §482.26(b), §482.41(a)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.01.01, EP 5	The hospital maintains all grounds and equipment. CoPs: §482.41(a)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.01.01, EP 7	The hospital identifies individuals entering its facilities. Note: The hospital determines which of those individuals require identification and how to do so. CoPs: §482.13(c)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.01.01, EP 8	The hospital controls access to and from areas it identifies as security sensitive. CoPs: §482.13(c)(2), §482.53(b)	Moved	NPG.11.01.01, EP 1	The hospital controls access to and from areas it identifies as security sensitive.
EC.02.01.01, EP 9	The hospital has written procedures to follow in the event of a security incident, including an infant or pediatric abduction. CoPs: §482.13(c)(2)	Consolidation of EC.02.01.01, EP 9; EC.02.01.01, EP 10	NPG.11.01.01, EP 2	The hospital develops and implements written policies and procedures to follow in the event of a security incident, including an infant or pediatric abduction.
EC.02.01.01, EP 10	When a security incident occurs, the hospital follows its identified procedures. CoPs: §482.13(c)(2)	Consolidation of EC.02.01.01, EP 9; EC.02.01.01, EP 10	NPG.11.01.01, EP 2	The hospital develops and implements written policies and procedures to follow in the event of a security incident, including an infant or pediatric abduction.
EC.02.01.01, EP 11	The hospital responds to product notices and recalls. CoPs: §482.25(b), §482.41(a)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.01.01, EP 14	The hospital manages magnetic resonance imaging (MRI) safety risks associated with the following: - Patients who may experience claustrophobia, anxiety, or emotional distress - Patients who may require urgent or emergent medical care - Patients with medical implants, devices, or imbedded metallic foreign objects (such as shrapnel)	Moved	NPG.13.03.01, EP 1	The hospital manages magnetic resonance imaging (MRI) safety risks associated with the following: - Patients who may experience claustrophobia, anxiety, or emotional distress - Patients who may require urgent or emergent medical care - Patients with medical implants, devices, or imbedded metallic foreign objects (such as shrapnel)

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	- Ferromagnetic objects entering the MRI environment - Acoustic noise			- Ferromagnetic objects entering the MRI environment - Acoustic noise
EC.02.01.01, EP 16	The hospital manages magnetic resonance imaging (MRI) safety risks by doing the following: - Restricting access of everyone not trained in MRI safety or screened by staff trained in MRI safety from the scanner room and the area that immediately precedes the entrance to the MRI scanner room. - Making sure that these restricted areas are controlled by and under the direct supervision of staff trained in MRI safety. - Posting signage at the entrance to the MRI scanner room that conveys that potentially dangerous magnetic fields are present in the room. Signage should also indicate that the magnet is always on except in cases where the MRI system, by its design, can have its magnetic field routinely turned on and off by the operator.	Moved	NPG.13.03.01, EP 2	The hospital manages magnetic resonance imaging (MRI) safety risks by doing the following: - Restricting access of everyone not trained in MRI safety or screened by staff trained in MRI safety from the scanner room and the area that immediately precedes the entrance to the MRI scanner room. - Making sure that these restricted areas are controlled by and under the direct supervision of staff trained in MRI safety. - Posting signage at the entrance to the MRI scanner room that conveys that potentially dangerous magnetic fields are present in the room. Signage should also indicate that the magnet is always on except in cases where the MRI system, by its design, can have its magnetic field routinely turned on and off by the operator.
EC.02.01.01, EP 17	The hospital conducts an annual worksite analysis related to its workplace violence prevention program. The hospital takes actions to mitigate or resolve the workplace violence safety and security risks based upon findings from the analysis. Note: A worksite analysis includes a proactive analysis of the worksite, an investigation of the hospital's workplace violence incidents, and an analysis of how the program's policies and procedures, training, education, and environmental design reflect best practices and conform to applicable laws and regulations.	Moved	NPG.02.04.01, EP 3	The hospital conducts an annual worksite analysis related to its workplace violence prevention program. The hospital takes actions to mitigate or resolve the workplace violence safety and security risks based on findings from the analysis. Note: A worksite analysis includes a proactive analysis of the worksite, an investigation of the hospital's workplace violence incidents, and an analysis of how the program's policies and procedures, training, education, and environmental design reflect best practices and conform to applicable laws and regulations.
EC.02.01.03, EP 4	Smoking materials are removed from patients receiving respiratory therapy. When a nasal cannula is delivering oxygen outside of a patient's room, no sources of ignition are within the site of intentional expulsion (within 1 foot). When other oxygen delivery equipment is used or oxygen is delivered inside a patient's room, no sources of ignition are within the area of administration (within 15 feet). Solid fuel–burning appliances are not in the area of administration. Nonmedical appliances with hot surfaces or sparking mechanisms are not within oxygen-delivery equipment or site of intentional expulsion. (For full text, refer to NFPA 99-2012: 11.5.1.1; Tentative Interim Amendment [TIA] 12-6) CoPs: §482.41(c)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.01.03, EP 6	The hospital takes action to maintain compliance with its smoking policy.	Deleted	N/A	N/A
EC.02.02.01, EP 1	The hospital maintains a written, current inventory of hazardous materials and waste that it uses, stores, or generates. The only materials that need to be included on the inventory are those whose handling, use, and storage are addressed by law and regulation. CoPs: §482.26(b)(1), §482.41(a)	Moved	PE.02.01.01, EP 1	The hospital maintains a written, current inventory of hazardous materials and waste that it uses, stores, or generates. The only materials that need to be included on the inventory are those whose handling, use, and storage are addressed by law and regulation.
EC.02.02.01, EP 3	The hospital has written procedures, including the use of precautions and personal protective equipment, to follow in response to hazardous material and waste spills or exposures. CoPs: §482.26(b), §482.26(b)(1), §482.26(b)(3), §482.41(a), §482.53(b)	Consolidation of EC.02.02.01, EP 3; EC.02.02.01, EP 4; EC.02.02.01, EP 5; EC.02.02.01, EP 6; EC.02.02.01, EP 7; EC.02.02.01, EP 8; EC.02.02.01, EP 9	PE.02.01.01, EP 4	The hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials. The policies and procedures address the following: - Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors - Disposal of hazardous medications - Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding - Periodic inspection of radiology equipment and prompt correction of hazards found during inspection

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				- 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) CoPs: §482.26(b), §482.26(b)(1), §482.26(b)(2), §482.53(b), §482.53(b)(2)
EC.02.02.01, EP 4	The hospital implements its procedures in response to hazardous material and waste spills or exposures. CoPs: §482.41(a), §482.53(b)	Consolidation of EC.02.02.01, EP 3; EC.02.02.01, EP 4; EC.02.02.01, EP 5; EC.02.02.01, EP 6; EC.02.02.01, EP 7; EC.02.02.01, EP 8; EC.02.02.01, EP 9	PE.02.01.01, EP 4	The hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials. The policies and procedures address the following: - Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors - Disposal of hazardous medications - Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding - Periodic inspection of radiology equipment and prompt correction of hazards found during inspection - Precautions to follow and personal protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers and MRIs). Note 2: Hazardous gases and vapors include but are not limited to ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9) CoPs: §482.26(b), §482.26(b)(1), §482.26(b)(2), §482.53(b), §482.53(b)(2)
EC.02.02.01, EP 5	The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemicals. CoPs: §482.41(a), §482.41(b)(4)	Consolidation of EC.02.02.01, EP 3; EC.02.02.01, EP 4; EC.02.02.01, EP 5; EC.02.02.01, EP 6; EC.02.02.01, EP 7; EC.02.02.01, EP 8; EC.02.02.01, EP 9	PE.02.01.01, EP 4	The hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials. The policies and procedures address the following: - Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors - Disposal of hazardous medications - Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding - Periodic inspection of radiology equipment and prompt correction of hazards found during inspection - Precautions to follow and personal protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers and MRIs).

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				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) CoPs: §482.26(b), §482.26(b)(1), §482.26(b)(2), §482.53(b), §482.53(b)(2)
EC.02.02.01, EP 6	The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of radioactive materials. CoPs: §482.26(b)(1), §482.41(b)(4), §482.53(b), §482.53(b)(2)	Consolidation of EC.02.02.01, EP 3; EC.02.02.01, EP 4; EC.02.02.01, EP 5; EC.02.02.01, EP 6; EC.02.02.01, EP 7; EC.02.02.01, EP 8; EC.02.02.01, EP 9	PE.02.01.01, EP 4	The hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials. The policies and procedures address the following: - Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors - Disposal of hazardous medications - Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding - Periodic inspection of radiology equipment and prompt correction of hazards found during inspection - Precautions to follow and personal protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers and MRIs). Note 2: Hazardous gases and vapors include but are not limited to ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9) CoPs: §482.26(b), §482.26(b)(1), §482.26(b)(2), §482.53(b), §482.53(b)(2)
EC.02.02.01, EP 7	The hospital minimizes risks associated with selecting and using hazardous energy sources. Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers and MRIs). Note 2: This includes the use of proper shielding during fluoroscopic procedures. CoPs: §482.26(b), §482.26(b)(1), §482.26(b)(3), §482.53(b)	Consolidation of EC.02.02.01, EP 3; EC.02.02.01, EP 4; EC.02.02.01, EP 5; EC.02.02.01, EP 6; EC.02.02.01, EP 7; EC.02.02.01, EP 8; EC.02.02.01, EP 9	PE.02.01.01, EP 4	The hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials. The policies and procedures address the following: - Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors - Disposal of hazardous medications - Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding - Periodic inspection of radiology equipment and prompt correction of hazards found during inspection - Precautions to follow and personal protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers and MRIs). Note 2: Hazardous gases and vapors include but are not limited to ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9)

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				CoPs: §482.26(b), §482.26(b)(1), §482.26(b)(2), §482.53(b), §482.53(b)(2)
EC.02.02.01, EP 8	The hospital minimizes risks associated with disposing of hazardous medications. CoPs: §482.26(b)(1), §482.41(a), §482.53(b), §482.53(b)(2)	Consolidation of EC.02.02.01, EP 3; EC.02.02.01, EP 4; EC.02.02.01, EP 5; EC.02.02.01, EP 6; EC.02.02.01, EP 7; EC.02.02.01, EP 8; EC.02.02.01, EP 9	PE.02.01.01, EP 4	The hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials. The policies and procedures address the following: - Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors - Disposal of hazardous medications - Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding - Periodic inspection of radiology equipment and prompt correction of hazards found during inspection - Precautions to follow and personal protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers and MRIs). Note 2: Hazardous gases and vapors include but are not limited to ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9) CoPs: §482.26(b), §482.26(b)(1), §482.26(b)(2), §482.53(b), §482.53(b)(2)
EC.02.02.01, EP 9	The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous gases and vapors. Note: Hazardous gases and vapors include, but are not limited to, ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9) CoPs: §482.41(d)(4)	Consolidation of EC.02.02.01, EP 3; EC.02.02.01, EP 4; EC.02.02.01, EP 5; EC.02.02.01, EP 6; EC.02.02.01, EP 7; EC.02.02.01, EP 8; EC.02.02.01, EP 9	PE.02.01.01, EP 4	The hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials. The policies and procedures address the following: - Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors - Disposal of hazardous medications - Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding - Periodic inspection of radiology equipment and prompt correction of hazards found during inspection - Precautions to follow and personal protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers and MRIs). Note 2: Hazardous gases and vapors include but are not limited to ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9) CoPs: §482.26(b), §482.26(b)(1), §482.26(b)(2), §482.53(b), §482.53(b)(2)
EC.02.02.01, EP 10	The hospital monitors levels of hazardous gases and vapors to determine that they are in safe range. Note: Law and regulation determine the frequency of monitoring hazardous gases	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

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	and vapors as well as acceptable ranges. CoPs: §482.41(a)	moved to guidance within SPG		
EC.02.02.01, EP 11	For managing hazardous materials and waste, the hospital has the permits, licenses, manifests, and safety data sheets required by law and regulation. CoPs: §482.26(b)(1), §482.41(a), §482.53(b), §482.53(b)(2)	Moved	PE.02.01.01, EP 2	For managing hazardous materials and waste, the hospital has the permits, licenses, manifests, and safety data sheets required by law and regulation.
EC.02.02.01, EP 12	The hospital labels hazardous materials and waste. Labels identify the contents and hazard warnings. * Footnote *: The Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens and Hazard Communications Standards and the National Fire Protection Association (NFPA) provide details on labeling requirements. CoPs: §482.26(b)(1), §482.41(a), §482.53(b), §482.53(b)(2)	Moved and Revised	PE.02.01.01, EP 3	The hospital labels hazardous materials and waste. Labels identify the contents and hazard warnings. Note: The Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens and Hazard Communications Standards and the National Fire Protection Association (NFPA) provide details on labeling requirements.
EC.02.02.01, EP 17	For hospitals that provide computed tomography (CT), positron emission tomography (PET), nuclear medicine (NM), or fluoroscopy services: The results of dosimetry monitoring are reviewed at least quarterly by the radiation safety officer, diagnostic medical physicist, or health physicist to assess whether staff radiation exposure levels are "as low as reasonably achievable" (ALARA) and below regulatory limits. Note 1: For the definition of ALARA, please refer to US Nuclear Regulatory Commission federal regulation 10 CFR 20.1003. Note 2: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.	Moved and Revised	NPG.13.03.01, EP 3	For hospitals that provide computed tomography (CT), positron emission tomography (PET), nuclear medicine (NM), or fluoroscopy services: The radiation safety officer, diagnostic medical physicist, or health physicist reviews the results of dosimetry monitoring at least quarterly to assess whether staff radiation exposure levels are "as low as reasonably achievable" (ALARA) and below regulatory limits. Note 1: For the definition of ALARA, please refer to US Nuclear Regulatory Commission federal regulation 10 CFR 20.1003. Note 2: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.
EC.02.02.01, EP 18	For hospitals that use Joint Commission accreditation for deemed status purposes: Radiation workers are checked periodically, by the use of exposure meters or badge tests, for the amount of radiation exposure. CoPs: §482.26(b)(3)	Moved and Revised	PE.02.01.01, EP 5	Radiation workers are checked periodically, using exposure meters or badge tests, for the amount of radiation exposure. CoPs: §482.26(b)(3)
EC.02.02.01, EP 19	The hospital has procedures for the proper routine storage and prompt disposal of trash and regulated medical waste. CoPs: §482.41(b)(4)	Moved	PE.02.01.01, EP 6	The hospital has procedures for the proper routine storage and prompt disposal of trash and regulated medical waste. CoPs: §482.41(b)(4)
EC.02.03.01, EP 1	The hospital minimizes the potential for harm from fire, smoke, and other products of combustion. CoPs: §482.41(b)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.01, EP 4	The hospital maintains free and unobstructed access to all exits. Note: This requirement applies to all buildings classified as business occupancy. The "Life Safety" (LS) chapter addresses the requirements for all other occupancy types. CoPs: §482.41(b)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.01, EP 9	The written fire response plan describes the specific roles of staff at and away from a fire's point of origin, including when and how to sound and report fire alarms, how to contain smoke and fire, how to use a fire extinguisher, how to assist and relocate patients, how to evacuate to areas of refuge, and how staff will cooperate with	Moved and Revised	PE.03.01.01, EP 4	The hospital has written fire control plans that include provisions for prompt reporting of fires; extinguishing fires; protection of patients, staff, and guests; evacuation; and cooperation with firefighting authorities.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	firefighting authorities. Staff are periodically instructed on and kept informed of their duties under the plan, including cooperation with firefighting authorities. A copy of the plan is readily available with the telephone operator or security. Note: For full text, refer to NFPA 101-2012: 18/19.7.1; 7.2. CoPs: §482.15(b)(1)(ii)(C), §482.41(b)(5)			CoPs: §482.15(b)(1)(ii)(C), §482.41(b)(5)
EC.02.03.01, EP 11	Periodic evaluations, as determined by the hospital, are made of potential fire hazards that could be encountered during surgical procedures. Written fire prevention and response procedures, including safety precautions related to the use of flammable germicides or antiseptics, are established. CoPs: §482.51(b)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.01, EP 12	When flammable germicides or antiseptics are used during surgeries utilizing electrosurgery, cautery, or lasers, the following are required: - Nonflammable packaging - Unit-dose applicators - Preoperative "time-out" prior to the initiation of any surgical procedure to verify the following: - Application site is dry prior to draping and use of surgical equipment - Pooling of solution has not occurred or has been corrected - Solution-soaked materials have been removed from the operating room prior to draping and use of surgical devices (For full text, refer to NFPA 99-2012: 15.13) CoPs: §482.51(b)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.01, EP 13	The hospital meets all other Health Care Facilities Code fire protection requirements, as related to NFPA 99-2012: Chapter 15. CoPs: §482.41(c)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.03, EP 1	The hospital conducts fire drills once per shift per quarter in each building defined as a health care occupancy by the Life Safety Code. The hospital conducts quarterly fire drills in each building defined as an ambulatory health care occupancy by the Life Safety Code. Note 1: Evacuation of patients during drills is not required. Note 2: When drills are conducted between 9:00 P.M. and 6:00 A.M., the hospital may use a coded announcement to notify staff instead of activating audible alarms. For full text, refer to NFPA 101-2012: 18/19: 7.1.7. Note 3: In leased or rented facilities, drills need be conducted only in areas of the building that the hospital occupies. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.03, EP 2	The hospital conducts fire drills every 12 months from the date of the last drill in all freestanding buildings classified as business occupancies and in which patients are seen or treated. Note: In leased or rented facilities, drills need be conducted only in areas of the building that the hospital occupies. CoPs: §482.41(b)(5)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
EC.02.03.03, EP 3	When quarterly fire drills are required, they are unannounced and held at unexpected times and under varying conditions. Fire drills include transmission of fire alarm signal and simulation of emergency fire conditions. Note 1: When drills are conducted between 9:00 P.M. and 6:00 A.M., the hospital may use a coded announcement to notify staff instead of activating audible alarms. Note 2: Fire drills vary by at least one hour for each shift from quarter to quarter, through four consecutive quarters. Note 3: For full text, refer to NFPA 101-2012: 18/19: 7.1; 7.1.7; 7.2; 7.3. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.03, EP 4	Staff who work in buildings where patients are housed or treated participate in drills according to the hospital's fire response plan. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.03, EP 5	The hospital critiques fire drills to evaluate fire safety equipment, fire safety building features, and staff response to fire. The evaluation is documented. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.03, EP 7	The hospital conducts annual fire exit drills for operating rooms/surgical suites. (For full text, refer to NFPA 99-2012: 15.13.3.10.3) Note 1: This drill involves applicable staff and focuses on prevention as well as simulated extinguishment and evacuation. Note 2: An announced annual fire exit drill cannot be used to meet one of the unannounced quarterly fire drills required by NFPA 101-2012: 18/19.7.1.6. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.03, EP 8	For hospitals that have hyperbaric facilities, emergency procedures and fire training drills are conducted annually. (For full text, refer to NFPA 99-2012: 14.2.4.5.4; 14.3.1.4.5) Note 1: This drill includes recording the time to evacuate all persons from the area, involves applicable staff, and focuses on prevention as well as simulated extinguishment and evacuation. Response procedures for fires within and outside the hyperbaric chamber address the role of the inside observer, the chamber operator, medical personnel, and other personnel, as applicable. For additional guidance, refer to NFPA 99-2012: B.14.2 and B.14.3. Note 2: If the hospital conducts an unannounced drill, it may serve as one of the required fire drills. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.05, EP 1	The hospital tests supervisory signal devices on the inventory in accordance with the following time frames: - Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices - Semiannually for valve supervisory switches - Annually for other supervisory initiating devices	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	The results and completion dates are documented. Note 1: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5. Note 2: Water storage tanks and associated water storage equipment do not require testing. CoPs: §482.41(d)(2)			
EC.02.03.05, EP 2	Every 6 months, the hospital tests vane-type and pressure-type water flow devices and valve tamper switches on the inventory. The results and completion dates are documented. Note 1: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5. Note 2: Mechanical water flow devices (including, but not limited to, water motor gongs) should be tested quarterly. The results and completion dates are documented. (For full text, refer to NFPA 25-2011: Table 5.1.1.2) CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.05, EP 3	Every 12 months, the hospital tests duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors on the inventory. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5; 17.14. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.05, EP 4	Every 12 months, the hospital tests visual and audible fire alarms, including speakers and door-releasing devices on the inventory. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.05, EP 5	Every 12 months, the hospital tests fire alarm equipment on the inventory for notifying off-site fire responders. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.05, EP 6	For automatic sprinkler systems: The hospital tests electric motor–driven fire pumps monthly and diesel engine–driven fire pumps every week under no-flow conditions. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 25-2011: 8.3.1; 8.3.2. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.05, EP 9	For automatic sprinkler systems: Every 12 months, the hospital tests main drains at system low point or at all system risers. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.05, EP 10	For automatic sprinkler systems: Every quarter, the hospital inspects all fire department water supply connections. The results and completion dates are documented.	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	Note: For additional guidance on performing tests, see NFPA 25-2011: 13.7; Table 13.1.1.2. CoPs: §482.41(d)(2)	moved to guidance within SPG		
EC.02.03.05, EP 11	For automatic sprinkler systems: Every 12 months, the hospital tests fire pumps under flow. Fire pump supervisory signals for "pump running" and "pump power loss" are tested annually. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 25-2011: 8.3.3; 8.3.3.4. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.05, EP 12	Every 5 years, the hospital conducts hydrostatic and water flow tests for standpipe systems. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 25-2011: 6.3.1; 6.3.2; Table 6.1.1.2. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.05, EP 13	Every 6 months, the hospital inspects any automatic fire-extinguishing system in a kitchen. The results and completion dates are documented. Note 1: Discharge of the fire-extinguishing systems is not required. Note 2: For additional guidance on performing inspections, see NFPA 96-2011: 11.2. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.05, EP 14	The hospital tests automatic fire-extinguishing systems as follows: - Carbon dioxide systems every 12 months - Halon systems every 6 months - Other special systems per National Fire Protection Association standards and manufacturers' recommendations. The results and completion dates are documented. Note 1: Discharge of the fire-extinguishing systems is not required. Note 2: For full text, refer to NFPA 12-2011: 4.8.3.2 (for carbon dioxide systems) and NFPA 12A-2009: 6.1 (for halon systems). Note 3: For full text, refer to NFPA 11-2010; NFPA 16-2011; NFPA 17-2009; NFPA 17A-2009 for other extinguishing systems. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.05, EP 15	At least monthly, the hospital inspects portable fire extinguishers. The results and completion dates are documented. Note 1: There are many ways to document the inspections, such as using bar-coding equipment, using check marks on a tag, or using an inventory. Note 2: Inspections involve a visual check to determine correct type of and clear and unobstructed access to a fire extinguisher, in addition to a check for broken parts and full charge. Note 3: For additional guidance on inspection of fire extinguishers, see NFPA 10-2010: 7.2.2; 7.2.4. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.05, EP 16	Every 12 months, the hospital performs maintenance on portable fire extinguishers, including recharging. Individuals performing annual maintenance on extinguishers are certified. The results and completion dates are documented.	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	Note 1: There are many ways to document the maintenance, such as using bar-coding equipment, using check marks on a tag, or using an inventory. Note 2: For additional guidance on maintaining fire extinguishers, see NFPA 10-2010: 7.1.2; 7.2.2; 7.2.4; 7.3.1. CoPs: §482.41(d)(2)	moved to guidance within SPG		
EC.02.03.05, EP 17	The hospital conducts hydrostatic tests on standpipe occupant hoses 5 years after installation and every 3 years thereafter. The results and completion dates are documented. Note: For additional guidance on hydrostatic testing, see NFPA 1962-2008: Chapter 7 and NFPA 25-2011: Chapter 6. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.05, EP 18	The hospital operates fire and smoke dampers one year after installation and then at least every six years to verify that they fully close. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 90A-2012: 5.4.8; NFPA 80-2010: 19.4; NFPA 105-2010: 6.5. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.05, EP 19	Every 12 months, the hospital tests automatic smoke-detection shutdown devices for air-handling equipment. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 90A-2012: 6.4.1. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.05, EP 20	Every 12 months, the hospital tests sliding and rolling fire doors, smoke barrier sliding or rolling doors, and sliding and rolling fire doors in corridor walls and partitions for proper operation and full closure. The results and completion dates are documented. Note: For full text, refer to NFPA 80-2010: 5.2.14.3; NFPA 105-2010: 5.2.1; 5.2.2. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.05, EP 25	The hospital has annual inspection and testing of fire door assemblies by individuals who can demonstrate knowledge and understanding of the operating components of the door being tested. Testing begins with a pre-test visual inspection; testing includes both sides of the opening. Note 1: Nonrated doors, including corridor doors to patient care rooms and smoke barrier doors, are not subject to the annual inspection and testing requirements of either NFPA 80 or NFPA 105. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: Nonrated doors should be routinely inspected and maintained in accordance with the facility maintenance program. Note 3: For additional guidance on testing of door assemblies, see NFPA 101-2012: 7.2.1.5.10.1; 7.2.1.5.11; 7.2.1.15; NFPA 80-2010: 4.8.4; 5.2.1; 5.2.3; 5.2.4; 5.2.6; 5.2.7; 6.3.1.7; NFPA 105-2010: 5.2.1. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.03.05, EP 27	Elevators with firefighters' emergency operations are tested monthly. The test completion dates and results are documented. (For full text, refer to NFPA 101-2012:	Deleted EP - Replaced with more	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	9.4.3; 9.4.6) CoPs: §482.41(d)(2)	direct EP(s) or moved to guidance within SPG		
EC.02.03.05, EP 28	Documentation of maintenance, testing, and inspection activities for Standard EC.02.03.05, EPs 1–20, 25 (including fire alarm and fire protection systems) includes the following: - Name of the activity - Date of the activity - Inventory of devices, equipment, or other items - Required frequency of the activity - Name and contact information, including affiliation, of the person who performed the activity - NFPA standard(s) referenced for the activity - Results of the activity Note: For additional guidance on documenting activities, see NFPA 25-2011: 4.3; 4.4; NFPA 72-2010: 14.2.1; 14.2.2; 14.2.3; 14.2.4. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.04.01, EP 2	For hospitals that do not use Joint Commission accreditation for deemed status purposes: The hospital maintains either a written inventory of all medical equipment or a written inventory of selected equipment categorized by physical risk associated with use (including all life-support equipment) and equipment incident history. The hospital evaluates new types of equipment before initial use to determine whether they should be included in the inventory. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital maintains a written inventory of all medical equipment. CoPs: §482.26(b)(2), §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.04.01, EP 3	The hospital identifies high-risk medical equipment on the inventory for which there is a risk of serious injury or death to a patient or staff member should the equipment fail. Note: High-risk medical equipment includes life-support equipment. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.04.01, EP 4	The hospital identifies the activities and associated frequencies, in writing, for maintaining, inspecting, and testing all medical equipment on the inventory. Note: Activities and associated frequencies for maintaining, inspecting, and testing of medical equipment must have a 100% completion rate. CoPs: §482.26(b)(2), §482.41(d)(2), §482.53(c)(1)	Consolidation of EC.02.04.01, EP 4; EC.02.04.03, EP 1; EC.02.04.03, EP 2; EC.02.04.03, EP 3	PE.04.01.01, EP 4	The hospital maintains equipment and supplies appropriate for the types of nuclear medicine services offered. The equipment is maintained for safe operation and efficient performance. CoPs: §482.53(c), §482.53(c)(1)
EC.02.04.01, EP 5	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's activities and frequencies for inspecting, testing, and maintaining the following items must be in accordance with manufacturers' recommendations: - Equipment subject to federal or state law or Medicare Conditions of Participation in which inspecting, testing, and maintaining must be in accordance with the manufacturers' recommendations, or otherwise establishes more stringent maintenance requirements - Medical laser devices	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	- Imaging and radiologic equipment (whether used for diagnostic or therapeutic purposes) - New medical equipment with insufficient maintenance history to support the use of alternative maintenance strategies Note: Maintenance history includes any of the following documented evidence: - Records provided by the hospital's contractors - Information made public by nationally recognized sources - Records of the hospital's experience over time CoPs: §482.41(d)(2)			
EC.02.04.01, EP 6	For hospitals that use Joint Commission accreditation for deemed status purposes: A qualified individual(s) uses written criteria to support the determination whether it is safe to permit medical equipment to be maintained in an alternate manner that includes the following: - How the equipment is used, including the seriousness and prevalence of harm during normal use - Likely consequences of equipment failure or malfunction, including seriousness of and prevalence of harm - Availability of alternative or backup equipment in the event the equipment fails or malfunctions - Incident history of identical or similar equipment - Maintenance requirements of the equipment (For more information on defining staff qualifications, refer to Standard HR.01.01.01) CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.04.01, EP 7	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital identifies medical equipment on its inventory that is included in an alternative equipment maintenance program. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.04.01, EP 9	The hospital has written procedures to follow when medical equipment fails, including using emergency clinical interventions and backup equipment. CoPs: §482.41(a), §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.04.01, EP 10	The hospital identifies quality control and maintenance activities to maintain the quality of the diagnostic computed tomography (CT), positron emission tomography (PET), magnetic resonance imaging (MRI), and nuclear medicine (NM) images produced. The hospital identifies how often these activities should be conducted.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.04.01, EP 11	The hospital monitors and reports all incidents in which medical equipment is suspected in or attributed to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Devices Act of 1990. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.04.03, EP 1	For hospitals that do not use Joint Commission accreditation for deemed status purposes: Before initial use of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks.	Consolidation of EC.02.04.01, EP 4; EC.02.04.03, EP 1;	PE.04.01.01, EP 4	The hospital maintains equipment and supplies appropriate for the types of nuclear medicine services offered. The equipment is maintained for safe operation and efficient performance.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	For hospitals that use Joint Commission accreditation for deemed status purposes: Before initial use and after major repairs or upgrades of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. CoPs: §482.26(b)(1), §482.26(b)(2), §482.41(d)(2), §482.53(c)(1)	EC.02.04.03, EP 2; EC.02.04.03, EP 3		CoPs: §482.53(c), §482.53(c)(1)
EC.02.04.03, EP 2	The hospital inspects, tests, and maintains all high-risk equipment. These activities are documented. Note 1: High-risk equipment includes medical equipment for which there is a risk of serious injury or even death to a patient or staff member should it fail, which includes life-support equipment. Note 2: Required activities and associated frequencies for maintaining, inspecting, and testing of medical equipment must have a 100% completion rate. CoPs: §482.41(d)(2), §482.53(c)	Consolidation of EC.02.04.01, EP 4; EC.02.04.03, EP 1; EC.02.04.03, EP 2; EC.02.04.03, EP 3	PE.04.01.01, EP 4	The hospital maintains equipment and supplies appropriate for the types of nuclear medicine services offered. The equipment is maintained for safe operation and efficient performance. CoPs: §482.53(c), §482.53(c)(1)
EC.02.04.03, EP 3	The hospital inspects, tests, and maintains non-high-risk equipment identified on the medical equipment inventory. These activities are documented. CoPs: §482.26(b)(1), §482.26(b)(2), §482.41(d)(2), §482.53(c), §482.53(c)(1)	Consolidation of EC.02.04.01, EP 4; EC.02.04.03, EP 1; EC.02.04.03, EP 2; EC.02.04.03, EP 3	PE.04.01.01, EP 4	The hospital maintains equipment and supplies appropriate for the types of nuclear medicine services offered. The equipment is maintained for safe operation and efficient performance. CoPs: §482.53(c), §482.53(c)(1)
EC.02.04.03, EP 4	The hospital conducts performance testing of and maintains all sterilizers. These activities are documented. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.04.03, EP 5	The hospital performs equipment maintenance and chemical and biological testing of water used in hemodialysis. These activities are documented. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.04.03, EP 8	Equipment listed for use in oxygen-enriched atmospheres is clearly and permanently labeled (withstands cleaning/disinfecting) as follows: - Oxygen-metering equipment, pressure-reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier. - Oxygen-metering equipment and pressure reducing regulators are labeled "OXYGEN–USE NO OIL." - Labels on flowmeters, pressure-reducing regulators, and oxygen-dispensing apparatuses designate the gases for which they are intended. - Cylinders and containers are labeled in accordance with Compressed Gas Association (CGA) C-7. (For full text, refer to NFPA 99-2012: 11.5.3.1) Note: Color coding is not utilized as the primary method of determining cylinder or container contents. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.04.03, EP 10	All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99-2012: Chapter 14.	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.41(d)(2)	moved to guidance within SPG		
EC.02.04.03, EP 16	For hospitals that use Joint Commission accreditation for deemed status purposes: Qualified hospital staff inspect, test, and calibrate nuclear medicine equipment annually. The results and completion dates are documented. CoPs: §482.53(c)(2)	Consolidation of EC.02.04.03, EP 16; EC.02.04.03, EP 23	PE.05.01.01, EP 1	At least annually, a diagnostic medical physicist or nuclear medicine physicist inspects, tests, and calibrates all nuclear medicine (NM) imaging equipment. The results, along with recommendations for correcting any problems identified, are documented. These activities are conducted for all of the image types produced clinically by each NM scanner (for example, planar and/or tomographic) and include the use of phantoms to assess the following imaging metrics: - Image uniformity/system uniformity - High-contrast resolution/system spatial resolution - Sensitivity - 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) CoPs: §482.53(c)(2)
EC.02.04.03, EP 18	The hospital maintains the quality of the diagnostic computed tomography (CT), positron emission tomography (PET), magnetic resonance imaging (MRI), and nuclear medicine (NM) images produced.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.04.03, EP 20	For diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist does the following: - Measures the radiation dose (in the form of volume computed tomography dose index [CTDIvol]) produced by each diagnostic CT imaging system for the following four CT protocols: adult brain, adult abdomen, pediatric brain, and pediatric abdomen. If one or more of these protocols is not used by the hospital, other commonly used CT protocols may be substituted. - Verifies that the radiation dose (in the form of CTDIvol) produced and measured for each protocol tested is within 20 percent of the CTDIvol displayed on the CT console. The dates, results, and verifications of these measurements are documented. Note 1: This element of performance is only applicable for systems capable of calculating and displaying radiation doses. Note 2: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. Note 3: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. (For more information, refer to HR.01.01.01, EP 1; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1)	Moved and Revised	NPG.13.03.01, EP 4	For diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist does the following: - Measures the radiation dose (in the form of volume computed tomography dose index [CTDIvol]) produced by each diagnostic CT imaging system for the following four CT protocols: adult brain, adult abdomen, pediatric brain, and pediatric abdomen. If one or more of these protocols is not used by the hospital, other commonly used CT protocols may be substituted. - Verifies that the radiation dose (in the form of CTDIvol) produced and measured for each protocol tested is within 20 percent of the CTDIvol displayed on the CT console. The dates, results, and verifications of these measurements are documented. Note 1: This element of performance is only applicable for systems capable of calculating and displaying radiation doses. Note 2: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. Note 3: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. (For more information, refer to HR.11.01.03, EP 1; HR.11.02.01, EP 2; NPG.12.04.01, EP 3)
EC.02.04.03, EP 21	For diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist conducts a performance evaluation of all CT imaging equipment.	Moved and Revised	NPG.13.03.01, EP 5	For diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist conducts a performance evaluation of all CT imaging equipment.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes the use of phantoms to assess the following imaging metrics: - Image uniformity - Scout prescription accuracy - Alignment light accuracy - Table travel accuracy - Radiation beam width - High-contrast resolution - Low-contrast detectability - Geometric or distance accuracy - CT number accuracy and uniformity - Artifact evaluation Note 1: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. Note 2: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. (For more information, refer to HR.01.01.01, EP 1; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1)			The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes the use of phantoms to assess the following imaging metrics: - Image uniformity - Scout prescription accuracy - Alignment light accuracy - Table travel accuracy - Radiation beam width - High-contrast resolution - Low-contrast detectability - Geometric or distance accuracy - CT number accuracy and uniformity - Artifact evaluation Note 1: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. Note 2: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. (For more information, refer to HR.11.01.03, EP 1; HR.11.02.01, EP 2; NPG.12.04.01, EP 3)
EC.02.04.03, EP 22	At least annually, a diagnostic medical physicist or magnetic resonance imaging (MRI) scientist conducts a performance evaluation of all MRI imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes the use of phantoms to assess the following imaging metrics: - Image uniformity for all radiofrequency (RF) coils used clinically - Signal-to-noise ratio (SNR) for all coils used clinically - Slice thickness accuracy - Slice position accuracy - Alignment light accuracy - High-contrast resolution - Low-contrast resolution (or contrast-to-noise ratio) - Geometric or distance accuracy - Magnetic field homogeneity - Artifact evaluation Note: Medical physicists or MRI scientists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the medical physicist or MRI scientist. (For more information, refer to HR.01.01.01, EP 1; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1)	Moved and Revised	NPG.13.03.01, EP 6	At least annually, a diagnostic medical physicist or magnetic resonance imaging (MRI) scientist conducts a performance evaluation of all MRI imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes the use of phantoms to assess the following imaging metrics: - Image uniformity for all radiofrequency (RF) coils used clinically - Signal-to-noise ratio (SNR) for all coils used clinically - Slice thickness accuracy - Slice position accuracy - Alignment light accuracy - High-contrast resolution - Low-contrast resolution (or contrast-to-noise ratio) - Geometric or distance accuracy - Magnetic field homogeneity - Artifact evaluation Note: Medical physicists or MRI scientists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the medical physicist or MRI scientist. (For more information, refer to HR.11.01.03, EP 1; HR.11.02.01, EP 2; NPG.12.04.01, EP 3)
EC.02.04.03, EP 23	At least annually, a diagnostic medical physicist or nuclear medicine physicist conducts a performance evaluation of all nuclear medicine imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluations 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	Consolidation of EC.02.04.03, EP 16; EC.02.04.03, EP 23	PE.05.01.01, EP 1	At least annually, a diagnostic medical physicist or nuclear medicine physicist inspects, tests, and calibrates all nuclear medicine (NM) imaging equipment. The results, along with recommendations for correcting any problems identified, are documented. These activities are conducted for all of the image types produced clinically by each NM scanner (for example, planar and/or tomographic) and include the use of phantoms to assess the following imaging metrics: - Image uniformity/system uniformity - High-contrast resolution/system spatial resolution - Sensitivity

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	- 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.01.01.01, EP 1; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1)			- 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) CoPs: §482.53(c)(2)
EC.02.04.03, EP 24	At least annually, a diagnostic medical physicist conducts a performance evaluation of all positron emission tomography (PET) imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluations are conducted for all of the image types produced clinically by each PET 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 - Low-contrast resolution or detectability (not applicable for planar acquisitions) - Artifact evaluation Note 1: The following tests are recommended, but not required, for PET scanner testing: sensitivity, energy resolution, and count-rate performance. Note 2: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the medical physicist. (For more information, refer to HR.01.01.01, EP 1; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1)	Moved and Revised	PE.05.01.01, EP 2	At least annually, a diagnostic medical physicist conducts a performance evaluation of all positron emission tomography (PET) imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluations are conducted for all of the image types produced clinically by each PET 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 - Low-contrast resolution or detectability (not applicable for planar acquisitions) - Artifact evaluation Note 1: The following tests are recommended but not required for PET scanner testing: sensitivity, energy resolution, and count-rate performance. Note 2: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the medical physicist. (For more information, refer to HR.11.01.03, EPs 1 and 2; HR.11.02.01, EP 2)
EC.02.04.03, EP 25	For computed tomography (CT), positron emission tomography (PET), nuclear medicine (NM), or magnetic resonance imaging (MRI) services: The annual performance evaluation conducted by the diagnostic medical physicist or MRI scientist (for MRI only) includes testing of image acquisition display monitors for maximum and minimum luminance, luminance uniformity, resolution, and spatial accuracy. Note 1: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. Note 2: Medical physicists or MRI scientists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist or MRI scientist. (For more information, refer to HR.01.01.01, EP 1; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1)	Moved and Revised	PE.05.01.01, EP 3	For computed tomography (CT), positron emission tomography (PET), nuclear medicine (NM), or magnetic resonance imaging (MRI) services: The annual performance evaluation conducted by the diagnostic medical physicist or MRI scientist (for MRI only) includes testing of image acquisition display monitors for maximum and minimum luminance, luminance uniformity, resolution, and spatial accuracy. Note 1: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. Note 2: Medical physicists or MRI scientists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist or MRI scientist. (For more information, refer to HR.11.01.03, EPs 1 and 2; HR.11.02.01, EP 2)
EC.02.04.03, EP 26	The hospital performs equipment maintenance on anesthesia apparatus. The apparatus are tested at the final path to patient after any adjustment, modification, or repair. Before the apparatus is returned to service, each connection is checked to verify proper gas flow and an oxygen analyzer is used to verify oxygen concentration. Areas designated for servicing of oxygen equipment are clean and free of oil, grease, or other flammables. (For full text, refer to NFPA 99-2012: 11.4.1.3; 11.5.1.3; 11.6.2.5; 11.6.2.6)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.52(b)			
EC.02.04.03, EP 27	The hospital meets NFPA 99-2012: Health Care Facilities Code requirements related to electrical equipment in the patient care vicinity. (For full text, refer to NFPA 99-2012: Chapter 10) Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the applicable provisions of the Health Care Facilities Code Tentative Interim Amendment (TIA) 12-5. CoPs: §482.41(c), §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.04.03, EP 34	For hospitals that provide fluoroscopic services: At least annually, a diagnostic medical physicist conducts a performance evaluation of fluoroscopic imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes an assessment of the following: - Beam alignment and collimation - Tube potential/kilovolt peak (kV/kVp) accuracy - Beam filtration (half-value layer) - High-contrast resolution - Low-contrast detectability - Maximum exposure rate in fluoroscopic mode - Displayed air-kerma rate and cumulative-air kerma accuracy (when applicable) Note 1: Medical physicists conducting performance evaluations may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. Note 2: This element of performance does not apply to fluoroscopy equipment used for therapeutic radiation treatment planning or delivery.	Moved	PE.05.01.01, EP 4	For hospitals that provide fluoroscopic services: At least annually, a diagnostic medical physicist conducts a performance evaluation of fluoroscopic imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes an assessment of the following: - Beam alignment and collimation - Tube potential/kilovolt peak (kV/kVp) accuracy - Beam filtration (half-value layer) - High-contrast resolution - Low-contrast detectability - Maximum exposure rate in fluoroscopic mode - Displayed air-kerma rate and cumulative-air kerma accuracy (when applicable) Note 1: Medical physicists conducting performance evaluations may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. Note 2: This element of performance does not apply to fluoroscopy equipment used for therapeutic radiation treatment planning or delivery.
EC.02.05.01, EP 1	The hospital designs and installs utility systems according to National Fire Protection Association codes to meet patient care and operational needs. CoPs: §482.41	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.01, EP 2	New building systems and modifications to existing building systems are designed to meet the National Fire Protection Association's Categories 1–4 requirements. (For full text, refer to NFPA 99-2012: Chapter 4 for descriptions of the four categories related to gas, vacuum, electrical, and electrical equipment.) CoPs: §482.41(c)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.01, EP 3	For hospitals that do not use Joint Commission accreditation for deemed status purposes: The hospital maintains a written inventory of all operating components of utility systems or maintains a written inventory of selected operating components of utility systems based on risks for infection, occupant needs, and systems critical to patient care (including all life-support systems). The hospital evaluates new types of utility components before initial use to determine whether they should be included in the inventory. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital maintains a written inventory of all operating components of utility systems.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.41(d)(2)			
EC.02.05.01, EP 4	The hospital identifies high-risk operating components of utility systems on the inventory for which there is a risk of serious harm or death to a patient or staff member should the component fail. Note: High-risk utility system components include life-support equipment. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.01, EP 5	The hospital identifies the activities and associated frequencies, in writing, for inspecting, testing, and maintaining all operating components of utility systems on the inventory. Note: For guidance on maintenance and testing activities for Essential Electric Systems (Type I), see NFPA 99-2012: 6.4.4. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.01, EP 6	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's activities and frequencies for inspecting, testing, and maintaining the following items must be in accordance with manufacturers' recommendations: - Equipment subject to federal or state law or Medicare Conditions of Participation in which inspecting, testing, and maintaining be in accordance with the manufacturers' recommendations, or otherwise establishes more stringent maintenance requirements - New operating components with insufficient maintenance history to support the use of alternative maintenance strategies Note: Maintenance history includes any of the following documented evidence: - Records provided by the hospital's contractors - Information made public by nationally recognized sources - Records of the hospital's experience over time CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.01, EP 7	For hospitals that use Joint Commission accreditation for deemed status purposes: A qualified individual(s) uses written criteria to support the determination of whether it is safe to permit operating components of utility systems to be maintained in an alternate manner that includes the following: - How the equipment is used, including the seriousness and prevalence of harm during normal use - Likely consequences of equipment failure or malfunction, including seriousness of and prevalence of harm - Availability of alternative or backup equipment in the event the equipment fails or malfunctions - Incident history of identical or similar equipment - Maintenance requirements of the equipment (For more information on defining staff qualifications, refer to Standard HR.01.01.01) CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.01, EP 8	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital identifies operating components of utility systems on its inventory that are included in an alternative equipment maintenance program.	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.41(d)(2)	moved to guidance within SPG		
EC.02.05.01, EP 9	The hospital labels utility system controls to facilitate partial or complete emergency shutdowns. Note 1: Examples of utility system controls that should be labeled are utility source valves, utility system main switches and valves, and individual circuits in an electrical distribution panel. Note 2: For example, the fire alarm system's circuit is clearly labeled as Fire Alarm Circuit; the disconnect method (that is, the circuit breaker) is marked in red; and access is restricted to authorized personnel. Information regarding the dedicated branch circuit for the fire alarm panel is located in the control unit. For additional guidance, see NFPA 101-2012: 18/19.3.4.1; 9.6.1.3; NFPA 72-2010: 10.5.5.2. CoPs: §482.41(a)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.01, EP 10	The hospital has written procedures for responding to utility system disruptions. CoPs: §482.41(a), §482.41(a)(2)	Consolidation of EC.02.05.01, EP 10; EC.02.05.01, EP 11; EC.02.05.01, EP 13	NPG.11.03.01, EP 1	The hospital develops and implements written procedures for responding to utility system disruptions. The procedures include but are not limited to shutting off a malfunctioning system and notifying staff in the affected areas.
EC.02.05.01, EP 11	The hospital's procedures address shutting off the malfunctioning system and notifying staff in affected areas. CoPs: §482.41(a), §482.41(a)(2), §482.41(d)(2)	Consolidation of EC.02.05.01, EP 10; EC.02.05.01, EP 11; EC.02.05.01, EP 13	NPG.11.03.01, EP 1	The hospital develops and implements written procedures for responding to utility system disruptions. The procedures include but are not limited to shutting off a malfunctioning system and notifying staff in the affected areas.
EC.02.05.01, EP 12	The hospital's procedures address performing emergency clinical interventions during utility system disruptions. CoPs: §482.41(a), §482.41(a)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.01, EP 13	The hospital responds to utility system disruptions as described in its procedures. CoPs: §482.41(a), §482.41(a)(2)	Consolidation of EC.02.05.01, EP 10; EC.02.05.01, EP 11; EC.02.05.01, EP 13	NPG.11.03.01, EP 1	The hospital develops and implements written procedures for responding to utility system disruptions. The procedures include but are not limited to shutting off a malfunctioning system and notifying staff in the affected areas.
EC.02.05.01, EP 15	In critical care areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, filtration efficiencies, temperature, and humidity. For new and existing health care facilities, or altered, renovated, or modernized portions of existing systems or individual components (constructed or plans approved on or after July 5, 2016), heating, cooling, and ventilation are in accordance with NFPA 99-2012, which includes 2008 ASHRAE 170, or state design requirements if more stringent. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: Existing facilities may elect to implement a Centers for Medicare & Medicaid Services (CMS) categorical waiver to reduce their relative humidity to 20% in operating rooms and other anesthetizing locations. Should the facility elect the waiver, it must be included in its Basic Building Information (BBI), and the facility's equipment and supplies must be compatible with the humidity reduction. For further information on waiver and equivalency requests, see https://www.jointcommission.org/resources/patient-safety-topics/the-physical-environment/life-safety-code-information-and-resources/. Note 2: For hospitals that use Joint Commission accreditation for deemed status	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	purposes: Existing facilities may comply with the 2012 NFPA 99 ventilation requirements or the ventilation requirements in the edition of the NFPA code previously adopted by CMS at the time of installation (for example, 1999 NFPA 99). CoPs: §482.41(d)(2), §482.42			
EC.02.05.01, EP 16	In non–critical care areas, the ventilation system provides required pressure relationships, temperature, and humidity. Note: Examples of non–critical care areas are general care nursing units; clean and soiled utility rooms in acute care areas; laboratories, pharmacies, diagnostic and treatment areas, food preparation areas, and other support departments. CoPs: §482.41(d)(4)	Moved and Revised	PE.04.01.01, EP 3	The hospital has proper ventilation, lighting, and temperature control in all pharmaceutical, patient care, and food preparation areas. CoPs: §482.41(d)(4)
EC.02.05.01, EP 17	The hospital maps the distribution of its utility systems. CoPs: §482.41(a)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.01, EP 18	Medical gas storage rooms and transfer and manifold rooms comply with NFPA 99-2012: 9.3.7. CoPs: §482.41(c), §482.41(d)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.01, EP 19	The emergency power supply system's equipment and environment are maintained per manufacturers' recommendations, including ambient temperature not less than 40°F; ventilation supply and exhaust; and water jacket temperature (when required). (For full text, refer to NFPA 99-2012: 9.3.10) CoPs: §482.41(c), §482.41(d)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.01, EP 20	Operating rooms are considered wet procedure locations, unless otherwise determined by a risk assessment authorized by the facility governing body. Operating rooms defined as wet locations are protected by either isolated power or ground-fault circuit interrupters. A written record of the risk assessment is maintained and available for inspection. (For full text, refer to NFPA 99-2012: 6.3.2.2.8.4; 6.3.2.2.8.7; 6.4.4.2) CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.01, EP 21	Electrical distribution in the hospital is based on the following categories: - Category 1: Critical care rooms served by a Type 1 essential electrical system (EES) in which electrical system failure is likely to cause major injury or death to patients, including all rooms where electric life support equipment is required. - Category 2: General care rooms served by a Type 1 or Type 2 EES in which electrical system failure is likely to cause minor injury to patients. - Category 3: Basic care rooms in which electrical system failure is not likely to cause injury to patients. Patient care rooms are required to have a Type 3 EES where the life safety branch has an alternate source of power that will be effective for 1 1/2 hours. (For full text, refer to NFPA 99-2012: 3.3.138; 6.3.2.2.10; 6.6.2.2.2; 6.6.3.1.1) CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
EC.02.05.01, EP 22	Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered are tested after initial installation, replacement, or servicing. In pediatric locations, receptacles in patient rooms (other than nurseries), bathrooms, play rooms, and activity rooms are listed tamper-resistant or have a listed tamper-resistant cover. Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. (For full text, refer to NFPA 99-2012: 6.3.2; 6.3.3; 6.3.4; 6.4.2.2.6; 6.5.2.2.4.2; 6.6.2.2.3.2) CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.01, EP 23	Power strips in a patient care vicinity are only used for components of movable electrical equipment assemblies used for patient care. These power strips meet UL 1363A or UL 60601-1. Power strips used outside of a patient care vicinity, but within the patient care room, meet UL 1363. In non–patient care rooms, power strips meet other UL standards. (For full text, refer to NFPA 99-2012: 10.2.3.6; 10.2.4; NFPA 70-2011: 400-8; 590.3(D); Tentative Interim Amendment [TIA] 12-5) Note 1: The mounting of power strips to medical equipment assemblies or the reconfiguration of equipment powered by power strips in a medical equipment assembly must be performed by personnel who are qualified to make certain that this is done in accordance with NFPA 99-2012: 10.2.3.6. Note 2: Per NFPA 99-2012: 3.3.138, patient care room is defined as any room of a health care facility wherein patients are intended to be examined or treated. Per NFPA 99-2012: 3.3.139, patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 1.8 meters (6 feet) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment and extending vertically to 2.3 meters (7 feet, 6 inches) above the floor. Note 3: In new facilities, the number of receptacles shall be in accordance with NFPA 99-2012: 6.3.2.2.6.2. If patient bed locations in existing health care facilities undergo renovation or a change in occupancy, the number of receptacles must be increased to meet the requirements of NFPA 99-2012: 6.3.2.2.6.2 to eliminate the need for power strips. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.01, EP 24	Extension cords are not used as a substitute for fixed wiring in a building. Extension cords used temporarily are removed immediately upon completion of the intended purpose. (For full text, refer to NFPA 99-2012: 10.2.3.6; 10.2.4; NFPA 70-2011: 400-8; 590.3(D); Tentative Interim Amendment [TIA] 12-5) CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.01, EP 25	Areas designated for administration of general anesthesia (specifically, inhaled anesthetics) using medical gases or vacuum are in accordance with NFPA 101-2012: 8.7 and NFPA 99-2012 as follows: - Zone valves are located immediately outside each anesthetizing location for medical gas or vacuum, readily accessible in an emergency, and arranged so shutting off any one anesthetizing location will not affect others. - Area alarm panels are installed to monitor all medical gas, medical-surgical vacuum, and piped waste anesthetic gas disposal (WAGD) systems. Alarm panels include visual and audible sensors and are in locations that provide for surveillance, including medical gas pressure decreases of 20% and vacuum decreases of 12-inch	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

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	gauge HgV (mercury vacuum). - Alarm sensors are installed either on the source side of individual room zone valve box assemblies or on the patient/use side of each of the individual zone valve box assemblies. (For full text, refer to NFPA 101-2012: 18/19.3.2.3; NFPA 99-2012: 5.1.4.8.7; 5.1.9.3) CoPs: §482.41(d)(2)			
EC.02.05.01, EP 26	Areas designated for administration of general anesthesia (specifically, inhaled anesthetics) using medical gases or vacuum are in accordance with NFPA 101-2012: 8.7 and NFPA 99-2012 as follows: The essential electrical system's (EES) critical branch supplies power for task illumination, fixed equipment, select receptacles, and select power circuits. The EES equipment system supplies power to the ventilation system. (For full text, refer to NFPA 101-2012: 18/19.3.2.3; NFPA 99-2012: 6.4.2.2.4.2) CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.01, EP 27	Newly engineered smoke control systems are designed, installed, maintained, and tested per NFPA 92-2012. Existing smoke control systems are tested and maintained to established engineering principles unless specifically exempted by the authority having jurisdiction. Systems not meeting the performance requirements of the testing specified in NFPA 101-2012: 19.7.7.1 can be continued in operation only with the specific approval of the authority having jurisdiction. (For full text, refer to NFPA 101-2012: 18/19: 7.7; NFPA 92-2012) Note: The smoke plume created by the thermal destruction of tissue by cauterizing equipment and lasers is addressed at Standard EC.02.02.01, EP 9. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.02, EP 1	The water management program has an individual or a team responsible for the oversight and implementation of the program, including but not limited to development, management, and maintenance activities. CoPs: §482.41(d)(2), §482.42(a)(3)	Moved	PE.04.01.05, EP 1	The water management program has an individual or a team responsible for the oversight and implementation of the program, including but not limited to development, management, and maintenance activities. CoPs: §482.41(d)(2), §482.42(a)(3)
EC.02.05.02, EP 2	The individual or team responsible for the water management program develops the following: - A basic diagram that maps all water supply sources, treatment systems, processing steps, control measures, and end-use points Note: An example would be a flow chart with symbols showing sinks, showers, water fountains, ice machines, and so forth. - A water risk management plan based on the diagram that includes an evaluation of the physical and chemical conditions of each step of the water flow diagram to identify any areas where potentially hazardous conditions may occur (these conditions are most likely to occur in areas with slow or stagnant water) Note: Refer to the Centers for Disease Control and Prevention's "Water Infection Control Risk Assessment (WICRA) for Healthcare Settings" tool as an example for conducting a water-related risk assessment. - A plan for addressing the use of water in areas of buildings where water may have been stagnant for a period of time (for example, unoccupied or temporarily closed areas) - An evaluation of the patient populations served to identify patients who are	Moved	PE.04.01.05, EP 2	The individual or team responsible for the water management program develops the following: - A basic diagram that maps all water supply sources, treatment systems, processing steps, control measures, and end-use points Note: An example would be a flow chart with symbols showing sinks, showers, water fountains, ice machines, and so forth. - A water risk management plan based on the diagram that includes an evaluation of the physical and chemical conditions of each step of the water flow diagram to identify any areas where potentially hazardous conditions may occur (these conditions are most likely to occur in areas with slow or stagnant water) Note: Refer to the Centers for Disease Control and Prevention's "Water Infection Control Risk Assessment (WICRA) for Healthcare Settings" tool as an example for conducting a water-related risk assessment. - A plan for addressing the use of water in areas of buildings where water may have been stagnant for a period of time (for example, unoccupied or temporarily closed areas) - An evaluation of the patient populations served to identify patients who are

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	immunocompromised - Monitoring protocols and acceptable ranges for control measures Note: Hospitals should consider incorporating basic practices for water monitoring within their water management programs that include monitoring of water temperature, residual disinfectant, and pH. In addition, protocols should include specificity around the parameters measured, locations where measurements are made, and appropriate corrective actions taken when parameters are out of range. CoPs: §482.41(d)(2), §482.42(a)(3)			immunocompromised - Monitoring protocols and acceptable ranges for control measures Note: Hospitals should consider incorporating basic practices for water monitoring within their water management programs that include monitoring of water temperature, residual disinfectant, and pH. In addition, protocols should include specificity around the parameters measured, locations where measurements are made, and appropriate corrective actions taken when parameters are out of range. CoPs: §482.41(d)(2), §482.42(a)(3)
EC.02.05.02, 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 EC.04.01.01, EP 1 for the process of monitoring, reporting, and investigating utility system issues. CoPs: §482.41(d)(2)	Moved and Revised	PE.04.01.05, EP 3	The individual or team responsible for the water management program manages the following: - Documenting results of all monitoring activities - Corrective actions and procedures to follow if a test result outside of acceptable limits is obtained, including when a probable or confirmed waterborne pathogen(s) indicates action is necessary - Documenting corrective actions taken when control limits are not maintained Note: See PE.07.01.01, EP 1 for the process of monitoring, reporting, and investigating utility system issues. CoPs: §482.41(d)(2)
EC.02.05.02, EP 4	The individual or team responsible for the water management program reviews the program annually and when the following occurs: - Changes have been made to the water system that would add additional risk. - New equipment or an at-risk water system(s) has been added that could generate aerosols or be a potential source for Legionella. This includes the commissioning of a new wing or building. Note 1: The Joint Commission and the Centers for Medicare & Medicaid Services (CMS) do not require culturing for Legionella or other waterborne pathogens. Testing protocols are at the discretion of the hospital unless required by law or regulation. Note 2: Refer to ASHRAE Standard 188-2018 “Legionellosis: Risk Management for Building Water Systems” and the Centers for Disease Control and Prevention Toolkit "Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings" for additional guidance on creating a water management plan. For additional guidance, consult ANSI/ASHRAE Guideline 12-2020 “Managing the Risk of Legionellosis Associated with Building Water Systems.” CoPs: §482.41(d)(2)	Moved and Revised	PE.04.01.05, EP 4	The individual or team responsible for the water management program reviews the program annually and when the following occurs: - Changes have been made to the water system that would add additional risk. - New equipment or an at-risk water system(s) has been added that could generate aerosols or be a potential source for Legionella. This includes the commissioning of a new wing or building. Note 1: The Joint Commission and the Centers for Medicare & Medicaid Services (CMS) do not require culturing for Legionella or other waterborne pathogens. Testing protocols are at the discretion of the hospital unless required by law or regulation. Note 2: Refer to ASHRAE Standard 188-2018 “Legionellosis: Risk Management for Building Water Systems” and the Centers for Disease Control and Prevention Toolkit "Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings" for guidance on creating a water management plan. For additional guidance, consult ANSI/ASHRAE Guideline 12-2020 “Managing the Risk of Legionellosis Associated with Building Water Systems.” CoPs: §482.41(d)(2)
EC.02.05.03, EP 1	For facilities that were constructed, or had a change in occupancy type, or have undergone an electrical system upgrade since 1983, the hospital has a Type 1 or Type 3 essential electrical system in accordance with NFPA 99, 2012 edition. This essential electrical system must be divided into three branches, including the life safety branch, critical branch, and equipment branch. Both the life safety branch and the critical branch are kept independent of all other wiring and equipment, and they transfer within 10 seconds of electrical interruption. Each branch has at least one automatic transfer switch. For additional guidance, see NFPA 99-2012: 6.4.2.2.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.03, EP 2	The hospital provides emergency power within 10 seconds for the following: Alarm systems, as required by the Life Safety Code. Note: For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99-2012: 6.4.1.1; 6.4.2.2; NFPA	Consolidation of EC.02.05.03, EP 2; EC.02.05.03, EP 3; EC.02.05.03, EP 4;	PE.04.01.03, EP 1	The hospital has emergency power and lighting in the following areas, at a minimum: - Operating rooms - Recovery rooms - Intensive care

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	110-2010: 4.1; Table 4.1(b). CoPs: §482.41(a)(1)	EC.02.05.03, EP 5; EC.02.05.03, EP 6; EC.02.05.03, EP 7; EC.02.05.03, EP 13; EC.02.05.03, EP 16		- Emergency rooms - Stairwells Battery lamps and flashlights are available in all other areas not serviced by the emergency power supply source. CoPs: §482.41(a)(1)
EC.02.05.03, EP 3	The hospital provides emergency power within 10 seconds for the following: Exit route and exit sign illumination, as required by the Life Safety Code. Note: For guidance in establishing a reliable emergency system (that is, an essential electrical distribution system), see NFPA 99-2012: 6.4.1.1; 6.4.2.2; NFPA 110-2010: 4.1; Table 4.1(b). CoPs: §482.41(a)(1)	Consolidation of EC.02.05.03, EP 2; EC.02.05.03, EP 3; EC.02.05.03, EP 4; EC.02.05.03, EP 5; EC.02.05.03, EP 6; EC.02.05.03, EP 7; EC.02.05.03, EP 13; EC.02.05.03, EP 16	PE.04.01.03, EP 1	The hospital has emergency power and lighting in the following areas, at a minimum: - Operating rooms - Recovery rooms - Intensive care - Emergency rooms - Stairwells Battery lamps and flashlights are available in all other areas not serviced by the emergency power supply source. CoPs: §482.41(a)(1)
EC.02.05.03, EP 4	New buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the life safety branch of the electrical system described in NFPA 99. (For full text, refer to NFPA 101-2012: 18.2.9.2; 18.2.10.5; NFPA 99-2012: 6.4.2.2) CoPs: §482.41(a)(1)	Consolidation of EC.02.05.03, EP 2; EC.02.05.03, EP 3; EC.02.05.03, EP 4; EC.02.05.03, EP 5; EC.02.05.03, EP 6; EC.02.05.03, EP 7; EC.02.05.03, EP 13; EC.02.05.03, EP 16	PE.04.01.03, EP 1	The hospital has emergency power and lighting in the following areas, at a minimum: - Operating rooms - Recovery rooms - Intensive care - Emergency rooms - Stairwells Battery lamps and flashlights are available in all other areas not serviced by the emergency power supply source. CoPs: §482.41(a)(1)
EC.02.05.03, EP 5	The hospital provides emergency power within 10 seconds for the following: Emergency communication systems, as required by the Life Safety Code. Note: For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99-2012: 6.4.2.2; NFPA 110-2010: 4.1; Table 4.1(b). CoPs: §482.41(a)(1)	Consolidation of EC.02.05.03, EP 2; EC.02.05.03, EP 3; EC.02.05.03, EP 4; EC.02.05.03, EP 5; EC.02.05.03, EP 6; EC.02.05.03, EP 7; EC.02.05.03, EP 13; EC.02.05.03, EP 16	PE.04.01.03, EP 1	The hospital has emergency power and lighting in the following areas, at a minimum: - Operating rooms - Recovery rooms - Intensive care - Emergency rooms - Stairwells Battery lamps and flashlights are available in all other areas not serviced by the emergency power supply source. CoPs: §482.41(a)(1)
EC.02.05.03, EP 6	The hospital provides emergency power within 10 seconds for the following: Equipment that could cause patient harm when it fails, including life-support systems; blood, bone, and tissue storage systems; medical air compressors; and medical and surgical vacuum systems. Note: For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99-2012: 6.4.1.1; 6.4.2.2; NFPA 110-2010: 4.1; Table 4.1(b). CoPs: §482.41(a)(1)	Consolidation of EC.02.05.03, EP 2; EC.02.05.03, EP 3; EC.02.05.03, EP 4; EC.02.05.03, EP 5; EC.02.05.03, EP 6; EC.02.05.03, EP 7; EC.02.05.03, EP 13; EC.02.05.03, EP 16	PE.04.01.03, EP 1	The hospital has emergency power and lighting in the following areas, at a minimum: - Operating rooms - Recovery rooms - Intensive care - Emergency rooms - Stairwells Battery lamps and flashlights are available in all other areas not serviced by the emergency power supply source. CoPs: §482.41(a)(1)
EC.02.05.03, EP 7	The hospital provides emergency power within 10 seconds for the following: Areas in which loss of power could result in patient harm, including intensive care, emergency rooms, operating rooms, recovery rooms, obstetrical delivery rooms, and	Consolidation of EC.02.05.03, EP 2; EC.02.05.03, EP 3;	PE.04.01.03, EP 1	The hospital has emergency power and lighting in the following areas, at a minimum: - Operating rooms - Recovery rooms

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	nurseries. Note: For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99-2012: 6.4.1.1; 6.4.2; NFPA 110-2010: 4.1; Table 4.1(b). CoPs: §482.41(a)(1)	EC.02.05.03, EP 4; EC.02.05.03, EP 5; EC.02.05.03, EP 6; EC.02.05.03, EP 7; EC.02.05.03, EP 13; EC.02.05.03, EP 16		- Intensive care - Emergency rooms - Stairwells Battery lamps and flashlights are available in all other areas not serviced by the emergency power supply source. CoPs: §482.41(a)(1)
EC.02.05.03, EP 11	The hospital provides emergency power within 10 seconds for the following: Emergency lighting at emergency generator locations. The hospital's emergency power system (EPS) has a remote manual stop station (with identifying label) to prevent inadvertent or unintentional operation. A remote annunciator (powered by storage battery) is located outside the EPS location. Note: For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), refer to NFPA 99-2012: 6.4.1.1.6; 6.4.1.1.17; 6.4.2.2; NFPA 110-2010: 5.6.5.6; 7.3.1.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.03, EP 12	Equipment designated to be powered by emergency power supply is energized by the hospital's design. Staging of equipment startup is permissible. (For full text, refer to NFPA 99-2012: 6.4.2.2) CoPs: §482.41(a)(1)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.03, EP 13	The hospital provides emergency power for elevators selected to provide service to patients during interruption of normal power (at least one for nonambulatory patients). Note: For guidance in establishing a reliable emergency power system for the equipment branch (that is, an essential electrical distribution system), refer to NFPA 99-2012: 6.4.2.2. CoPs: §482.41(a)(1)	Consolidation of EC.02.05.03, EP 2; EC.02.05.03, EP 3; EC.02.05.03, EP 4; EC.02.05.03, EP 5; EC.02.05.03, EP 6; EC.02.05.03, EP 7; EC.02.05.03, EP 13; EC.02.05.03, EP 16	PE.04.01.03, EP 1	The hospital has emergency power and lighting in the following areas, at a minimum: - Operating rooms - Recovery rooms - Intensive care - Emergency rooms - Stairwells Battery lamps and flashlights are available in all other areas not serviced by the emergency power supply source. CoPs: §482.41(a)(1)
EC.02.05.03, EP 14	The hospital implements a policy to provide emergency backup for essential medication dispensing equipment identified by the hospital, such as automatic dispensing cabinets, medication carousels, and central medication robots. Note: Examples of emergency backup can include emergency power, battery-based indoor generators, or other actions describing how dispensing and administration of medications will continue when emergency backup is needed.	Moved and Revised	NPG.11.03.01, EP 2	The hospital develops and implements a policy to provide emergency backup for essential medication dispensing equipment identified by the hospital, such as automatic dispensing cabinets, medication carousels, and central medication robots. Note: Examples of emergency backup can include emergency power, battery-based indoor generators, or other actions describing how dispensing and administration of medications will continue when emergency backup is needed.
EC.02.05.03, EP 15	The hospital implements a policy to provide emergency backup for essential refrigeration for medications identified by the hospital, such as designated refrigerators and freezers. Note: Examples of emergency backup can include emergency power, battery-based indoor generators, or other actions describing how refrigeration of medications will continue when emergency backup is needed.	Moved and Revised	NPG.11.03.01, EP 3	The hospital develops and implements a policy to provide emergency backup for essential refrigeration for medications identified by the hospital, such as designated refrigerators and freezers. Note: Examples of emergency backup can include emergency power, battery-based indoor generators, or other actions describing how refrigeration of medications will continue when emergency backup is needed.
EC.02.05.03, EP 16	For hospitals that use Joint Commission accreditation for deemed status purposes: Battery lamps and flashlights are available in areas not serviced by the emergency supply source. CoPs: §482.41(a)(1)	Consolidation of EC.02.05.03, EP 2; EC.02.05.03, EP 3; EC.02.05.03, EP 4; EC.02.05.03, EP 5; EC.02.05.03, EP 6;	PE.04.01.03, EP 1	The hospital has emergency power and lighting in the following areas, at a minimum: - Operating rooms - Recovery rooms - Intensive care - Emergency rooms - Stairwells

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		EC.02.05.03, EP 7; EC.02.05.03, EP 13; EC.02.05.03, EP 16		Battery lamps and flashlights are available in all other areas not serviced by the emergency power supply source. CoPs: §482.41(a)(1)
EC.02.05.05, EP 1	When performing repairs or maintenance activities, the hospital has a process to manage risks associated with air-quality requirements; infection control; utility requirements; noise, odor, dust, vibration; and other hazards that affect care, treatment, or services for patients, staff, and visitors.	Moved and Revised	PE.04.01.03, EP 4	When performing repairs or maintenance activities, the hospital has a process to manage risks associated with air-quality requirements; infection control; utility requirements; noise, odor, dust, and vibration; and other hazards that affect care, treatment, or services for patients, staff, and visitors.
EC.02.05.05, EP 2	For hospitals that do not use Joint Commission accreditation for deemed status purposes: The hospital tests utility system components on the inventory before initial use. The completion dates and test results are documented. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital tests utility system components on the inventory before initial use and after major repairs or upgrades. The completion date and the results of the tests are documented. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.05, EP 4	The hospital inspects, tests, and maintains the following: High-risk utility system components on the inventory. The completion date and the results of the activities are documented. Note 1: A high-risk utility system includes components for which there is a risk of serious injury or even death to a patient or staff member should it fail, which includes life-support equipment. Note 2: Required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components must have a 100% completion rate. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.05, EP 5	The hospital inspects, tests, and maintains the following: Infection control utility system components on the inventory. The completion date and the results of the activities are documented. Note: Required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components must have a 100% completion rate. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.05, EP 6	The hospital inspects, tests, and maintains the following: Non-high-risk utility system components on the inventory. The completion date and the results of the activities are documented. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.05, EP 7	Line isolation monitors (LIM), if installed, are tested at least monthly by actuating the LIM test switch per NFPA 99-2012: 6.3.2.6.3.6, which activates both visual and audible alarms. For LIM circuits with automated self-testing, a manual test is performed at least annually. LIM circuits are tested per NFPA 99-2012: 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. (For full text, refer to NFPA 99-2012: 6.3.2; 6.3.3; 6.3.4) CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

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EC.02.05.05, EP 8	The hospital meets NFPA 99-2012: Health Care Facilities Code requirements related to electrical systems and heating, ventilation, and air conditioning (HVAC). (For full text, refer to NFPA 99-2012: Chapters 6 and 9) Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the applicable provisions of the Health Care Facilities Code Tentative Interim Amendments (TIAs) 12-2 and 12-3. CoPs: §482.41(c), §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.07, EP 1	At least monthly, the hospital performs a functional test of emergency lighting systems and exit signs required for egress and task lighting for a minimum duration of 30 seconds, along with a visual inspection of other exit signs. The test results and completion dates are documented. (For full text, refer to NFPA 101-2012: 7.9.3; 7.10.9; NFPA 99-2012: 6.3.2.2.11.5) CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.07, EP 2	Every 12 months, the hospital performs a functional test of battery-powered lights on the inventory required for egress and exit signs for a duration of 1 1/2 hours. For new construction, renovation, or modernization, battery-powered lighting in locations where deep sedation and general anesthesia are administered is tested annually for 30 minutes. The test results and completion dates are documented. (For full text, refer to NFPA 101-2012: 7.9.3; 7.10.9; NFPA 99-2012: 6.3.2.2.11.5) CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.07, EP 3	The hospital performs a functional test of Level 1 stored emergency power supply systems (SEPSS) on a monthly basis and performs a test of Level 2 SEPSS on a quarterly basis. Test duration is for five minutes or as specified for its class (whichever is less). The hospital performs an annual test at full load for 60% of the full duration of its class. The test results and completion dates are documented. Note 1: Non–SEPSS battery backup emergency power systems that the hospital has determined to be critical for operations during a power failure (for example, laboratory equipment or electronic health records) should be properly tested and maintained in accordance with manufacturers' recommendations. Note 2: Level 1 SEPSS are intended to automatically supply illumination or power to critical areas and equipment essential for safety to human life. Included are systems that supply emergency power for such functions as illumination for safe exiting, ventilation where it is essential to maintain life, fire detection and alarm systems, public safety communications systems, and processes where the current interruption would produce serious life safety or health hazards to patients, the public, or staff. Note 3: Class defines the minimum time for which the SEPSS is designed to operate at its rated load without being recharged. Note 4: For additional guidance on operational inspection and testing, see NFPA 111-2010: 8.4. CoPs: §482.15(e)(2), §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.07, EP 4	Every week, the hospital inspects the emergency power supply system (EPSS), including all associated components and batteries. The results and completion dates of the inspections are documented. (For full text, refer to NFPA 110-2010: 8.3.1; 8.3.3; 8.3.4; 8.3.7; 8.4.1)	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.15(e)(2)	moved to guidance within SPG		
EC.02.05.07, EP 5	At least monthly, the hospital tests each emergency generator beginning with a cold start under load for at least 30 continuous minutes. The cooldown period is not part of the 30 continuous minutes. The test results and completion dates are documented. (For full text, refer to NFPA 99-2012: 6.4.4.1) CoPs: §482.15(e)(2), §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.07, EP 6	The monthly tests for diesel-powered emergency generators are conducted with a dynamic load that is at least 30% of the nameplate rating of the generator or meets the manufacturer's recommended prime movers' exhaust gas temperature. If the hospital does not meet either the 30% of nameplate rating or the recommended exhaust gas temperature during any test in EC.02.05.07, EP 5, then it must test the emergency generator once every 12 months using supplemental (dynamic or static) loads of 50% of nameplate rating for 30 minutes, followed by 75% of nameplate rating for 60 minutes, for a total of 1½ continuous hours. (For full text, refer to NFPA 99-2012: 6.4.4.1) Note: Tests for non-diesel-powered generators need only be conducted with available load. CoPs: §482.15(e)(2), §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.07, EP 7	At least monthly, the hospital tests all automatic and manual transfer switches on the inventory. The test results and completion dates are documented. (For full text, refer to NFPA 99-2012: 6.4.4.1) CoPs: §482.15(e)(2), §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.07, EP 8	At least annually, the hospital tests the fuel quality to ASTM standards. The test results and completion dates are documented. Note: For additional guidance, see NFPA 110-2010: 8.3.8. CoPs: §482.15(e)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.07, EP 9	At least once every 36 months, hospitals with a generator providing emergency power test each emergency generator for a minimum of 4 continuous hours. The test results and completion dates are documented. Note: For additional guidance, see NFPA 110-2010, Chapter 8. CoPs: §482.15(e)(2), §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.07, EP 10	The 36-month diesel-powered emergency generator test uses a dynamic or static load that is at least 30% of the nameplate rating of the generator or meets the manufacturer's recommended prime movers' exhaust gas temperature. Note 1: Tests for non-diesel-powered generators need only be conducted with available load. Note 2: For additional guidance, see NFPA 110-2010, Chapter 8. CoPs: §482.15(e)(2), §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.07, EP 11	The hospital meets all other emergency power system requirements found in NFPA 99-2012 Health Care Facilities Code, NFPA 110-2010 Standard for Emergency and Standby Power Systems, and NFPA 101-2012 Life Safety Code requirements.	Moved and Revised	PE.04.01.03, EP 3	The hospital meets the emergency power system and generator requirements found in NFPA 99-2012 Health Care Facilities Code, NFPA 110-2010 Standard for Emergency and Standby Power Systems, and NFPA 101-2012 Life Safety Code requirements.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.15(e)(1), §482.15(e)(2), §482.15(h)(1)(xii)			CoPs: §482.15(e)(1), §482.15(e)(2), §482.15(h)(1)(xii)
EC.02.05.09, EP 1	Medical gas, medical air, surgical vacuum, waste anesthetic gas disposal (WAGD), and air supply systems are designated as follows: - Category 1: Systems in which failure is likely to cause major injury or death. - Category 2: Systems in which failure is likely to cause minor injury to patients. - Category 3: Systems in which failure is not likely to cause injury but can cause discomfort to patients. Deep sedation and general anesthesia are not administered when using Category 3 medical gas systems. - Category 4: Systems in which failure would have no impact on patient care. (For full text, refer to NFPA 99-2012: 5.1.1.1; 5.2.1; 5.3.1.1; 5.3.1.5; 5.1.14.2) CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.09, EP 2	All master, area, and local alarm systems used for medical gas and vacuum systems comply with the category 1–3 warning system requirements. (For full text, refer to NFPA 99-2012: 5.1.9; 5.2.9; 5.3.6.2.2) CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.09, EP 3	Containers, cylinders, and tanks are designed, fabricated, tested, and marked in accordance with NFPA 99-2012: 5.1.3.1.1–5.1.3.1.7. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.09, EP 4	Locations containing positive pressure gases, other than oxygen or medical air, have doors labeled “Positive Pressure Gases: NO Smoking or Open Flame. Room May Have Insufficient Oxygen. Open Door and Allow Room to Ventilate Before Entering.” Locations containing central supply systems or cylinders only containing oxygen or medical air have doors labeled “Medical Gases: NO Smoking or Open Flame.” (For full text, refer to NFPA 99-2012: 5.1.3.1.8 and 5.1.3.1.9) CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.09, EP 5	A precautionary sign readable from 5 feet away is on each door or gate of a cylinder storage room, where the sign, at a minimum, includes the wording "CAUTION: OXIDIZING GAS(ES) STORED WITHIN. NO SMOKING.” Storage is planned so cylinders are used in the order they are received from the supplier. Only gas cylinders and reusable shipping containers and their accessories are permitted to be stored in rooms containing central supply systems or gas cylinders. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.09, EP 6	When the hospital uses cylinders with an integral pressure gauge, a threshold pressure considered empty is established when the volume of stored gases is as follows: - When more than 300 but less than 3,000 cubic feet, the storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2-hour fire protection rating. - When less than 301 cubic feet in a single smoke compartment, individual cylinders	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in NFPA 99-2012: 11.6.2. (For full text, refer to NFPA 99-2012: 5.1.3.1; 5.1.3.2.3; 5.2.3.1; 5.3.10; 11.3; 11.6.5.2.1) CoPs: §482.41(d)(2)			
EC.02.05.09, EP 7	In time frames defined by the hospital, the hospital inspects, tests, and maintains critical components of piped medical gas and vacuum systems, waste anesthetic gas disposal (WAGD), and support gas systems on the inventory. This inventory of critical components includes at least all source subsystems, control valves, alarms, manufactured assemblies containing patient gases, and inlets and outlets. Activities, dates, and results are documented. Persons maintaining the systems are qualified by training and certification to the requirements of the American Society of Sanitary Engineers (ASSE) 6030 or 6040. (For full text, refer to NFPA 99-2012: 5.1.14.2; 5.1.15; 5.2.14; 5.3.13) CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.09, EP 8	When the hospital has bulk oxygen systems above ground, they are in a locked enclosure (such as a fence) at least 10 feet from vehicles and sidewalks. There is permanent signage stating "OXYGEN – NO SMOKING – NO OPEN FLAMES." Note: For additional guidance, refer to NFPA 99-2012: 5.1.3.5.12.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.09, EP 9	The hospital's emergency oxygen supply connection is installed in a manner that allows a temporary auxiliary source to connect to it. Note: For additional guidance, refer to NFPA 99-2012: 5.1.3.5.13.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.09, EP 10	The hospital tests piped medical gas and vacuum systems for purity, correct gas, and proper pressure when these systems are installed, modified, or repaired. The test results and completion dates are documented. (For full text, refer to NFPA 99-2012: 5.1.2; 5.1.4; 5.1.14.4.1; 5.1.14.4.6; 5.2.13) CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.09, EP 11	The hospital makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control. Piping is labeled by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (see NFPA 99-2012: Table 5.1.11), and operating pressure if other than standard. Labels are at intervals of 20 feet or less and are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency. (For full text, refer to NFPA 99-2012: 5.1.4; 5.1.11.1; 5.1.11.2; 5.1.14.3; 5.2.11; 5.3.13.3; 5.3.11) CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.09, EP 12	The hospital implements a policy on all cylinders within the hospital that includes the following: - Labeling, handling, and transporting (for example, in carts, attached to equipment,	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	on racks) in accordance with NFPA 99-2012: 11.5.3.1 and 11.6.2 - Physically segregating full and empty cylinders from each other in order to assist staff in selecting the proper cylinder - Adaptors or conversion fittings are prohibited - Oxygen cylinders, containers, and associated equipment are protected from contamination, damage, and contact with oil and grease - Cylinders are kept away from heat and flammable materials and do not exceed a temperature of 130°F - Nitrous oxide and carbon dioxide cylinders do not reach temperatures lower than manufacturer recommendations or -20°F - Valve protection caps (if supplied) are secured in place when cylinder is not in use - Labeling empty cylinders - Prohibiting transfilling in any compartment with patient care (For full text, refer to NFPA 99-2012: 11.6.1; 11.6.2; 11.6.5; 11.7.3)	moved to guidance within SPG		
EC.02.05.09, EP 13	At no time is transfilling done in any patient care room. A designated area is used away from any section of the hospital where patients are housed, treated, or examined. The designated area is separated by a barrier of at least 1-hour fire-resistant construction from any patient care areas. Transfilling cylinders is only of the same gas (no mixing of different compressed gases). Transfilling of liquid oxygen is only done in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring. Storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections NFPA 99-2012: 11.7.2–11.7.4. (For full text, refer to NFPA 99-2012: 11.5.2.2; 11.5.2.3.1; 11.5.2.3.2; 11.7.2–11.7.4) CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.05.09, EP 14	The hospital meets all other NFPA 99-2012: Health Care Facilities Code requirements related to gas and vacuum systems and gas equipment. (For full text, refer to NFPA 99-2012: Chapters 5 and 11) Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the applicable provisions of the Health Care Facilities Code Tentative Interim Amendments (TIAs) 12-4 and 12-6. CoPs: §482.41(c)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.06.01, EP 1	Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided. CoPs: §482.13(c)(2), §482.41, §482.41(a)	Split to PE.01.01.01, EP 1; PE.01.01.01, EP 2	PE.01.01.01, EP 1	The hospital's building is constructed, arranged, and maintained to allow safe access and to protect the safety and well-being of patients. Note 1: Diagnostic and therapeutic facilities are located in areas appropriate for the services provided. Note 2: When planning for new, altered, or renovated space, the hospital uses state rules and regulations or the current Guidelines for Design and Construction of Hospitals published by the Facility Guidelines Institute. If the state rules and regulations or the Guidelines do not address the design needs of the hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria. CoPs: §482.41, §482.41(a), §482.41(d), §482.41(d)(1), §482.42(a)(3)
EC.02.06.01, EP 1	Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided. CoPs: §482.13(c)(2), §482.41, §482.41(a)	Split to PE.01.01.01, EP 1; PE.01.01.01, EP 2	PE.01.01.01, EP 2	The hospital has adequate space and facilities for the services it provides, including facilities for the diagnosis and treatment of patients and for any special services offered to meet the needs of the community served. Note: The extent and complexity of facilities is determined by the services offered.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
				CoPs: §482.41, §482.41(a), §482.41(d), §482.41(d)(3)
EC.02.06.01, EP 11	Lighting is suitable for care, treatment, and services. CoPs: §482.41, §482.41(d)(4)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.06.01, EP 20	Areas used by patients are clean and free of offensive odors. CoPs: §482.41	Consolidation of EC.02.06.01, EP 20	PE.01.01.01, EP 3	The hospital's premises are clean and orderly. Note: Clean and orderly means an uncluttered physical environment where patients and staff can function. This includes but is not limited to storing equipment and supplies in their proper spaces, attending to spills, and keeping areas neat. CoPs: §482.41(a)
EC.02.06.01, EP 26	The hospital keeps furnishings and equipment safe and in good repair. CoPs: §482.41, §482.41(a)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.06.05, EP 1	When planning for new, altered, or renovated space, the hospital uses one of the following design criteria: - State rules and regulations - The most current edition of the Guidelines for Design and Construction of Hospitals published by the Facility Guidelines Institute When the above rules, regulations, and guidelines do not meet specific design needs, use other reputable standards and guidelines that provide equivalent design criteria. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital complies with National Fire Protection Association requirements, including emergency generator location requirements as follows: - Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6) - Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4) - NFPA 110-2010 when a new structure is built or when an existing structure or building is renovated CoPs: §482.41, §482.41(e)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.06.05, EP 2	When planning for demolition, construction, renovation, or general maintenance, the hospital conducts a preconstruction risk assessment for air quality requirements, infection control, utility requirements, noise, vibration, and other hazards that affect care, treatment, and services. Note: See LS.01.02.01 for information on fire safety procedures to implement during construction or renovation. CoPs: §482.41, §482.42(a)(3)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.06.05, EP 3	The hospital takes action based on its assessment to minimize risks during demolition, construction, renovation, or general maintenance. CoPs: §482.41, §482.42(a)(3)	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
		moved to guidance within SPG		
EC.02.06.05, EP 4	For computed tomography (CT), positron emission tomography (PET), or nuclear medicine (NM) services: Prior to installation of new imaging equipment, replacement of existing imaging equipment, or modification to rooms where ionizing radiation will be emitted or radioactive materials will be stored (such as scan rooms or hot labs), a medical physicist or health physicist conducts a structural shielding design * assessment to specify required radiation shielding. Note: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. Footnote *: For additional guidance on shielding designs and radiation protection surveys, see National Council on Radiation Protection and Measurements Report No. 147 (NCRP-147).	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.02.06.05, EP 6	For computed tomography (CT), positron emission tomography (PET), or nuclear medicine (NM) services: After installation of imaging equipment or construction in rooms where ionizing radiation will be emitted or radioactive materials will be stored, a medical physicist or health physicist conducts a radiation protection survey to verify the adequacy of installed shielding. * This survey is conducted prior to clinical use of the room. Note: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. Footnote *: For additional guidance on shielding designs and radiation protection surveys, see National Council on Radiation Protection and Measurements Report No. 147 (NCRP-147).	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.03.01.01, EP 1	Staff responsible for the maintenance, inspection, testing, and use of medical equipment, utility systems and equipment, fire safety systems and equipment, and safe handling of hazardous materials and waste are competent and receive continuing education and training. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.03.01.01, EP 2	Staff can describe or demonstrate actions to take in the event of an environment of care incident. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.04.01.01, EP 1	The hospital establishes a process(es) for continually monitoring, internally reporting, and investigating the following: - Injuries to patients or others within the hospital's facilities - Occupational illnesses and staff injuries - Incidents of damage to its property or the property of others - Safety and security incidents involving patients, staff, or others within its facilities, including those related to workplace violence - Hazardous materials and waste spills and exposures - Fire safety management problems, deficiencies, and failures - Medical or laboratory equipment management problems, failures, and use errors - Utility systems management problems, failures, or use errors Note 1: All the incidents and issues listed above may be reported to staff in quality	Moved and Revised	NPG.11.01.01, EP 3	The hospital develops and implements a process(es) for continually monitoring, internally reporting, and investigating the following: - Injuries to patients or others within the hospital's facilities and grounds - Occupational illnesses and staff injuries - Incidents of damage to its property or the property of others - Safety and security incidents involving patients, staff, or others within its facilities, including those related to workplace violence - Hazardous materials and waste spills and exposures - Fire safety management problems, deficiencies, and failures - Medical or laboratory equipment management problems, failures, and use errors - Utility systems management problems, failures, or use errors Note 1: All the incidents and issues listed above may be reported to staff in quality

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	assessment, improvement, or other functions. A summary of such incidents may also be shared with the person designated to coordinate safety management activities. Note 2: Review of incident reports often requires that legal processes be followed to preserve confidentiality. Opportunities to improve care, treatment, and services, or to prevent similar incidents, are not lost as a result of following the legal process. CoPs: §482.13(c)(2), §482.41(d)(2)			assessment, improvement, or other functions. A summary of such incidents may also be shared with the person designated to coordinate safety management activities. Note 2: Review of incident reports often requires that legal processes be followed to preserve confidentiality. Opportunities to improve care, treatment, and services, or to prevent similar incidents, are not lost as a result of following the legal process.
EC.04.01.01, EP 3	Based on its process(es), the hospital reports and investigates the following: Injuries to patients or others in the hospital's facilities. CoPs: §482.13(c)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.04.01.01, EP 4	Based on its process(es), the hospital reports and investigates the following: Occupational illnesses and staff injuries.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.04.01.01, EP 5	Based on its process(es), the hospital reports and investigates the following: Incidents of damage to its property or the property of others.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.04.01.01, EP 6	Based on its process(es), the hospital reports and investigates the following: Safety and security incidents involving patients, staff, or others within its facilities, including those related to workplace violence. CoPs: §482.13(c)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.04.01.01, EP 8	Based on its process(es), the hospital reports and investigates the following: Hazardous materials and waste spills and exposures. CoPs: §482.26(b)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.04.01.01, EP 9	Based on its process(es), the hospital reports and investigates the following: Fire safety management problems, deficiencies, and failures. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.04.01.01, EP 10	Based on its process(es), the hospital reports and investigates the following: Medical/laboratory equipment management problems, failures, and use errors. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.04.01.01, EP 11	Based on its process(es), the hospital reports and investigates the following: Utility systems management problems, failures, or use errors. CoPs: §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
EC.04.01.01, EP 15	Every 12 months, the hospital evaluates each environment of care management plan, including a review of the plan's objectives, scope, performance, and effectiveness. CoPs: §482.41(a), §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.04.01.03, EP 2	The hospital uses the results of data analysis to identify opportunities to resolve environmental safety issues. CoPs: §482.41(a), §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EC.04.01.05, EP 1	The hospital takes action on the identified opportunities to resolve environmental safety issues. CoPs: §482.41(a), §482.41(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
EM.09.01.01, EP 4	For hospitals that use Joint Commission accreditation for deemed status purposes: If a hospital has one or more transplant programs the following must occur: - A representative from each transplant program must be included in the development and maintenance of the hospital's emergency preparedness program - The hospital must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the hospital, each transplant program, and the organ procurement organization (OPO) for the donation service area where the hospital is situated, unless the hospital has been granted a waiver to work with another OPO, during an emergency CoPs: §482.15(g)(1), §482.15(g)(2)	Revised	EM.09.01.01, EP 4	For hospitals that use Joint Commission accreditation for deemed status purposes: If a hospital has one or more transplant programs (as defined in 42 CFR 482.70) the following must occur: - A representative from each transplant program must be included in the development and maintenance of the hospital's emergency preparedness program - The hospital must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the hospital, each transplant program, and the organ procurement organization (OPO) for the donation service area where the hospital is situated, unless the hospital has been granted a waiver to work with another OPO, during an emergency CoPs: §482.15(g)(1), §482.15(g)(2)
EM.10.01.01, EP 1	The hospital's senior leaders provide oversight and support for the following emergency management program activities: - Allocation of resources for the emergency management program - Review of the emergency management program documents - Review of the emergency operations plan, policies and procedures, and training and education that support the emergency management program - Review of after-action reports (AAR) and improvement plans Note 1: The hospital defines who the members of the senior leadership group are as well as their roles and responsibilities for emergency management–related activities. Note 2: An AAR provides a detailed critical summary or analysis of a planned exercise or actual emergency or disaster incident. The report summarizes what took place during the event, analyzes the actions taken by participants, and identifies areas needing improvement.	Moved	NPG.03.01.01, EP 1	The hospital's senior leaders provide oversight and support for the following emergency management program activities: - Allocation of resources for the emergency management program - Review of the emergency management program documents - Review of the emergency operations plan, policies and procedures, and training and education that support the emergency management program - Review of after-action reports (AAR) and improvement plans Note 1: The hospital defines who the members of the senior leadership group are as well as their roles and responsibilities for emergency management–related activities. Note 2: An AAR provides a detailed critical summary or analysis of a planned exercise or actual emergency or disaster incident. The report summarizes what took place during the event, analyzes the actions taken by participants, and identifies areas needing improvement.
EM.10.01.01, EP 2	The hospital's senior leaders identify a qualified individual to lead the emergency management program who has defined responsibilities that include, but are not limited to, the following: - Developing and maintaining the emergency operations plan and policies and procedures - Implementing the four phases of emergency management (mitigation, preparedness, response, and recovery) - Implementing emergency management activities across the six critical areas (communications, staffing, patient clinical and support services, safety and security, resources and assets, and utilities)	Moved	NPG.03.01.01, EP 2	The hospital's senior leaders identify a qualified individual to lead the emergency management program who has defined responsibilities that include, but are not limited to, the following: - Developing and maintaining the emergency operations plan and policies and procedures - Implementing the four phases of emergency management (mitigation, preparedness, response, and recovery) - Implementing emergency management activities across the six critical areas (communications, staffing, patient clinical and support services, safety and security, resources and assets, and utilities)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	- Coordinating the emergency management exercises and developing after-action reports - Collaborating across clinical and operational areas to implement organizationwide emergency management - Identifying and collaborating with community response partners Note: Education, training, and experience in emergency management should be taken into account when considering the qualifications of the individual(s) who lead the program.			- Coordinating the emergency management exercises and developing after-action reports - Collaborating across clinical and operational areas to implement organizationwide emergency management - Identifying and collaborating with community response partners Note: Education, training, and experience in emergency management should be taken into account when considering the qualifications of the individual(s) who lead the program.
EM.10.01.01, EP 3	The hospital has a multidisciplinary committee that oversees the emergency management program. The committee includes the emergency program lead and other participants identified by the hospital; meeting frequency, goals, and responsibilities are defined by the committee. Note 1: Other multidisciplinary committee participants may include representatives from senior leadership, nursing services, medical staff, pharmacy services, infection prevention and control, facilities engineering, security, and information technology. Note 2: The multidisciplinary committee that oversees the emergency management program may be incorporated into an existing committee.	Moved	NPG.03.01.01, EP 3	The hospital has a multidisciplinary committee that oversees the emergency management program. The committee includes the emergency program lead and other participants identified by the hospital; meeting frequency, goals, and responsibilities are defined by the committee. Note 1: Other multidisciplinary committee participants may include representatives from senior leadership, nursing services, medical staff, pharmacy services, infection prevention and control, facilities engineering, security, and information technology. Note 2: The multidisciplinary committee that oversees the emergency management program may be incorporated into an existing committee.
EM.10.01.01, EP 4	The multidisciplinary committee provides input and assists in the coordination of the preparation, development, implementation, evaluation, and maintenance of the hospital's emergency management program. The activities include, but are not limited to, the following: - Hazard vulnerability analysis - Emergency operations plan, policies, and procedures - Continuity of operations plan - Training and education - Planning and coordinating incident response exercises (seminars; workshops; tabletop exercises; functional exercises; full-scale, community-based exercises) - After-action reports and improvement plans Note: An after-action report (AAR) provides a detailed critical summary or analysis of a planned exercise or actual emergency or disaster incident. The report summarizes what took place during the event, analyzes the actions taken by participants, and specifies areas needing improvement.	Moved and Revised	NPG.03.01.01, EP 4	The multidisciplinary committee provides input and assists in the coordination of the preparation, development, implementation, evaluation, and maintenance of the hospital's emergency management program. The activities include, but are not limited to, the following: - Hazard vulnerability analysis - Emergency operations plan, policies, and procedures - Continuity of operations plan - Training and education - Planning and coordinating incident response exercises (seminars; workshops; tabletop exercises; functional exercises; full-scale, community-based exercises) - After-action reports and improvement plans Note: An after-action report (AAR) provides a detailed critical summary or analysis of a planned exercise or actual emergency or disaster incident. The report summarizes what took place during the event, analyzes the actions taken by participants, and specifies areas needing improvement.
EM.12.01.01, EP 5	The hospital's incident command structure describes the overall incident command operations, including specific incident command roles and responsibilities. The incident command structure is flexible and scalable to respond to varying types and degrees of emergencies or disaster incidents. Note: The incident command structure may include facilities, equipment, staff, procedures, and communications within a defined organizational structure.	Moved	NPG.03.02.01, EP 1	The hospital's incident command structure describes the overall incident command operations, including specific incident command roles and responsibilities. The incident command structure is flexible and scalable to respond to varying types and degrees of emergencies or disaster incidents. Note: The incident command structure may include facilities, equipment, staff, procedures, and communications within a defined organizational structure.
EM.12.01.01, EP 7	The hospital identifies the individual(s) who has the authority to activate the hospital's emergency operations plan and/or the hospital's incident command.	Moved	NPG.03.02.01, EP 2	The hospital identifies the individual(s) who has the authority to activate the hospital's emergency operations plan and/or the hospital's incident command.
EM.12.01.01, EP 8	The hospital identifies its primary and alternate sites for incident command operations and determines how it will maintain and support operations at these sites. Note 1: Alternate command center sites may include the use of virtual command centers. Note 2: Maintaining and supporting operations at alternate sites include having appropriate supplies, resources, communications, and information technology capabilities.	Moved and Revised	NPG.03.02.01, EP 3	The hospital identifies its primary and alternate sites for incident command operations and determines how it will maintain and support operations at these sites. Note 1: Alternate command center sites may include the use of virtual command centers. Note 2: Maintaining and supporting operations at alternate sites include having appropriate supplies, resources, communications, and information technology capabilities.

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EM.12.01.01, EP 9	The hospital must develop and implement emergency preparedness policies and procedures that address the role of the hospital under a waiver declared by the Secretary, in accordance with section 1135 of the Social Security Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. Note 1: This element of performance is applicable only to hospitals that receive Medicare, Medicaid, or Children's Health Insurance Program reimbursement. Note 2: For more information on 1135 waivers, visit https://www.cms.gov/about-cms/what-we-do/emergency-response/how-can-we-help/waivers-flexibilities and https://www.cms.gov/about-cms/agency-information/emergency/downloads/consolidated_medicare_ffs_emergency_qsas.pdf. CoPs: §482.15(b)(8)	Moved	EM.12.01.01, EP 7	The hospital must develop and implement emergency preparedness policies and procedures that address the role of the hospital under a waiver declared by the Secretary, in accordance with section 1135 of the Social Security Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. Note 1: This element of performance is applicable only to hospitals that receive Medicare, Medicaid, or Children's Health Insurance Program reimbursement. Note 2: For more information on 1135 waivers, visit https://www.cms.gov/about-cms/what-we-do/emergency-response/how-can-we-help/waivers-flexibilities and https://www.cms.gov/about-cms/agency-information/emergency/downloads/consolidated_medicare_ffs_emergency_qsas.pdf. CoPs: §482.15(b)(8)
EM.12.02.01, EP 2	The hospital's communications plan describes how it will establish and maintain communications in order to deliver coordinated messages and information during an emergency or disaster incident to the following individuals: - Staff and volunteers (including individuals providing care at alternate sites) - Patients and family members, including people with disabilities and other access and functional needs - Community partners (such as fire department, emergency medical services, police, public health department) - Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) - Media and other stakeholders Note: Examples of means of communication include text messaging, phone system alerts, email, social media, and augmentative and alternative communication (AAC) for those with difficulties communicating using speech.	Moved and Revised	NPG.03.02.02, EP 1	The hospital's communications plan describes how it will establish and maintain communications in order to deliver coordinated messages and information during an emergency or disaster incident to the following individuals: - Staff and volunteers (including individuals providing care at alternate sites) - Patients and family members, including people with disabilities and other access and functional needs - Community partners (such as fire department, emergency medical services, police, public health department) - Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) - Media and other stakeholders Note: Examples of means of communication include text messaging, phone system alerts, email, social media, and augmentative and alternative communication (AAC) for those with difficulties communicating using speech.
EM.12.02.01, EP 4	The emergency response communications plan identifies the hospital's warning and notification alerts specific to emergency and disaster events and the procedures to follow when an emergency or disaster incident occurs.	Moved	NPG.03.02.02, EP 2	The emergency response communications plan identifies the hospital's warning and notification alerts specific to emergency and disaster events and the procedures to follow when an emergency or disaster incident occurs.
EM.12.02.01, EP 5	In the event of an emergency or evacuation, the hospital's communications plan includes a method for sharing and/or releasing location information and medical documentation for patients under the hospital's care to the following individuals or entities, in accordance with law and regulation: - Patient's family, representative, or others involved in the care of the patient - Disaster relief organizations and relevant authorities - Other health care providers Note: Sharing and releasing of patient information is consistent with 45 CFR 164.510(b)(1)(ii) and (b)(4). CoPs: §482.15(c)(4), §482.15(c)(5), §482.15(c)(6)	Moved	EM.12.02.01, EP 4	In the event of an emergency or evacuation, the hospital's communications plan includes a method for sharing and/or releasing location information and medical documentation for patients under the hospital's care to the following individuals or entities, in accordance with law and regulation: - Patient's family, representative, or others involved in the care of the patient - Disaster relief organizations and relevant authorities - Other health care providers Note: Sharing and releasing of patient information is consistent with 45 CFR 164.510(b)(1)(ii) and (b)(4). CoPs: §482.15(c)(4), §482.15(c)(5), §482.15(c)(6)
EM.12.02.01, EP 6	The hospital's communications plan identifies its primary and alternate means for communicating with staff and relevant authorities (such as federal, state, tribal, regional, and local emergency preparedness staff). The plan includes procedures for the following: - How and when alternate/backup communication methods are used - Verifying that its communications systems are compatible with those of community partners and relevant authorities the hospital plans to communicate with	Moved	EM.12.02.01, EP 5	The hospital's communications plan identifies its primary and alternate means for communicating with staff and relevant authorities (such as federal, state, tribal, regional, and local emergency preparedness staff). The plan includes procedures for the following: - How and when alternate/backup communication methods are used - Verifying that its communications systems are compatible with those of community partners and relevant authorities the hospital plans to communicate with

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	- Testing the functionality of the hospital's alternate/backup communication systems or equipment Note: Examples of alternate/backup communication systems include amateur radios, portable radios, text-based notifications, cell and satellite phones, and reverse 911 notification systems. CoPs: §482.15(b)(3), §482.15(c)(3)(i), §482.15(c)(3)(ii)			- Testing the functionality of the hospital's alternate/backup communication systems or equipment Note: Examples of alternate/backup communication systems include amateur radios, portable radios, text-based notifications, cell and satellite phones, and reverse 911 notification systems. CoPs: §482.15(b)(3), §482.15(c)(3)(i), §482.15(c)(3)(ii)
EM.12.02.03, EP 4	The hospital's staffing plan describes in writing how it will manage volunteer licensed practitioners when the emergency operations plan has been activated and the hospital is unable to meet its patient needs. The hospital does the following: - Verifies and documents the identity of all volunteer licensed practitioners - Completes primary source verification of licensure as soon as the immediate situation is under control or within 72 hours from the time the volunteer licensed practitioner presents to the organization - Provides oversight of the care, treatment, and services provided by volunteer licensed practitioners Note: If primary source verification of licensure cannot be completed within 72 hours, the hospital documents the reason(s) it could not be performed.	Moved and Revised	NPG.03.02.03, EP 1	The hospital's staffing plan describes in writing how it will manage volunteer licensed practitioners when the emergency operations plan has been activated and the hospital is unable to meet its patient needs. The hospital does the following: - Verifies and documents the identity of all volunteer licensed practitioners - Completes primary source verification of licensure as soon as the immediate situation is under control or within 72 hours from the time the volunteer licensed practitioner presents to the organization - Provides oversight of the care, treatment, and services provided by volunteer licensed practitioners Note: If primary source verification of licensure cannot be completed within 72 hours, the hospital documents the reason(s) it could not be performed.
EM.12.02.03, EP 5	The hospital identifies the individual(s) responsible for granting disaster privileges to volunteer physicians and other licensed practitioners and has a process for granting these privileges. This is documented in the medical staff bylaws, rules and regulations, or policies and procedures.	Moved	NPG.03.02.03, EP 2	The hospital identifies the individual(s) responsible for granting disaster privileges to volunteer physicians and other licensed practitioners and has a process for granting these privileges. This is documented in the medical staff bylaws, rules and regulations, or policies and procedures.
EM.12.02.03, EP 6	The emergency response staffing plan describes how it will provide employee assistance and support, which includes the following: - Staff support needs (for example, housing or transportation) - Family support needs of staff (for example, child care, elder care) - Mental health and wellness needs	Moved and Revised	NPG.03.02.03, EP 3	The emergency response staffing plan describes how it will provide employee assistance and support, which includes the following: - Staff support needs (for example, housing, transportation) - Family support needs of staff (for example, child care, elder care) - Mental health and wellness needs
EM.12.02.05, EP 2	The hospital's plan for providing patient care and clinical support includes written procedures for managing individuals that may present during a disaster or emergency that are not in need of medical care (such as visitors).	Moved	NPG.03.02.04, EP 1	The hospital's plan for providing patient care and clinical support includes written procedures for managing individuals that may present during a disaster or emergency that are not in need of medical care (such as visitors).
EM.12.02.05, EP 3	The hospital coordinates with the local medical examiner's office, local mortuary services, and other local, regional, or state services when there is a surge of unidentified or deceased patients.	Moved	NPG.03.02.04, EP 2	The hospital coordinates with the local medical examiner's office, local mortuary services, and other local, regional, or state services when there is a surge of unidentified or deceased patients.
EM.12.02.07, EP 1	The hospital has a plan for safety and security measures. The plan describes the roles that community security agencies (for example, police, sheriff, National Guard) will have in the event of an emergency and how the hospital will coordinate security activities with these agencies.	Moved	NPG.03.02.05, EP 1	The hospital has a plan for safety and security measures. The plan describes the roles that community security agencies (for example, police, sheriff, National Guard) will have in the event of an emergency and how the hospital will coordinate security activities with these agencies.
EM.12.02.09, EP 1	The hospital's plan for managing its resources and assets describes in writing how it will document, track, monitor, and locate the following resources (on-site and off-site inventories) and assets during and after an emergency or disaster incident: - Medications and related supplies - Medical/surgical supplies - Medical gases including oxygen and supplies - Potable or bottled water and nutrition - Non-potable water - Laboratory equipment and supplies - Personal protective equipment - Fuel for operations - Equipment and nonmedical supplies to sustain operations Note: The hospital should be aware of the resources and assets it has readily available and what resources and assets may be quickly depleted depending on the type of emergency or disaster incident. CoPs: §482.15(e)(3), §482.41(d)(2)	Revised	EM.12.02.09, EP 1	The hospital's plan for managing its resources and assets describes in writing how it will document, track, monitor, and locate the following resources (on-site and off-site inventories) and assets during and after an emergency or disaster incident: - Medications and related supplies - Medical/surgical supplies - Medical gases, including oxygen and supplies - Potable or bottled water and nutrition - Non-potable water - Laboratory equipment and supplies - Personal protective equipment - Fuel for operations - Equipment and nonmedical supplies to sustain operations Note: The hospital should be aware of the resources and assets it has readily available and what resources and assets may be quickly depleted depending on the type of emergency or disaster incident. CoPs: §482.15(e)(3)

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EM.12.02.09, EP 3	The hospital's plan for managing its resources and assets describes in writing the actions the hospital will take to sustain the needs of the hospital for up to 96 hours based on calculations of current resource consumptions. Note 1: Hospitals are not required to remain fully functional for 96 hours or stockpile 96 hours' worth of supplies. Note 2: The 96-hour time frame provides a framework for hospitals to evaluate their capability to be self-sufficient for at least 96 hours. For example, if a hospital loses electricity and has backup generators, the emergency response plan for resources and assets establishes how much fuel is on hand and how long those generators can be operated before determining next steps. The plan may also address conservation of resources and assets, such as rationing existing resources, canceling noncritical procedures, or redirecting resources.	Moved and Revised	NPG.03.02.06, EP 1	The hospital's plan for managing its resources and assets describes in writing the actions the hospital will take to sustain the needs of the hospital for up to 96 hours based on calculations of current resource consumptions. Note 1: Hospitals are not required to remain fully functional for 96 hours or stockpile 96 hours' worth of supplies. Note 2: The 96-hour time frame provides a framework for hospitals to evaluate their capability to be self-sufficient for at least 96 hours. For example, if a hospital loses electricity and has backup generators, the emergency response plan for resources and assets establishes how much fuel is on hand and how long those generators can be operated before determining next steps. The plan may also address conservation of resources and assets, such as rationing existing resources, canceling noncritical procedures, or redirecting resources.
EM.14.01.01, EP 1	The hospital has a disaster recovery plan that describes in writing its strategies for when and how it will do the following: - Conduct hospitalwide damage assessments - Restore critical systems and essential services - Return to full operations	Moved and Revised	NPG.03.03.01, EP 1	The hospital has a disaster recovery plan that describes in writing its strategies for when and how it will do the following: - Conduct hospitalwide damage assessments - Restore critical systems and essential services - Return to full operations
EM.14.01.01, EP 2	The hospital's disaster recovery plan describes in writing how the hospital will address family reunification and coordinate with its local community partners to help locate and assist with the identification of adults and unaccompanied children.	Moved	NPG.03.03.01, EP 2	The hospital's disaster recovery plan describes in writing how the hospital will address family reunification and coordinate with its local community partners to help locate and assist with the identification of adults and unaccompanied children.
EM.15.01.01, EP 4	The hospital requires that incident command staff participate in education and training specific to their duties and responsibilities in the incident command structure. Note: The hospital may choose to develop its own training, or it may require incident command staff to take an incident command–related course(s) such as those offered by the Federal Emergency Management Agency.	Moved and Revised	NPG.03.04.01, EP 1	The hospital requires that incident command staff participate in education and training specific to their duties and responsibilities in the incident command structure. Note: The hospital may choose to develop its own training, or it may require incident command staff to take an incident command–related course(s) such as those offered by the Federal Emergency Management Agency.
EM.16.01.01, EP 3	Each accredited freestanding outpatient care building that provides patient care, treatment, and services is required to conduct at least one operations-based or discussion-based exercise per year to test its emergency response procedures, if not conducted in conjunction with the hospital's emergency exercises. Exercises and actual emergency or disaster incidents are documented.	Moved and Revised	NPG.03.05.01, EP 1	Each accredited freestanding outpatient care building that provides patient care, treatment, and services is required to conduct at least one operations-based or discussion-based exercise per year to test its emergency response procedures, if not conducted in conjunction with the hospital's emergency exercises. Exercises and actual emergency or disaster incidents are documented.
EM.17.01.01, EP 2	The after-action reports, identified opportunities for improvement, and recommended actions to improve the emergency management program are forwarded to senior hospital leaders for review.	Moved and Revised	NPG.03.06.01, EP 1	The after-action reports, identified opportunities for improvement, and recommended actions to improve the emergency management program are forwarded to senior hospital leaders for review.
HR.01.01.01, EP 1	The hospital defines staff qualifications specific to their job responsibilities. Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control). Note 2: Qualifications for laboratory personnel are described in the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88), under Subpart M: "Personnel for Nonwaived Testing" §493.1351-§493.1495. A complete description of the requirement is located at https://www.ecfr.gov/cgi-bin/text-idx?SID=0854acca5427c69e771e5beb52b0b986&mc=true&node=sp42.5.493.m&rgn=div6. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists (as defined in 42 CFR 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are	Moved and Revised	HR.11.02.01, EP 1	The hospital defines staff qualifications specific to their job responsibilities. Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control). Note 2: Qualifications for laboratory personnel are described in the Clinical Laboratory Improvement Amendments (CLIA), under Subpart M: "Personnel for Nonwaived Testing" §493.1351-§493.1495. A complete description of the requirement is located at https://www.ecfr.gov/cgi-bin/text-idx?SID=0854acca5427c69e771e5beb52b0b986&mc=true&node=sp42.5.493.m&rgn=div6. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists, as defined in 42 CFR 484, provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are

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	provided by the hospital. The provision of care and staff qualifications are in accordance with national acceptable standards of practice and also meet the requirements of 409.17. See Appendix A for 409.17 requirements. Note 4: Qualifications for language interpreters and translators may be met through language proficiency assessment, education, training, and experience. The use of qualified interpreters and translators is supported by the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and Title VI of the Civil Rights Act of 1964. Note 5: For hospitals that use Joint Commission accreditation for deemed status purposes: Staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing. CoPs: §482.23(b)(5), §482.24(a), §482.26, §482.28, §482.28(a)(1)(iii), §482.28(a)(2), §482.42(a)(1), §482.43(a)(5), §482.51(a)(1), §482.51(a)(2), §482.51(a)(3), §482.53(a)(2), §482.54(b)(2), §482.55(b)(2), §482.56(a)(2), §482.56(b)(2), §482.57(a)(2), §482.57(b)(1), §482.58(b)(4)			provided by the hospital. See Glossary for definitions of physical therapist, physical therapist assistant, occupational therapist, occupational therapy assistant, speech-language pathologist, and audiologist. Note 4: Qualifications for language interpreters and translators may be met through language proficiency assessment, education, training, and experience. The use of qualified interpreters and translators is supported by the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and Title VI of the Civil Rights Act of 1964. Note 5: If respiratory care services are provided, staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing. CoPs: §482.42(a)(1), §482.56(a)(2), §482.57(b)(1), §482.58(b)(6), §483.65(b)
HR.01.01.01, EP 2	The hospital verifies and documents the following: - Credentials of staff using the primary source when licensure, certification, or registration is required by law and regulation to practice their profession. This is done at the time of hire and at the time credentials are renewed. - Credentials of staff (primary source not required) when licensure, certification, or registration is not required by law and regulation. This is done at the time of hire and at the time credentials are renewed. Note 1: It is acceptable to verify current licensure, certification, or registration with the primary source via a secure electronic communication or by telephone, if this verification is documented. 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. CoPs: §482.11(c), §482.23(b)(2), §482.28	Consolidation of HR.01.01.01, EP 2; HR.01.01.01, EP 3; HR.01.02.07, EP 1	HR.11.01.03, EP 1	All staff who provide patient care, treatment, and services are qualified and possess a current license, certification, or registration, in accordance with law and regulation. CoPs: §482.11(c)
HR.01.01.01, EP 3	The hospital verifies and documents that the applicant has the education and experience required by the job responsibilities. CoPs: §482.11(c), §482.28, §482.28(a)(1)(iii), §482.28(a)(2), §482.51(a)(1), §482.54(b)(2), §482.55(b)(2), §482.56(a)(1), §482.56(a)(2), §482.56(b)(2), §482.57(a)(2)	Consolidation of HR.01.01.01, EP 2; HR.01.01.01, EP 3; HR.01.02.07, EP 1	HR.11.01.03, EP 1	All staff who provide patient care, treatment, and services are qualified and possess a current license, certification, or registration, in accordance with law and regulation. CoPs: §482.11(c)
HR.01.01.01, EP 4	The hospital obtains a criminal background check on the applicant as required by law and regulation or hospital policy. Criminal background checks are documented.	Moved and Revised	NPG.12.04.01, EP 1	The hospital obtains a criminal background check on the applicant as required by law and regulation or hospital policy. Criminal background checks are documented.
HR.01.01.01, EP 5	Staff comply with applicable health screening as required by law and regulation or hospital policy. Health screening compliance is documented.	Moved	NPG.12.04.01, EP 2	Staff comply with applicable health screening as required by law and regulation or hospital policy. Health screening compliance is documented.
HR.01.01.01, EP 7	Before providing care, treatment, and services, the hospital confirms that nonemployees who are brought into the hospital by a physician or other licensed practitioner to provide care, treatment, or services have the same qualifications and competencies required of employed individuals performing the same or similar	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

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	services at the hospital. Note 1: This confirmation can be accomplished either through the hospital's regular process or with the physician or other licensed practitioner who brought in the individual. Note 2: When the care, treatment, and services provided by the nonemployee are not currently performed by anyone employed by the hospital, leadership consults the appropriate professional hospital guidelines for the required credentials and competencies.	moved to guidance within SPG		
HR.01.01.01, EP 18	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The facility does not employ individuals who have been found guilty by a court of law of abusing, neglecting, exploiting, misappropriating property, or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of residents' property. CoPs: §482.58(b)(3), §483.12(a)(3)(i), §483.12(a)(3)(ii)	Moved and Revised	HR.11.02.01, EP 4	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital does not employ individuals who have been found guilty by a court of law of abusing, neglecting, exploiting, misappropriating property, or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of residents' property. CoPs: §482.58(b)(3), §483.12(a)(3)(i), §483.12(a)(3)(ii)
HR.01.01.01, EP 30	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The director of psychiatric nursing is a registered nurse who has a master's degree in psychiatric or mental health nursing, or its equivalent, from a school of nursing accredited by the National League for Nursing, or is qualified by education and experience in the care of the mentally ill. The director of psychiatric nursing demonstrates competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished. CoPs: §482.62(d), §482.62(d)(1), §482.62(d)(1)	Moved and Revised	HR.11.02.01, EP 2	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a director of psychiatric nursing that is a registered nurse who has a master's degree in psychiatric or mental health nursing, or its equivalent, from a school of nursing accredited by the National League for Nursing or is qualified by education and experience in the care of the mentally ill. The director of psychiatric nursing demonstrates competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care provided. CoPs: §482.62(d), §482.62(d)(1), §482.62(d)(1)
HR.01.01.01, EP 31	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The director of the social work department or service has a master's degree from an accredited school of social work or is qualified by education and experience in the social services needs of the mentally ill. Note: If the director does not hold a master's degree in social work, at least one staff member has this qualification. CoPs: §482.62(f)(1)	Moved and Revised	HR.11.02.01, EP 5	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The director of social services has a master's degree from an accredited school of social work or is qualified by education and experience in the social services needs of the mentally ill. Note: If the director does not hold a master's degree in social work, at least one staff member has this qualification. CoPs: §482.62(f)(1)
HR.01.01.01, EP 32	Technologists who perform diagnostic computed tomography (CT) exams have advanced-level certification by the American Registry of Radiologic Technologists (ARRT) or the Nuclear Medicine Technology Certification Board (NMTCB) in computed tomography or have one of the following qualifications: - State licensure that permits them to perform diagnostic CT exams and documented training on the provision of diagnostic CT exams or - Registration and certification in radiography by ARRT and documented training on the provision of diagnostic CT exams or - Certification in nuclear medicine technology by ARRT or NMTCB and documented training on the provision of diagnostic CT exams Note 1: This element of performance does not apply to CT exams performed for therapeutic radiation treatment planning or delivery, or for calculating attenuation coefficients for nuclear medicine studies. Note 2: This element of performance does not apply to dental cone beam CT	Moved and Revised	NPG.13.01.01, EP 1	Technologists who perform diagnostic computed tomography (CT) exams have advanced-level certification by the American Registry of Radiologic Technologists (ARRT) or the Nuclear Medicine Technology Certification Board (NMTCB) in computed tomography or have one of the following qualifications: - State licensure that permits them to perform diagnostic CT exams and documented training on the provision of diagnostic CT exams - Registration and certification in radiography by ARRT and documented training on the provision of diagnostic CT exams - Certification in nuclear medicine technology by ARRT or NMTCB and documented training on the provision of diagnostic CT exams Note 1: This element of performance does not apply to CT exams performed for therapeutic radiation treatment planning or delivery or for calculating attenuation coefficients for nuclear medicine studies. Note 2: This element of performance does not apply to dental cone beam CT

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.			radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.
HR.01.01.01, EP 33	The hospital verifies and documents that diagnostic medical physicists who support computed tomography (CT) services have board certification in diagnostic radiologic physics or radiologic physics by the American Board of Radiology, or in Diagnostic Imaging Physics by the American Board of Medical Physics, or in Diagnostic Radiological Physics by the Canadian College of Physicists in Medicine, or meet all of the following requirements: - A graduate degree in physics, medical physics, biophysics, radiologic physics, medical health physics, or a closely related science or engineering discipline from an accredited college or university - College coursework in the biological sciences with at least one course in biology or radiation biology and one course in anatomy, physiology, or a similar topic related to the practice of medical physics - Documented experience in a clinical CT environment conducting at least 10 CT performance evaluations under the direct supervision of a board-certified medical physicist Note: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.	Moved and Revised	NPG.13.01.01, EP 2	The hospital verifies and documents that diagnostic medical physicists who support computed tomography (CT) services have board certification in diagnostic radiologic physics or radiologic physics by the American Board of Radiology, or in diagnostic imaging physics by the American Board of Medical Physics, or in diagnostic radiological physics by the Canadian College of Physicists in Medicine, or meet all of the following requirements: - A graduate degree in physics, medical physics, biophysics, radiologic physics, medical health physics, or a closely related science or engineering discipline from an accredited college or university - College coursework in the biological sciences with at least one course in biology or radiation biology and one course in anatomy, physiology, or a similar topic related to the practice of medical physics - Documented experience in a clinical CT environment conducting at least 10 CT performance evaluations under the direct supervision of a board-certified medical physicist Note: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.
HR.01.02.01, EP 1	The equivalent process for credentialing and privileging physician assistants and advanced practice registered nurses who practice within the hospital is approved by the governing body.	Deleted	N/A	N/A
HR.01.02.01, EP 2	The equivalent process for credentialing and privileging physician assistants and advanced practice registered nurses who practice within the hospital includes the following: - A documented evaluation of the applicant's credentials - An evaluation of the applicant's current competence - Documented peer recommendations - Input from individuals and committees, including the medical staff, to make an informed decision regarding requests for privileges	Deleted	N/A	N/A
HR.01.02.05, EP 2	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a qualified dietitian on a full-time, part-time, or consultative basis. CoPs: §482.28, §482.28(a)(2), §482.28(b)(1)	Moved and Revised	NPG.12.01.01, EP 9	The hospital has a qualified dietitian on a full-time, part-time, or consultative basis. CoPs: §482.28(a)(2)
HR.01.02.05, EP 28	For hospitals that use Joint Commission accreditation for deemed status purposes: A full-time, part-time, or consulting pharmacist develops, supervises, and coordinates all the activities of the pharmacy department or pharmacy services. CoPs: §482.25(a)(1)	Moved and Revised	NPG.12.01.01, EP 11	The hospital has a full-time, part-time, or consulting pharmacist who is responsible for developing, supervising, and coordinating all pharmacy services activities. CoPs: §482.25(a)(1)
HR.01.02.07, EP 1	All staff who provide patient care, treatment, and services possess a current license, certification, or registration, in accordance with law and regulation.	Consolidation of HR.01.01.01, EP 2; HR.01.01.01, EP 3; HR.01.02.07, EP 1	HR.11.01.03, EP 1	All staff who provide patient care, treatment, and services are qualified and possess a current license, certification, or registration, in accordance with law and regulation. CoPs: §482.11(c)
HR.01.02.07, EP 2	Staff who provide patient care, treatment, and services practice within the scope of their license, certification, or registration and as required by law and regulation.	Moved and Revised	NPG.12.04.01, EP 3	Staff who provide patient care, treatment, and services practice within the scope of their license, certification, or registration, in accordance with law and regulation.

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	CoPs: §482.23(c)(3), §482.23(c)(3)(ii), §482.51(a)(2), §482.51(a)(3), §482.52(a)(5), §482.56(b)(2)			
HR.01.04.01, EP 1	The hospital orients its staff to the key safety content it identifies before staff provides care, treatment, and services. Completion of this orientation is documented. Note: Key safety content may include specific processes and procedures related to the provision of care, treatment, or services; the environment of care; and infection control. CoPs: §482.23(b)(6), §482.41(b)(5)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
HR.01.04.01, EP 3	The hospital orients staff on the following: - Relevant hospitalwide and unit-specific policies and procedures - Their specific job duties, including those related to infection prevention and control and assessing and managing pain - Sensitivity to cultural diversity based on their job duties and responsibilities - Patient rights, including ethical aspects of care, treatment, or services and the process used to address ethical issues based on their job duties and responsibilities Completion of this orientation is documented.	Moved and Revised	NPG.12.05.01, EP 1	The hospital orients staff on the following: - Relevant hospitalwide and unit-specific policies and procedures - Their specific job duties, including those related to infection prevention and control and assessing and managing pain - Sensitivity to cultural diversity based on their job duties and responsibilities - Patient rights, including ethical aspects of care, treatment, or services and the process used to address ethical issues based on their job duties and responsibilities Completion of this orientation is documented.
HR.01.05.03, EP 1	Staff participate in ongoing education and training to maintain or increase their competency and, as needed, when staff responsibilities change. Staff participation is documented. CoPs: §482.42(c)(2)(iv), §482.51	Moved	HR.11.03.01, EP 1	Staff participate in ongoing education and training to maintain or increase their competency and, as needed, when staff responsibilities change. Staff participation is documented. CoPs: §482.42(c)(2)(iv)
HR.01.05.03, EP 14	The hospital verifies and documents that individuals who perform diagnostic computed tomography (CT) examinations participate in ongoing education that includes annual training on the following: - Radiation dose optimization techniques and tools for pediatric and adult patients addressed in the Image Gently® and Image Wisely® campaigns - Safe procedures for operation of the types of CT equipment they will use Note 1: Information on the Image Gently and Image Wisely initiatives can be found online at https://www.imagegently.org and https://www.imagewisely.org, respectively. Note 2: This element of performance does not apply to CT systems used for therapeutic radiation treatment planning or delivery, or for calculating attenuation coefficients for nuclear medicine studies. Note 3: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.	Moved and Revised	NPG.13.01.01, EP 3	The hospital verifies and documents that individuals who perform diagnostic computed tomography (CT) examinations participate in ongoing education that includes annual training on the following: - Radiation dose optimization techniques and tools for pediatric and adult patients addressed in the Image Gently® and Image Wisely® campaigns - Safe procedures for operation of the types of CT equipment they will use Note 1: Information on the Image Gently and Image Wisely initiatives can be found online at https://www.imagegently.org and https://www.imagewisely.org, respectively. Note 2: This element of performance does not apply to CT systems used for therapeutic radiation treatment planning or delivery or for calculating attenuation coefficients for nuclear medicine studies. Note 3: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.
HR.01.05.03, EP 25	The hospital verifies and documents that technologists who perform magnetic resonance imaging (MRI) examinations participate in ongoing education that includes annual training on safe MRI practices in the MRI environment, including the following: - Patient screening criteria that address ferromagnetic items, electrically conductive items, medical implants and devices, and risk for nephrogenic systemic fibrosis (NSF) - Proper patient and equipment positioning activities to avoid thermal injuries - Equipment and supplies that have been determined to be acceptable for use in the MRI environment (MR safe or MR conditional) * - MRI safety response procedures for patients who require urgent or emergent	Moved and Revised	NPG.13.01.01, EP 4	The hospital verifies and documents that technologists who perform magnetic resonance imaging (MRI) examinations participate in ongoing education, including annual training on safe MRI practices in the MRI environment that addresses the following: - Patient screening criteria that address ferromagnetic items, electrically conductive items, medical implants and devices, and risk for nephrogenic systemic fibrosis (NSF) - Proper patient and equipment positioning activities to avoid thermal injuries - Equipment and supplies that have been determined to be acceptable for use in the MRI environment (MR safe or MR conditional) - MRI safety response procedures for patients who require urgent or emergent

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	medical care - MRI system emergency shutdown procedures, such as MRI system quench and cryogen safety procedures - Patient hearing protection - Management of patients with claustrophobia, anxiety, or emotional distress Footnote *: Terminology for defining the safety of items in the magnetic resonance environment is provided in ASTM F2503 Standard Practice for Marking Medical Devices and Other Items for Safety in the Magnetic Resonance Environment (http://www.astm.org).			medical care - MRI system emergency shutdown procedures, such as MRI system quench and cryogen safety procedures - Patient hearing protection - Management of patients with claustrophobia, anxiety, or emotional distress Note: Terminology for defining the safety of items in the magnetic resonance environment is provided in ASTM F2503 Standard Practice for Marking Medical Devices and Other Items for Safety in the Magnetic Resonance Environment (http://www.astm.org).
HR.01.05.03, EP 29	As part of its workplace violence prevention program, the hospital provides training, education, and resources (at time of hire, annually, and whenever changes occur regarding the workplace violence prevention program) to leadership, staff, and licensed practitioners. The hospital determines what aspects of training are appropriate for individuals based on their roles and responsibilities. The training, education, and resources address prevention, recognition, response, and reporting of workplace violence as follows: - What constitutes workplace violence - Education on the roles and responsibilities of leadership, clinical staff, security personnel, and external law enforcement - Training in de-escalation, nonphysical intervention skills, physical intervention techniques, and response to emergency incidents - The reporting process for workplace violence incidents	Moved and Revised	NPG.02.04.01, EP 2	As part of its workplace violence prevention program, the hospital provides training, education, and resources (at time of hire, annually, and whenever changes occur regarding the workplace violence prevention program) to leaders, staff, and licensed practitioners. The hospital determines what aspects of training are appropriate for individuals based on their roles and responsibilities. The training, education, and resources address prevention, recognition, response, and reporting of workplace violence as follows: - What constitutes workplace violence - Education on the roles and responsibilities of leaders, clinical staff, security personnel, and external law enforcement - Training in de-escalation, nonphysical intervention skills, physical intervention techniques, and response to emergency incidents - The reporting process for workplace violence incidents
HR.01.06.01, EP 1	The hospital defines the competencies it requires of its staff who provide patient care, treatment, or services. CoPs: §482.23(b)(5), §482.23(c)(1), §482.26, §482.28(a)(3), §482.42(c)(2)(iv), §482.51, §482.53(a)(2), §482.54(b)(2), §482.55(b)(2), §482.56(a)(1), §482.56(a)(2), §482.56(b)(2), §482.57(a)(2), §482.57(b)(1)	Split to HR.11.01.01, EP 1; HR.11.02.01, EP 3	HR.11.01.01, EP 1	The hospital's food and dietetic services administrative and technical staff are competent to perform their responsibilities. CoPs: §482.28(a)(3)
HR.01.06.01, EP 1	The hospital defines the competencies it requires of its staff who provide patient care, treatment, or services. CoPs: §482.23(b)(5), §482.23(c)(1), §482.26, §482.28(a)(3), §482.42(c)(2)(iv), §482.51, §482.53(a)(2), §482.54(b)(2), §482.55(b)(2), §482.56(a)(1), §482.56(a)(2), §482.56(b)(2), §482.57(a)(2), §482.57(b)(1)	Split to HR.11.01.01, EP 1; HR.11.02.01, EP 3	HR.11.02.01, EP 3	The director of rehabilitation services has the knowledge, experience, and capabilities to supervise and administer the services. CoPs: §482.56(a)(1)
HR.01.06.01, EP 3	An individual with the educational background, experience, or knowledge related to the skills being reviewed assesses competence. Note: When a suitable individual cannot be found to assess staff competence, the hospital can utilize an outside individual for this task. If a suitable individual inside or outside the hospital cannot be found, the hospital may consult the competency guidelines from an appropriate professional organization to make its assessment. CoPs: §482.23(b)(5), §482.23(b)(6), §482.23(c)(1), §482.42(c)(2)(iv), §482.51	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
HR.01.06.01, EP 5	Staff competence is initially assessed and documented as part of orientation. CoPs: §482.23(b)(5), §482.23(b)(6), §482.23(c)(1), §482.28(a)(3), §482.42(c)(2)(iv), §482.51	Moved and Revised	HR.11.04.01, EP 1	Staff competence is initially assessed and documented as part of orientation and once every three years, or more frequently as required by hospital policy or in accordance with law and regulation. CoPs: §482.42(c)(2)(iv)

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HR.01.06.01, EP 6	Staff competence is assessed and documented once every three years, or more frequently as required by hospital policy or in accordance with law and regulation. CoPs: §482.23(b)(5), §482.23(c)(1), §482.28(a)(3), §482.42(c)(2)(iv), §482.51	Consolidation of HR.01.06.01, EP 5; HR.01.06.01, EP 6	HR.11.04.01, EP 1	Staff competence is initially assessed and documented as part of orientation and once every three years, or more frequently as required by hospital policy or in accordance with law and regulation. CoPs: §482.42(c)(2)(iv)
HR.01.07.01, EP 1	The hospital evaluates staff based on performance expectations that reflect their job responsibilities.	Consolidation of HR.01.07.01, EP 1; HR.01.07.01, EP 2	NPG.12.05.01, EP 2	The hospital evaluates staff performance once every three years, or more frequently as required by hospital policy or in accordance with law and regulation. Staff are evaluated based on performance expectations that reflect their job responsibilities. This evaluation is documented.
HR.01.07.01, EP 2	The hospital evaluates staff performance once every three years, or more frequently as required by hospital policy or in accordance with law and regulation. This evaluation is documented.	Consolidation of HR.01.07.01, EP 1; HR.01.07.01, EP 2	NPG.12.05.01, EP 2	The hospital evaluates staff performance once every three years, or more frequently as required by hospital policy or in accordance with law and regulation. Staff are evaluated based on performance expectations that reflect their job responsibilities. This evaluation is documented.
N/A	N/A	New, more-direct EP for CoP requirement	HR.11.01.03, EP 3	The hospital develops and implements a procedure to verify and document the following: - Credentials of staff using the primary source when licensure, certification, or registration is required by federal, state, or local law and regulation. This is done at the time of hire and at the time credentials are renewed. - Credentials of staff (primary source not required) when licensure, certification, or registration is not required by law and regulation. This is done at the time of hire and at the time credentials are renewed. Note 1: It is acceptable to verify current licensure, certification, or registration with the primary source via a secure electronic communication or by telephone, if this verification is documented. Note 2: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source. Note 3: An external organization (for example, a credentials verification organization [CVO]) may be used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary. Note 4: The hospital determines the required qualifications for staff based on job responsibilities. CoPs: §482.23(b)(2)
IC.04.01.01, EP 1	The hospital's governing body, based on the recommendation of the medical staff and nursing leaders, appoints an infection preventionist(s) or infection control professional(s) qualified through education, training, experience, or certification in infection prevention to be responsible for the infection prevention and control program. CoPs: §482.42(a)(1)	Moved	NPG.12.01.01, EP 12	The hospital's governing body, based on the recommendation of the medical staff and nursing leaders, appoints an infection preventionist(s) or infection control professional(s) qualified through education, training, experience, or certification in infection prevention to be responsible for the infection prevention and control program. CoPs: §482.42(a)(1)
IC.04.01.01, EP 2	The infection preventionist(s) or infection control professional(s) is responsible for the following: - Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines - Documentation of the infection prevention and control program and its surveillance, prevention, and control activities - Competency-based training and education of hospital staff on infection prevention and control policies and procedures and their application - Prevention and control of health care–associated infections and other infectious diseases,	Revised	IC.04.01.01, EP 2	The infection preventionist(s) or infection control professional(s) is responsible for the following: - Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines - Documentation of the infection prevention and control program and its surveillance, prevention, and control activities - Competency-based training and education of hospital personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the hospital, on infection prevention and control policies and procedures

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	including auditing staff adherence to infection prevention and control policies and procedures - Communication and collaboration with all components of the hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program - Communication and collaboration with the hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.01.06.01 EPs 1, 3, 5, 6). CoPs: §482.42, §482.42(c)(2)(i), §482.42(c)(2)(ii), §482.42(c)(2)(iii), §482.42(c)(2)(iv), §482.42(c)(2)(v), §482.42(c)(2)(vi)			and their application - Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures - Communication and collaboration with all components of the hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program - Communication and collaboration with the hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.11.04.01 EP 1). CoPs: §482.42, §482.42(c)(2)(i), §482.42(c)(2)(ii), §482.42(c)(2)(iii), §482.42(c)(2)(iv), §482.42(c)(2)(v), §482.42(c)(2)(vi)
IC.04.01.01, EP 5	The infection prevention and control program reflects the scope and complexity of the hospital services provided by addressing all locations, patient populations, and staff. CoPs: §482.42, §482.42(a)(4)	Revised	IC.04.01.01, EP 5	The infection prevention and control program reflects the scope and complexity of the hospital services provided by addressing all locations, patient populations, and staff. CoPs: §482.42, §482.42(a)(4)
IC.06.01.01, EP 1	To prioritize the program's activities, the hospital identifies risks for infection, contamination, and exposure that pose a risk to patients and staff based on the following: - Its geographic location, community, and population served - The care, treatment, and services it provides - The analysis of surveillance activities and other infection control data - Relevant infection control issues identified by the local, state, or federal public health authorities that could impact the hospital Note: Risks may include organisms with a propensity for transmission within health care facilities based on published reports and the occurrence of clusters of patients (for example, norovirus, respiratory syncytial virus [RSV], influenza, measles, organisms with antimicrobial resistance such as Carbapenem-resistant Enterobacterales [CRE] and Candida auris).	Moved and Revised	NPG.05.01.01, EP 1	To prioritize the program's activities, the hospital identifies risks for infection, contamination, and exposure that pose a risk to patients and staff based on the following: - Its geographic location, community, and population served - The care, treatment, and services it provides - The analysis of surveillance activities and other infection control data - Relevant infection control issues identified by the local, state, or federal public health authorities that could impact the hospital Note: Risks may include organisms with a propensity for transmission within health care facilities based on published reports and the occurrence of clusters of patients (for example, norovirus, respiratory syncytial virus, influenza, measles, organisms with antimicrobial resistance such as Carbapenem-resistant Enterobacterales [CRE] and Candida auris).
IC.06.01.01, EP 2	The hospital reviews identified risks at least annually or whenever significant changes in risk occur.	Moved	NPG.05.01.01, EP 2	The hospital reviews identified risks at least annually or whenever significant changes in risk occur.
IC.06.01.01, EP 3	The hospital implements activities for the surveillance, prevention, and control of health care–associated infections and other infectious diseases, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and addresses any infection control issues identified by public health authorities that could impact the hospital. CoPs: §482.42, §482.42(a)(3), §482.51	Revised	IC.06.01.01, EP 3	The hospital implements activities for the surveillance, prevention, and control of health care–associated infections and other infectious diseases, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and addresses any infection control issues identified by public health authorities that could impact the hospital. CoPs: §482.42, §482.42(a)(3)
IC.07.01.01, EP 1	The hospital develops and implements protocols for high-consequence infectious diseases or special pathogens. The protocols are readily available for use at the point of care and address the following: - Identify: Procedures for screening at the points of entry to the hospital for respiratory symptoms, fever, rash, and travel history to identify or initiate evaluation for high-consequence infectious diseases or special pathogens	Moved	NPG.05.02.01, EP 1	The hospital develops and implements protocols for high-consequence infectious diseases or special pathogens. The protocols are readily available for use at the point of care and address the following: - Identify: Procedures for screening at the points of entry to the hospital for respiratory symptoms, fever, rash, and travel history to identify or initiate evaluation for high-consequence infectious diseases or special pathogens

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	- Isolate: Procedures for transmission-based precautions - Inform: Procedures for informing public health authorities and key hospital staff - Required personal protective equipment and proper donning and doffing techniques - Infection control procedures to support continued and safe provision of care while the patient is in isolation and to reduce exposure among staff, patients, and visitors using the hierarchy of controls - Procedures for managing waste and cleaning and disinfecting patient care spaces, surfaces, and equipment Note 1: Points of entry may include the emergency department, urgent care, and ambulatory clinics. Note 2: See the Glossary for a definition of hierarchy of controls.			- Isolate: Procedures for transmission-based precautions - Inform: Procedures for informing public health authorities and key hospital staff - Required personal protective equipment and proper donning and doffing techniques - Infection control procedures to support continued and safe provision of care while the patient is in isolation and to reduce exposure among staff, patients, and visitors using the hierarchy of controls - Procedures for managing waste and cleaning and disinfecting patient care spaces, surfaces, and equipment Note 1: Points of entry may include the emergency department, urgent care, and ambulatory clinics. Note 2: See the Glossary for a definition of hierarchy of controls.
IC.07.01.01, EP 2	The hospital develops and implements education and training and assesses competencies for staff who will implement protocols for high-consequence infectious diseases or special pathogens.	Moved	NPG.05.02.01, EP 2	The hospital develops and implements education and training and assesses competencies for staff who will implement protocols for high-consequence infectious diseases or special pathogens.
IM.01.01.01, EP 2	The hospital identifies how data and information enter, flow within, and leave the organization. CoPs: §482.24(b)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
IM.01.01.03, EP 1	The hospital follows a written plan for managing interruptions to its information processes (paper-based, electronic, or a mix of paper-based and electronic). CoPs: §482.15(b)(5)	Moved and Revised	IM.11.01.01, EP 1	The hospital develops and implements policies and procedures regarding medical documentation and patient information during emergencies and other interruptions to information management systems, including security and availability of patient records to support continuity of care. Note: These policies and procedures are based on the emergency plan, risk assessment, and emergency communication plan and are reviewed and updated at least every 2 years. CoPs: §482.15(b)(5)
IM.01.01.03, EP 2	The hospital's plan for managing interruptions to information processes addresses the following: - Scheduled and unscheduled interruptions of electronic information systems - Training for staff on alternative procedures to follow when electronic information systems are unavailable - Backup of electronic information systems CoPs: §482.15(b)(5)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
IM.02.01.01, EP 1	The hospital follows a written policy addressing the privacy and confidentiality of health information. CoPs: §482.13(d)(1), §482.15(b)(5), §482.24(b)(3), §482.58(b)(1), §483.10(h), §483.10(h)(1), §483.10(h)(3)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
IM.02.01.01, EP 3	The hospital uses health information only for purposes permitted by law and regulation or as further limited by its policy on privacy. CoPs: §482.13(d)(1), §482.24(b)(3), §482.58(b)(1), §483.10(h), §483.10(h)(1), §483.10(h)(3)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
IM.02.01.01, EP 4	The hospital discloses health information only as authorized by the patient or as otherwise consistent with law and regulation.	Moved and Revised	IM.12.01.01, EP 2	The hospital discloses health information only as authorized by the patient with the patient's written consent or as otherwise required by law and regulation.

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	CoPs: §482.13(d)(1), §482.15(b)(5), §482.24(b)(3), §482.43(b), §482.58(b)(1), §483.10(h), §483.10(h)(1), §483.10(h)(3)(i), §483.10(h)(3)(ii)			Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital allows representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with state law. CoPs: §482.58(b)(1), §483.10(h)(3)(i), §483.10(h)(3)(ii)
IM.02.01.03, EP 1	The hospital follows a written policy that addresses the security of health information, including access, use, and disclosure. CoPs: §482.13(d)(1), §482.15(b)(5), §482.24(b), §482.24(b)(3)	Consolidation of IM.02.01.03, EP 1; IM.02.01.03, EP 2	IM.12.01.03, EP 1	The hospital develops and implements a written policy that addresses the security of health information, including the following: - Access and use of health information - Integrity of health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction - Intentional destruction of health information - When and by whom the removal of health information is permitted Note: Removal refers to those actions that place health information outside the hospital's control. CoPs: §482.24(b)(3)
IM.02.01.03, EP 2	The hospital implements a written policy addressing the following: - The integrity of health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction - The intentional destruction of health information - When and by whom the removal of health information is permitted Note: Removal refers to those actions that place health information outside the hospital's control. CoPs: §482.13(d)(1), §482.24(b)	Consolidation of IM.02.01.03, EP 1; IM.02.01.03, EP 2	IM.12.01.03, EP 1	The hospital develops and implements a written policy that addresses the security of health information, including the following: - Access and use of health information - Integrity of health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction - Intentional destruction of health information - When and by whom the removal of health information is permitted Note: Removal refers to those actions that place health information outside the hospital's control. CoPs: §482.24(b)(3)
IM.02.01.03, EP 5	The hospital protects against unauthorized access, use, and disclosure of health information. CoPs: §482.15(b)(5)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
IM.02.01.03, EP 6	The hospital protects health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction. CoPs: §482.24(b), §482.24(b)(3)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
IM.02.01.03, EP 7	The hospital controls the intentional destruction of health information.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
IM.02.02.01, EP 2	The hospital uses standardized terminology, definitions, abbreviations, acronyms, symbols, and dose designations.	Moved	IM.13.01.01, EP 1	The hospital uses standardized terminology, definitions, abbreviations, acronyms, symbols, and dose designations.
IM.02.02.01, EP 3	The hospital follows its list of prohibited abbreviations, acronyms, symbols, and dose designations, which includes the following: - U,u - IU	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	- Q.D., QD, q.d., qd - Q.O.D., QOD, q.o.d, qod - Trailing zero (X.0 mg) - Lack of leading zero (.X mg) - MS - MSO4 - MgSO4 Note 1: A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation. Note 2: The prohibited list applies to all orders, preprinted forms, and medication-related documentation. Medication-related documentation can be either handwritten or electronic.	moved to guidance within SPG		
IM.02.02.03, EP 2	The hospital's storage and retrieval systems make health information accessible when needed for patient care, treatment, and services. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical records system allows for timely retrieval of patient information by diagnosis and procedure. CoPs: §482.21(d)(2), §482.24(a), §482.24(b), §482.24(b)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
IM.02.02.03, EP 3	The hospital disseminates data and information in useful formats within time frames that are defined by the hospital and consistent with law and regulation. CoPs: §482.24(a), §482.24(b)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
IM.02.02.07, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital demonstrates that its electronic health records system (or other electronic administrative system) has a fully operational notification capacity and is used in accordance with applicable state and federal laws and regulations for the exchange of patient health information. CoPs: §482.24(d)(1), §482.61(f)(1)	Moved and Revised	IM.13.01.05, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital demonstrates that its electronic health records system's (or other electronic administrative system's) notification capacity is fully operational and is used in accordance with applicable state and federal laws and regulations for the exchange of patient health information. CoPs: §482.24(d)(1), §482.61(f)(1)
IM.02.02.07, EP 2	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital demonstrates that its electronic health records system (or other electronic administrative system) sends notifications that include at least the patient's name, treating licensed practitioner's name, and sending institution's name. CoPs: §482.24(d)(2), §482.61(f)(2)	Moved and Revised	IM.13.01.05, EP 2	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital demonstrates that its electronic health records system (or other electronic administrative system) sends notifications that include, at a minimum, the patient's name, treating licensed practitioner's name, and sending institution's name. CoPs: §482.24(d)(2), §482.61(f)(2)
IM.02.02.07, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes: In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, at the time of the patient's emergency department registration or inpatient admission. CoPs: §482.24(d)(3), §482.24(d)(3)(i), §482.24(d)(3)(ii), §482.61(f)(3), §482.61(f)(3)(i), §482.61(f)(3)(ii)	Moved and Revised	IM.13.01.05, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes: In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, at the following times, when applicable: - The patient's emergency department registration - The patient's inpatient admission

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
				CoPs: §482.24(d)(3), §482.24(d)(3)(i), §482.24(d)(3)(ii), §482.61(f)(3), §482.61(f)(3)(i), §482.61(f)(3)(ii)
IM.02.02.07, EP 4	For hospitals that use Joint Commission accreditation for deemed status purposes: In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, either immediately prior to or at the time of the patient's discharge or transfer from the hospital's emergency department or inpatient services. CoPs: §482.24(d)(4), §482.24(d)(4)(i), §482.24(d)(4)(ii), §482.61(f)(4), §482.61(f)(4)(i), §482.61(f)(4)(ii)	Moved	IM.13.01.05, EP 4	For hospitals that use Joint Commission accreditation for deemed status purposes: In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, either immediately prior to or at the time of the patient's discharge or transfer from the hospital's emergency department or inpatient services. CoPs: §482.24(d)(4), §482.24(d)(4)(i), §482.24(d)(4)(ii), §482.61(f)(4), §482.61(f)(4)(i), §482.61(f)(4)(ii)
IM.02.02.07, EP 5	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital makes a reasonable effort to confirm that its electronic health records system (or other electronic administrative system) sends the notifications to all applicable post-acute care services providers and suppliers, as well as any of the following who need to receive notification of the patient's status for treatment, care coordination, or quality improvement purposes: - The patient's established primary care licensed practitioner - The patient's established primary care practice group or entity - Other licensed practitioners, or other practice groups or entities, identified by the patient as primarily responsible for the patient's care Note: The term "reasonable effort" means that a hospital has a process to send patient event notifications while working within the constraints of its technology infrastructure. There may be instances in which a hospital (or its intermediary) cannot identify an applicable recipient for a patient event notification despite establishing processes for identifying recipients. In addition, some recipients may not be able to receive patient event notifications in a manner consistent with a hospital system's capabilities. CoPs: §482.24(d)(5), §482.24(d)(5)(i), §482.24(d)(5)(ii), §482.24(d)(5)(iii), §482.61(f)(5), §482.61(f)(5)(i), §482.61(f)(5)(ii), §482.61(f)(5)(iii)	Moved and Revised	IM.13.01.05, EP 5	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital makes a reasonable effort to confirm that its electronic health records system (or other electronic administrative system) sends the notifications to all applicable post–acute care service providers and suppliers, as well as any of the following who need to receive notification of the patient's status for treatment, care coordination, or quality improvement purposes: - Patient's established primary care licensed practitioner - Patient's established primary care practice group or entity - Other licensed practitioners, or other practice groups or entities, identified by the patient as primarily responsible for the patient's care Note: The term "reasonable effort" means that the hospital has a process to send patient event notifications while working within the constraints of its technology infrastructure. There may be instances in which the hospital (or its intermediary) cannot identify an applicable recipient for a patient event notification despite establishing processes for identifying recipients. In addition, some recipients may not be able to receive patient event notifications in a manner consistent with the hospital system's capabilities. CoPs: §482.24(d)(5), §482.24(d)(5)(i), §482.24(d)(5)(ii), §482.24(d)(5)(iii), §482.61(f)(5), §482.61(f)(5)(i), §482.61(f)(5)(ii), §482.61(f)(5)(iii)
IM.03.01.01, EP 1	The hospital provides access to knowledge-based information resources 24 hours a day, 7 days a week. CoPs: §482.25(b)(8)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
N/A	N/A	Moved and Revised	IM.12.01.01, EP 1	The hospital develops and implements policies and procedures addressing the privacy and confidentiality of health information. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Policies and procedures also address the resident's personal records. CoPs: §482.13(d)(1), §482.24(b)(3), §482.58(b)(1), §483.10(h), §483.10(h)(3)
N/A	N/A	Moved and Revised	IM.13.01.03, EP 1	The hospital has a system for coding and indexing medical records to make health information accessible when needed for patient care, treatment, and services. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical records system allows for timely retrieval of patient information by diagnosis and procedure.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
				CoPs: §482.24(b)(2)
LD.01.01.01, EP 1	The hospital identifies those responsible for governance. CoPs: §482.12	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.01.01.01, EP 2	The governing body identifies those responsible for planning, management, and operational activities. CoPs: §482.12, §482.12(d)(7)(ii)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.01.01.01, EP 3	The governing body identifies those responsible for the provision of care, treatment, and services. CoPs: §482.22	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.01.02.01, EP 1	Senior managers and leaders of the organized medical staff work with the governing body to define their shared and unique responsibilities and accountabilities.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.01.03.01, EP 1	The governing body defines in writing its responsibilities. CoPs: §482.12	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.01.03.01, EP 2	The governing body provides for organization management and planning. CoPs: §482.12, §482.12(d)(7)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.01.03.01, EP 3	The governing body approves the hospital's written scope of services. CoPs: §482.12(f)(1), §482.26, §482.27(a)(2), §482.51(a), §482.52, §482.52(a), §482.52(b), §482.53, §482.53, §482.53(a), §482.54, §482.54, §482.55, §482.56, §482.56(a), §482.57(a)	Split to LD.13.03.01, EP 11; LD.13.03.01, EP 14	LD.13.03.01, EP 11	The surgical services are consistent with the resources available. CoPs: §482.51(a), §482.51(b)
LD.01.03.01, EP 3	The governing body approves the hospital's written scope of services. CoPs: §482.12(f)(1), §482.26, §482.27(a)(2), §482.51(a), §482.52, §482.52(a), §482.52(b), §482.53, §482.53, §482.53(a), §482.54, §482.54, §482.55, §482.56, §482.56(a), §482.57(a)	Split to LD.13.03.01, EP 11; LD.13.03.01, EP 14	LD.13.03.01, EP 14	The hospital maintains a written description of the scope of laboratory services provided that is available to the medical staff. CoPs: §482.27(a)(2)
LD.01.03.01, EP 4	The governing body selects the chief executive responsible for managing the hospital. CoPs: §482.12(b)	Moved and Revised	LD.11.01.01, EP 6	The governing body appoints the chief executive officer responsible for managing the hospital. CoPs: §482.12(b)
LD.01.03.01, EP 5	The governing body provides for the resources needed to maintain safe, quality care, treatment, and services.	Consolidation of LD.01.03.01, EP 5;	LD.13.03.03, EP 2	The governing body is responsible for all services provided in the hospital, including contracted services. The governing body assesses that services are provided in a

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.12, §482.12(e)(1), §482.21(e)(1), §482.21(e)(4), §482.52(b), §482.53, §482.53, §482.53(a), §482.53(c), §482.54, §482.54, §482.55, §482.56(a), §482.57(a)	LD.04.03.09, EP 6; LD.04.03.09, EP 7		safe and effective manner and takes action to address issues pertaining to quality and performance. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The governing body makes certain that a contractor of services (including one for shared services and joint ventures) provides services that permit the hospital to comply with applicable Centers for Medicare & Medicaid Services (CMS) Conditions of Participation and standards for contract services. CoPs: §482.12(e), §482.12(e)(1)
LD.01.03.01, EP 6	The governing body works with the senior managers and leaders of the organized medical staff to annually evaluate the hospital's performance in relation to its mission, vision, and goals. CoPs: §482.21(e)(1)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.01.03.01, EP 8	The governing body provides the organized medical staff with the opportunity to participate in governance. CoPs: §482.12(d)(7)(ii)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.01.03.01, EP 9	The governing body provides the organized medical staff with the opportunity to be represented at governing body meetings (through attendance and voice) by one or more of its members, as selected by the organized medical staff.	Moved	LD.11.01.01, EP 3	The governing body provides the organized medical staff with the opportunity to be represented at governing body meetings (through attendance and voice) by one or more of its members, as selected by the organized medical staff.
LD.01.03.01, EP 10	Organized medical staff members are eligible for full membership in the hospital's governing body, unless legally prohibited.	Moved	LD.11.01.01, EP 4	Organized medical staff members are eligible for full membership in the hospital's governing body, unless legally prohibited.
LD.01.03.01, EP 12	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a governing body that assumes full legal responsibility for the operation of the hospital. CoPs: §482.12	Moved and Revised	LD.11.01.01, EP 1	The hospital has a governing body that assumes full legal responsibility for the conduct of the hospital. If the hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital carry out the functions that pertain to the governing body. CoPs: §482.12
LD.01.03.01, EP 13	For hospitals that use Joint Commission accreditation for deemed status purposes: The governing body consults directly with the individual assigned the responsibility for the organization and conduct of the hospital's medical staff, or the individual's designee. At a minimum, this direct consultation occurs periodically throughout the fiscal or calendar year and includes a discussion of matters related to the quality of medical care provided to patients of the hospital. For a multi-hospital system using a single governing body, the single multihospital system governing body consults directly with the individual responsible for the organized medical staff (or the individual's designee) of each hospital within its system. CoPs: §482.12(a)(10)	Moved and Revised	LD.11.01.01, EP 5	For hospitals that use Joint Commission accreditation for deemed status purposes: The governing body consults directly with the individual assigned the responsibility for the organization and conduct of the hospital's medical staff, or with the individual's designee. At a minimum, this direct consultation occurs periodically throughout the fiscal or calendar year and includes a discussion of matters related to the quality of medical care provided to the hospital's patients. For a multi-hospital system using a single governing body, the single multihospital system governing body consults directly with the individual responsible for the organized medical staff (or the individual's designee) of each hospital within its system. CoPs: §482.12(a)(10)
LD.01.03.01, EP 14	For hospitals that use Joint Commission accreditation for deemed status purposes: If a hospital is part of a system consisting of multiple separately certified hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, the system governing body can elect to have a unified and integrated quality assessment and performance improvement program for all of its member hospitals after determining that such decision is in accordance with all applicable state and local laws. The system governing body is responsible and accountable for making certain that each of its separately certified hospitals meets the requirements	Moved and Revised	LD.11.01.01, EP 9	For hospitals that use Joint Commission accreditation for deemed status purposes: If a hospital is part of a system consisting of multiple separately certified hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, the system governing body can elect to have a unified and integrated quality assessment and performance improvement program for all of its member hospitals after determining that such decision is in accordance with all applicable state and local laws. Each separately certified hospital subject to the system governing body

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	for quality assessment and performance improvement at 42 CFR 482.21. Each separately certified hospital subject to the system governing body demonstrates that the unified and integrated quality assessment and performance improvement program has the following characteristics: - Structured in a manner that accounts for each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital - Establishes and implements policies and procedures to make certain that the needs and concerns of each of its separately certified hospitals, regardless of practice or location, are given due consideration, and that the unified and integrated program has mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed CoPs: §482.21(f), §482.21(f)(1), §482.21(f)(2)			demonstrates that the unified and integrated quality assessment and performance improvement program does the following: - Accounts for each member hospital's unique circumstances and any significant differences in patient populations and services offered - Establishes and implements policies and procedures to make certain that the needs and concerns of each of its separately certified hospitals, regardless of practice or location, are given due consideration, and that the unified and integrated program has mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The system governing body is responsible and accountable for making certain that each of its separately certified hospitals meets the requirements for quality assessment and performance improvement at 42 CFR 482.21. CoPs: §482.21(f), §482.21(f)(1), §482.21(f)(2)
LD.01.03.01, EP 20	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home evaluates the effectiveness of how the primary care clinician and the interdisciplinary team partner with the patient to support continuity of care and comprehensive, coordinated care.	Moved	LD.11.01.01, EP 11	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home evaluates the effectiveness of how the primary care clinician and the interdisciplinary team partner with the patient to support continuity of care and comprehensive, coordinated care.
LD.01.03.01, EP 21	For hospitals that use Joint Commission accreditation for deemed status purposes: The governing body is responsible for making sure that performance improvement activities reflect the complexity of the hospital's organization and services, involve all departments and services, and include services provided under contract. (For more information on contracted services, see Standard LD.04.03.09) Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital is not required to participate in a quality improvement organization (QIO) cooperative project, but its own projects are required to be of comparable effort. CoPs: §482.21, §482.21(d)(4)	Moved and Revised	LD.11.01.01, EP 8	The governing body is responsible for making sure that performance improvement activities reflect the complexity of the hospital's organization and services; involve all departments and services including services provided under contract or arrangement; and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. (For more information on contracted services, see Standard LD.14.03.03) Note: For hospitals that do not use Joint Commission accreditation for deemed status purposes: If the hospital does not have a governing body, it identifies the leadership structure that is responsible for these activities. CoPs: §482.21
LD.01.03.01, EP 27	For hospitals that use Joint Commission accreditation for deemed status purposes: If a hospital is part of a hospital system consisting of separately certified hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member hospitals after determining that such a decision is in accordance with applicable law and regulation. The system governing body is responsible and accountable for making certain that each of its separately certified hospitals meet all of the requirements at 42 CFR 482.42(d). Each separately certified hospital subject to the system governing body demonstrates that the unified and integrated infection prevention and control program and the antibiotic stewardship program have the following characteristics: - Structured in a manner that accounts for each member hospital's unique circumstances and any significant differences in patient populations and services offered at each hospital - Establish and implement policies and procedures to make certain that the needs and concerns of each separately certified hospital, regardless of practice or location, are given due consideration - Have mechanisms in place to ensure that issues localized to particular hospitals	Moved and Revised	LD.11.01.01, EP 10	For hospitals that use Joint Commission accreditation for deemed status purposes: If a hospital is part of a hospital system consisting of separately certified hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member hospitals after determining that such a decision is in accordance with applicable law and regulation. Each separately certified hospital subject to the system governing body demonstrates that the unified and integrated infection prevention and control program and the antibiotic stewardship program do the following: - Account for each member hospital's unique circumstances and any significant differences in patient populations and services offered - Establish and implement policies and procedures to make certain that the needs and concerns of each separately certified hospital, regardless of practice or location, are given due consideration - Have mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed - Designate a qualified individual(s) at the hospital with expertise in infection prevention and control and in antibiotic stewardship as responsible for

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	are duly considered and addressed - A qualified individual(s) with expertise in infection prevention and control and in antibiotic stewardship has been designated at the hospital as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to hospital staff CoPs: §482.42(d), §482.42(d)(1), §482.42(d)(2), §482.42(d)(3), §482.42(d)(4)			communicating with the unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to hospital staff Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The system governing body is responsible and accountable for making certain that each of its separately certified hospitals meet all of the requirements at 42 CFR 482.42(d). CoPs: §482.42(d), §482.42(d)(1), §482.42(d)(2), §482.42(d)(3), §482.42(d)(4)
LD.01.04.01, EP 1	The chief executive provides for the following: - Information and support systems - Physical and financial assets	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.01.04.01, EP 5	The chief executive identifies a nurse leader at the executive level who participates in decision making.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.01.05.01, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes: There is a single organized medical staff. CoPs: §482.22	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.01.05.01, EP 2	For hospitals that do not use Joint Commission accreditation for deemed status purposes: There is a single organized medical staff unless criteria are met for an exception to the single medical staff requirements. (Refer to the introduction to MS.01.01.01)	Moved and Revised	LD.11.02.01, EP 4	For hospitals that do not use Joint Commission accreditation for deemed status purposes: There is a single organized medical staff unless criteria are met for an exception to the single medical staff requirements.
LD.01.05.01, EP 3	The organized medical staff is self governing. (Refer to the bulleted list describing self governance in the Overview to the "Medical Staff" [MS] chapter.)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.01.05.01, EP 4	The governing body approves the structure of the organized medical staff. CoPs: §482.22(b), §482.22(b)(1)	Moved	LD.11.02.01, EP 2	The governing body approves the structure of the organized medical staff. CoPs: §482.22(b)(1)
LD.01.05.01, EP 6	The organized medical staff is accountable to the governing body for the quality of care provided to patients. CoPs: §482.12(a)(5), §482.22, §482.22(b)	Moved and Revised	LD.11.02.01, EP 1	The hospital has an organized medical staff that is accountable to the governing body for the quality of care provided to patients. CoPs: §482.22(b)
LD.01.05.01, EP 7	For hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy, or, if permitted by state law, a doctor of dental surgery or dental medicine, or a doctor of podiatric medicine is responsible for the organization and conduct of the medical staff. CoPs: §482.22(b)(3)(i), §482.22(b)(3)(ii), §482.22(b)(3)(iii)	Moved and Revised	LD.11.02.01, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy or, if permitted by state law, a doctor of dental surgery or dental medicine, or a doctor of podiatric medicine is responsible for the organization and conduct of the medical staff. CoPs: §482.22(b)(3)(i), §482.22(b)(3)(ii), §482.22(b)(3)(iii)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
LD.02.01.01, EP 1	The governing body, senior managers, and leaders of the organized medical staff work together to create the hospital's mission, vision, and goals, which guide the actions of the leaders. The mission, vision, and goals are communicated to the staff and the population(s) the hospital serves.	Moved and Revised	NPG.02.01.01, EP 1	The governing body, senior managers, and leaders of the organized medical staff work together to create the hospital's mission, vision, and goals, which guide the leaders' actions. The mission, vision, and goals are communicated to staff and the population(s) served.
LD.02.02.01, EP 1	The governing body, senior managers, and leaders of the organized medical staff work together to define in writing conflicts of interest that could affect safety and quality of care, treatment, and services.	Moved	NPG.02.02.01, EP 1	The governing body, senior managers, and leaders of the organized medical staff work together to define in writing conflicts of interest that could affect safety and quality of care, treatment, and services.
LD.02.02.01, EP 2	The governing body, senior managers, and leaders of the organized medical staff work together to develop a written policy that defines how conflicts of interest will be addressed.	Moved and Revised	NPG.02.02.01, EP 3	Conflicts of interest are disclosed as defined by the hospital.
LD.02.02.01, EP 3	Conflicts of interest are disclosed as defined by the hospital.	Moved and Revised	NPG.02.02.01, EP 2	The governing body, senior managers, and leaders of the organized medical staff work together to develop a written policy that defines how conflicts of interest will be addressed.
LD.02.04.01, EP 1	Senior managers and leaders of the organized medical staff work with the governing body to develop and implement an ongoing process for managing conflict among leadership groups that has the potential to adversely affect patient safety or quality of care.	Moved	NPG.02.02.01, EP 4	Senior managers and leaders of the organized medical staff work with the governing body to develop and implement an ongoing process for managing conflict among leadership groups that has the potential to adversely affect patient safety or quality of care.
LD.03.01.01, EP 1	Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.	Consolidation of LD.03.01.01, EP 1; LD.03.01.01, EP 2	NPG.02.03.01, EP 11	Leaders regularly evaluate the culture of safety and quality using valid and reliable tools. Possible issues are identified by the culture of safety evaluation. Proposed improvements are prioritized and implemented.
LD.03.01.01, EP 2	Leaders prioritize and implement changes identified by the evaluation. CoPs: §482.21(b)(2)(ii)	Consolidation of LD.03.01.01, EP 1; LD.03.01.01, EP 2	NPG.02.03.01, EP 11	Leaders regularly evaluate the culture of safety and quality using valid and reliable tools. Possible issues are identified by the culture of safety evaluation. Proposed improvements are prioritized and implemented.
LD.03.01.01, EP 4	Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.	Moved	NPG.02.03.01, EP 12	Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.
LD.03.01.01, EP 5	Leaders create and implement a process for managing behaviors that undermine a culture of safety. CoPs: §482.12	Moved	NPG.02.03.01, EP 13	Leaders create and implement a process for managing behaviors that undermine a culture of safety.
LD.03.01.01, EP 9	The hospital has a workplace violence prevention program led by a designated individual and developed by a multidisciplinary team that includes the following: - Policies and procedures to prevent and respond to workplace violence - A process to report incidents in order to analyze incidents and trends - A process for follow up and support to victims and witnesses affected by workplace violence, including trauma and psychological counseling, if necessary - Reporting of workplace violence incidents to the governing body	Moved and Revised	NPG.02.04.01, EP 1	The hospital has a workplace violence prevention program led by a designated individual and developed by a multidisciplinary team that includes the following: - Policies and procedures to prevent and respond to workplace violence - A process to report incidents in order to analyze incidents and trends - A process for follow up and support to victims and witnesses affected by workplace violence, including trauma and psychological counseling, if necessary - Reporting of workplace violence incidents to the governing body
LD.03.02.01, EP 1	Leaders set expectations for using data and information for the following: - Improving the safety and quality of care, treatment, or services - Decision making that supports the safety and quality of care, treatment, and services - Identifying and responding to internal and external changes in the environment CoPs: §482.21, §482.21(a)(1), §482.21(b)(2)(i)	Moved and Revised	LD.12.01.01, EP 3	The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for the following: - An ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained - The hospitalwide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and all improvement actions are evaluated - Clear expectations for safety are established - Adequate resources are allocated for measuring, assessing, improving, and sustaining the hospital's performance and reducing risk to patients - The determination of the number of distinct improvement projects is conducted annually

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
				CoPs: §482.21(e)(1), §482.21(e)(2), §482.21(e)(3), §482.21(e)(4), §482.21(e)(5)
LD.03.02.01, EP 2	Leaders evaluate how effectively data and information are used throughout the hospital.	Deleted	N/A	N/A
LD.03.02.01, EP 4	For hospitals that use Joint Commission accreditation for deemed status purposes: The quality assessment and performance improvement program incorporates quality indicator data, including patient care data and other relevant data such as that submitted to or received from Medicare quality reporting and quality performance programs (for example, data related to hospital readmissions and hospital-acquired conditions). CoPs: §482.21(b)(1)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.03.03.01, EP 1	Planning activities focus on the following: - Improving patient safety and health care quality - Adapting to changes in the environment CoPs: §482.62(g)(1)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.03.03.01, EP 2	Planning is hospitalwide, systematic, and involves designated individuals and information sources. CoPs: §482.62(g)(1)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.03.03.01, EP 3	Leaders evaluate the effectiveness of planning activities.	Deleted	N/A	N/A
LD.03.04.01, EP 1	Communication processes are effective in doing the following: - Fostering the safety of the patient and their quality of care - Supporting safety and quality throughout the hospital - Meeting the needs of internal and external users - Informing those who work in the hospital of changes in the environment	Consolidation of LD.03.04.01, EP 1; LD.03.09.01, EP 9	NPG.02.03.01, EP 9	Communication processes are effective in doing the following: - Fostering the safety of the patient and their quality of care - Supporting a culture of safety and quality - Meeting the needs of internal and external users - Informing those who work in the hospital of changes in the environment - Disseminating lessons learned from comprehensive systematic analyses (for example, root cause analyses), system or process failures, and proactive risk assessments to all affected staff
LD.03.04.01, EP 2	Leaders evaluate the effectiveness of communication methods.	Moved	NPG.02.03.01, EP 10	Leaders evaluate the effectiveness of communication methods.
LD.03.05.01, EP 1	The hospital has a systematic approach to change and performance improvement. CoPs: §482.21, §482.21(a)(1), §482.21(d), §482.21(d)(1), §482.21(e)(1)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.03.05.01, EP 2	Structures for managing change and performance improvement do the following: - Foster the safety of the patient and the quality of care, treatment, and services - Support both safety and quality throughout the hospital - Adapt to changes in the environment CoPs: §482.21, §482.21(a)(1), §482.21(d)(1)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.03.05.01, EP 3	Leaders evaluate the effectiveness of processes for the management of change and performance improvement. CoPs: §482.21, §482.21(a)(1), §482.21(c)(3), §482.21(e)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
LD.03.06.01, EP 1	Leaders design work processes to focus individuals on safety and quality issues.	Moved to Standard	Standard NPG.02.03.01	The hospital's leaders design work processes to focus individuals on safety and quality issues.
LD.03.06.01, EP 2	Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. CoPs: §482.12, §482.23(a), §482.23(b), §482.23(b)(1), §482.24(a), §482.25(a)(2), §482.28, §482.28(a)(2), §482.51(a)(1), §482.51(a)(3), §482.52(a), §482.53(a)(2), §482.54(b)(2), §482.55(b)(2), §482.56, §482.57(a)(2), §482.58(b)(4), §482.58(b)(6), §482.62, §482.62(a)(1), §482.62(a)(2), §482.62(a)(3), §482.62(a)(4), §482.62(b), §482.62(c), §482.62(d), §482.62(d)(2), §482.62(d)(2), §482.62(g)(2), §483.65(b)	Moved and Revised	NPG.12.01.01, EP 1	Leaders provide for an adequate number and mix of qualified individuals to support safe, quality care, treatment, and services. Note 1: The number and mix of individuals is appropriate to the scope and complexity of the services offered. Services may include but are not limited to the following: - Rehabilitation services - Emergency services - Outpatient services - Respiratory services - Pharmaceutical services, including emergency pharmaceutical services - Diagnostic and therapeutic radiology services Note 2: Emergency services staff are qualified in emergency care. CoPs: §482.25(a)(2), §482.26, §482.26(a), §482.54(b)(2), §482.55(b)(2), §482.57(a)(2)
LD.03.06.01, EP 3	Those who work in the hospital are competent to complete their assigned responsibilities. CoPs: §482.51, §482.51(a)(1), §482.51(a)(3), §482.53(a)(2), §482.55(b)(2), §482.56(a)(2), §482.56(b)(2), §482.57(a), §482.58(b)(4), §482.58(b)(6), §482.62, §482.62(a)(1), §482.62(a)(2), §482.62(a)(3), §482.62(a)(4), §482.62(b), §482.62(d), §482.62(d)(2), §482.62(g)(2), §483.65(b)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.03.07.01, EP 1	Performance improvement occurs hospitalwide. CoPs: §482.21, §482.21(a)(1), §482.21(d), §482.21(d)(2), §482.21(e)(1)	Moved and Revised	LD.12.01.01, EP 1	The hospital develops, implements, maintains, and documents an effective, ongoing, data-driven, hospitalwide quality assessment and performance improvement program. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital maintains and demonstrates evidence of its QAPI program for review by CMS. CoPs: §482.21
LD.03.07.01, EP 2	As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities and patient health outcomes - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities - Identify the frequency of data collection for performance improvement activities - Reprioritize performance improvement activities in response to changes in the internal or external environment CoPs: §482.21, §482.21(a)(1), §482.21(a)(2), §482.21(b)(3), §482.21(c)(1)(i), §482.21(c)(1)(ii), §482.21(c)(1)(iii), §482.21(d), §482.21(d)(1), §482.21(d)(2), §482.21(d)(3), §482.21(e)(1), §482.21(e)(2), §482.21(e)(3), §482.21(e)(5)	Moved and Revised	LD.12.01.01, EP 2	As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities related to health outcomes that are shown to be predictive of desired patient outcomes, patient safety, and quality of care - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities and consider the incidence, prevalence, and severity of problems in those areas - Identify the frequency and detail of data collection for performance improvement activities CoPs: §482.21(b)(3), §482.21(c)(1)(i), §482.21(c)(1)(ii), §482.21(c)(1)(iii)
LD.03.07.01, EP 4	For hospitals that elect The Joint Commission Primary Care Medical Home option: The interdisciplinary team actively participates in performance improvement activities.	Moved	LD.12.01.01, EP 4	For hospitals that elect The Joint Commission Primary Care Medical Home option: The interdisciplinary team actively participates in performance improvement activities.
LD.03.07.01, EP 21	For hospitals that elect The Joint Commission Primary Care Medical Home option: Leaders use qualitative data collection methods to involve patients in performance improvement activities.	Moved and Revised	LD.12.01.01, EP 5	For hospitals that elect The Joint Commission Primary Care Medical Home option: Leaders use qualitative data collection methods to involve patients in performance improvement activities.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	Note: Qualitative data collection methods are used to provide insight into patients' opinions, along with underlying reasons, and motivations. Examples of qualitative methods include focus groups, telephonic or in-person patient interviews or patient rounding, and patient participation on performance improvement committees.			Note: Qualitative data collection methods are used to provide insight into patients' opinions, along with underlying reasons, and motivations. Examples of qualitative methods include focus groups, telephonic or in-person patient interviews or patient rounding, and patient participation on performance improvement committees.
LD.03.08.01, EP 1	The hospital's design of new or modified services or processes incorporates the following: - The needs of patients, staff, and others - The results of performance improvement activities - Information about potential risks to patients - Evidence-based information in the decision-making process - Information about sentinel events Note 1: A proactive risk assessment is one of several ways to assess potential risks to patients. For suggested components, refer to the "Proactive Risk Assessment" section at the beginning of this chapter. Note 2: Evidence-based information could include practice guidelines, successful practices, information from current literature, and clinical standards. CoPs: §482.21(c)(2), §482.25(a)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.03.09.01, EP 1	The leaders implement a hospitalwide patient safety program as follows: - One or more qualified individuals or an interdisciplinary group manage the safety program. - All departments, programs, and services within the hospital participate in the safety program. - The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as close calls [“near misses”] or good catches) to hazardous conditions and sentinel events. CoPs: §482.21, §482.21(a)(1), §482.21(d)(2), §482.21(e)(1), §482.21(e)(2), §482.21(e)(3)	Moved and Revised	NPG.02.03.01, EP 1	The leaders implement a hospitalwide patient safety program as follows: - One or more qualified individuals or an interdisciplinary group manage the safety program. - All departments, programs, and services within the hospital participate in the safety program. - The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as close calls [“near misses”] or good catches) to hazardous conditions and sentinel events.
LD.03.09.01, EP 2	As part of the safety program, the leaders create procedures for responding to system or process failures. Note: Responses might include continuing to provide care, treatment, and services to those affected, containing the risk to others, and preserving factual information for subsequent analysis. CoPs: §482.21(e)(1)	Moved and Revised	NPG.02.03.01, EP 3	As part of the safety program, the leaders create procedures for responding to system or process failures. Note: Responses might include continuing to provide care, treatment, and services to those affected, containing the risk to others, and preserving factual information for subsequent analysis.
LD.03.09.01, EP 3	The leaders provide and encourage the use of systems for blame-free internal reporting of a system or process failure, or the results of a proactive risk assessment. Note: This EP is intended to minimize staff reluctance to report errors in order to help an organization understand the source and results of system and process failures. The EP does not conflict with holding individuals accountable for their blameworthy errors. CoPs: §482.21(c)(2), §482.21(e)(1)	Moved and Revised	NPG.02.03.01, EP 4	The leaders provide and encourage the use of systems for internal reporting of a system or process failure, or the results of a proactive risk assessment, without the risk of retaliation. Note: This EP is intended to minimize staff reluctance to report errors in order to help an organization understand the source and results of system and process failures. The EP does not conflict with holding individuals accountable for errors due to negligence.
LD.03.09.01, EP 4	The leaders define patient safety event and communicate this definition throughout the organization. Note: At a minimum, the organization's definition includes those events subject to review as described in the "Sentinel Event Policy" (SE) chapter of this manual.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.21(c)(2), §482.21(e)(1)			
LD.03.09.01, EP 5	The hospital conducts thorough and credible comprehensive systematic analyses (for example, root cause analyses) in response to sentinel events as described in the "Sentinel Event Policy" (SE) chapter of this manual. CoPs: §482.21(a)(2), §482.21(c)(2), §482.21(e)(1)	Moved	NPG.02.03.01, EP 5	The hospital conducts thorough and credible comprehensive systematic analyses (for example, root cause analyses) in response to sentinel events as described in the "Sentinel Event Policy" (SE) chapter of this manual.
LD.03.09.01, EP 6	The leaders make support systems available for staff who have been involved in an adverse or sentinel event. Note: Support systems recognize that conscientious health care workers who are involved in sentinel events are themselves victims of the event and require support. Support systems provide staff with additional help and support as well as additional resources through the human resources function or an employee assistance program. Support systems also focus on the process rather than blaming the involved individuals. CoPs: §482.21(e)(1)	Moved and Revised	NPG.02.03.01, EP 6	The leaders make support systems available for staff who have been involved in an adverse or sentinel event. Note: Support systems recognize that health care workers who are involved in sentinel events may be negatively affected by the event and require support. Support systems provide staff with help and support as well as additional resources through the human resources function or an employee assistance program. Support systems also focus on the process rather than blaming the involved individuals.
LD.03.09.01, EP 7	At least every 18 months, the hospital selects one high-risk process and conducts a proactive risk assessment. Note: For suggested components, refer to the "Proactive Risk Assessment" section at the beginning of this chapter. CoPs: §482.21(c)(2), §482.21(e)(1)	Moved and Revised	NPG.02.03.01, EP 7	At least every 18 months, the hospital selects one high-risk process and conducts a proactive risk assessment. Note: For suggested components, refer to the Proactive Risk Assessment section at the beginning of this chapter.
LD.03.09.01, EP 8	To improve safety and to reduce the risk of medical errors, the hospital analyzes and uses information about system or process failures and the results of proactive risk assessments. CoPs: §482.21(a)(1), §482.21(b)(2)(i), §482.21(c)(2), §482.21(d)(1), §482.21(e)(1)	Moved and Revised	NPG.02.03.01, EP 8	To improve safety and to reduce the risk of medical errors, the hospital analyzes and uses information about system or process failures and the results of proactive risk assessments.
LD.03.09.01, EP 9	The leaders disseminate lessons learned from comprehensive systematic analyses (for example, root cause analyses), system or process failures, and the results of proactive risk assessments to all staff who provide services for the specific situation. CoPs: §482.21(c)(2), §482.21(e)(1)	Consolidation of LD.03.04.01, EP 1; LD.03.09.01, EP 9	NPG.02.03.01, EP 9	Communication processes are effective in doing the following: - Fostering the safety of the patient and their quality of care - Supporting a culture of safety and quality - Meeting the needs of internal and external users - Informing those who work in the hospital of changes in the environment - Disseminating lessons learned from comprehensive systematic analyses (for example, root cause analyses), system or process failures, and proactive risk assessments to all affected staff
LD.03.09.01, EP 10	At least once a year, the leaders provide governance with written reports on the following: - All system or process failures - The number and type of sentinel events - Whether the patients and the families were informed of the event - All actions taken to improve safety, both proactively and in response to actual occurrences - For hospitals that use Joint Commission accreditation for deemed status purposes: The determined number of distinct improvement projects to be conducted annually - All results of the analyses related to the adequacy of staffing CoPs: §482.21(c)(2), §482.21(d)(1), §482.21(d)(3), §482.21(e)(1), §482.21(e)(5)	Moved and Revised	NPG.12.06.01, EP 4	At least once a year, the leaders provide governance with written reports that include results of the analyses related to the adequacy of staffing.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
LD.03.09.01, EP 11	The leaders encourage external reporting of significant adverse events, including voluntary reporting programs in addition to mandatory programs. Note: Examples of voluntary programs include The Joint Commission Sentinel Event Database and the US Food and Drug Administration (FDA) MedWatch. Mandatory programs are often state initiated. CoPs: §482.21(d)(4)	Moved and Revised	NPG.02.03.01, EP 2	The leaders encourage external reporting of significant adverse events, including voluntary reporting programs in addition to mandatory programs. Note: Examples of voluntary programs include The Joint Commission Sentinel Event Database and the US Food and Drug Administration (FDA) MedWatch.
LD.03.10.01, EP 3	When clinical practice guidelines will be used in the design or modification of processes, the following occurs: - The hospital follows criteria to manage guideline selection and implementation. - The leaders of the hospital and the organized medical staff review, approve, and modify the clinical practice guidelines as needed. - The leaders of the hospital manage and evaluate the implementation of the guidelines. CoPs: §482.25(a), §482.28(b)(1), §482.51, §482.51(a), §482.53, §482.53, §482.54, §482.54, §482.56(b)(2), §482.57	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.04.01.01, EP 1	The hospital is licensed, is certified, or has a permit, in accordance with law and regulation, to provide the care, treatment, or services for which the hospital is seeking accreditation from The Joint Commission. Note 1: Each service location that performs laboratory testing (waived or nonwaived) must have a Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate as specified by the federal CLIA regulations (42 CFR 493.55 and 493.3) and applicable state law. Laboratory services meet the applicable requirements at 42 CFR 482.27. Note 2: For more information on how to obtain a CLIA certificate, see http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_Certificate_International_Laboratories.html. CoPs: §482.11(b)(1), §482.11(b)(2), §482.27, §482.27(a), §482.53(b)(3), §482.57(b)(2)	Moved and Revised	LD.13.01.01, EP 2	The hospital is licensed or approved as meeting the standards for licensing established by the state or responsible locality, in accordance with law and regulation to provide the care, treatment, or services for which the hospital is seeking accreditation from The Joint Commission. CoPs: §482.11(b)(1), §482.11(b)(2)
LD.04.01.01, EP 2	The hospital provides care, treatment, and services in accordance with licensure requirements, laws, and rules and regulations. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the Centers for Medicare & Medicaid Services' (CMS) definition of a hospital in accordance with 42 CFR 482.1(a)(1) and (b). (See Appendix A [AXA] for the language of this CMS requirement.) CoPs: §482.1(a)(1)(i), §482.1(a)(1)(ii), §482.1(b), §482.11(a), §482.12(d)(5), §482.12(d)(5) continued, §482.12(d)(5)(i), §482.12(d)(5)(ii), §482.12(d)(5)(iii), §482.12(d)(5)(iv), §482.12(d)(5)(v), §482.12(f)(1), §482.13(b)(3), §482.27, §482.56(b)(2)	Moved and Revised	LD.13.01.01, EP 1	The hospital provides care, treatment, and services in accordance with licensure requirements and federal, state, and local laws, rules, and regulations. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the Centers for Medicare & Medicaid Services' (CMS) definition of a hospital in accordance with 42 CFR 482.1(a)(1) and (b). (Refer to https://www.ecfr.gov/ for the language of this CMS requirement) CoPs: §482.1(a)(1)(i), §482.1(a)(1)(ii), §482.1(b), §482.11(a)
LD.04.01.01, EP 3	Leaders act on or comply with reports or recommendations from external authorized agencies, such as accreditation, certification, or regulatory bodies. CoPs: §482.12	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.04.01.01, EP 16	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes:	Moved and Revised	NPG.12.03.01, EP 1	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The psychiatric hospital does the following:

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	- The psychiatric hospital is primarily engaged in providing, by or under the supervision of a doctor of medicine or osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons. - The psychiatric hospital meets the Medicare Conditions of Participation specified in 42 CFR 482.1 through 482.23, and 42 CFR 482.25 through 482.57. - The psychiatric hospital maintains clinical records on all patients to determine the degree and intensity of treatments, as specified in 42 CFR 482.61. - The psychiatric hospital meets the staffing requirements specified in 42 CFR 482.62. CoPs: §482.60(a), §482.60(b), §482.60(c), §482.60(d), §482.61, §482.62			- Is primarily engaged in providing, by or under the supervision of a doctor of medicine or osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons. - Meets the Medicare Conditions of Participation specified in 42 CFR 482.1 through 482.23, and 42 CFR 482.25 through 482.57. - Meets the staffing requirements specified in 42 CFR 482.62. CoPs: §482.60(a), §482.60(b), §482.60(d)
LD.04.01.01, EP 17	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note 1: The hospital does not need to have a utilization review plan if either a Quality Improvement Organization (QIO) has assumed binding review for the hospital or the Centers for Medicare & Medicaid Services (CMS) has determined that the utilization review procedures established by the state under title XIX of the Social Security Act are superior to the procedures required in this section, and has required hospitals in that state to meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to "Appendix A: Medicare Requirements for Hospitals" (AXA). CoPs: §482.30, §482.30(a)(1), §482.30(a)(2), §482.30(b), §482.30(b)(1)(i), §482.30(b)(1)(ii), §482.30(b)(1)(ii)(A), §482.30(b)(1)(ii)(B), §482.30(b)(2), §482.30(b)(3)(i), §482.30(b)(3)(ii), §482.30(c)(1)(i), §482.30(c)(1)(ii), §482.30(c)(1)(iii), §482.30(c)(2), §482.30(c)(3), §482.30(c)(4)(i), §482.30(c)(4)(ii), §482.30(d)(1)(i), §482.30(d)(1)(ii), §482.30(d)(2), §482.30(d)(3), §482.30(e)(1), §482.30(e)(1)(i), §482.30(e)(1)(ii), §482.30(e)(2), §482.30(e)(3), §482.30(f)	Moved and Revised	LD.13.01.03, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan that provides for review of services provided by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. Note: The hospital does not need to have a utilization review plan if either a quality improvement organization (QIO) has assumed binding review for the hospital or the Centers for Medicare & Medicaid Services (CMS) has determined that the utilization review procedures established by the state under title XIX of the Social Security Act are superior to the procedures required in this section, and has required hospitals in that state to meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245. CoPs: §482.30, §482.30(a)(1), §482.30(a)(2)
LD.04.01.01, EP 18	For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself if either a Quality Improvement Organization (QIO) has assumed binding review for the hospital or the Centers for Medicare & Medicaid Services (CMS) has determined that the utilization review procedures established by the state under title XIX of the Social Security Act are superior to the procedures required in this section, and has required hospitals in that state to meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to "Appendix A: Medicare Requirements for Hospitals" (AXA). CoPs: §482.30(a)(1), §482.30(a)(2), §482.30(b), §482.30(b)(1)(i), §482.30(b)(1)(ii), §482.30(b)(1)(ii)(A), §482.30(b)(1)(ii)(B), §482.30(b)(2), §482.30(b)(3)(i), §482.30(b)(3)(ii), §482.30(c)(1)(i), §482.30(c)(1)(ii), §482.30(c)(1)(iii), §482.30(c)(2), §482.30(c)(3), §482.30(c)(4)(i), §482.30(c)(4)(ii), §482.30(d)(1)(i), §482.30(d)(1)(ii),	Split to LD.13.01.03, EP 2; LD.13.01.03, EP 3; LD.13.01.03, EP 4; LD.13.01.03, EP 5; LD.13.01.03, EP 6; LD.13.01.03, EP 7; LD.13.01.03, EP 8; LD.13.01.03, EP 9; LD.13.01.03, EP 10	LD.13.01.03, EP 2	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's utilization review plan provides for the review of Medicare and Medicaid patients with respect to the medical necessity of the following: - Admissions to the hospital - Duration of stays - Professional services provided, including drugs and biologicals Note 1: The hospital may perform reviews of admissions before, during, or after hospital admission. Note 2: The hospital may perform reviews on a sample basis, except for reviews of extended stay cases. CoPs: §482.30(c)(1), §482.30(c)(1)(i), §482.30(c)(1)(ii), §482.30(c)(1)(iii), §482.30(c)(2), §482.30(c)(3)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	§482.30(d)(2), §482.30(d)(3), §482.30(e)(1), §482.30(e)(1)(i), §482.30(e)(1)(ii), §482.30(e)(2), §482.30(e)(3), §482.30(f)			
LD.04.01.01, EP 18	For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself if either a Quality Improvement Organization (QIO) has assumed binding review for the hospital or the Centers for Medicare & Medicaid Services (CMS) has determined that the utilization review procedures established by the state under title XIX of the Social Security Act are superior to the procedures required in this section, and has required hospitals in that state to meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to "Appendix A: Medicare Requirements for Hospitals" (AXA). CoPs: §482.30(a)(1), §482.30(a)(2), §482.30(b), §482.30(b)(1)(i), §482.30(b)(1)(ii), §482.30(b)(1)(ii)(A), §482.30(b)(1)(ii)(B), §482.30(b)(2), §482.30(b)(3)(i), §482.30(b)(3)(ii), §482.30(c)(1)(i), §482.30(c)(1)(ii), §482.30(c)(1)(iii), §482.30(c)(2), §482.30(c)(3), §482.30(c)(4)(i), §482.30(c)(4)(ii), §482.30(d)(1)(i), §482.30(d)(1)(ii), §482.30(d)(2), §482.30(d)(3), §482.30(e)(1), §482.30(e)(1)(i), §482.30(e)(1)(ii), §482.30(e)(2), §482.30(e)(3), §482.30(f)	Split to LD.13.01.03, EP 2; LD.13.01.03, EP 3; LD.13.01.03, EP 4; LD.13.01.03, EP 5; LD.13.01.03, EP 6; LD.13.01.03, EP 7; LD.13.01.03, EP 8; LD.13.01.03, EP 9; LD.13.01.03, EP 10	LD.13.01.03, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review committee that is either a staff committee or a group outside the hospital established by the local medical society and some or all the hospitals in the locality or in a manner approved by the Centers for Medicare & Medicaid Services. Note: If, because of the small size of the hospital, it is impracticable to have a properly functioning staff committee, the utilization review committee is established by a group outside the hospital, as specified in 42 CFR 482.30(b)(1)(ii). CoPs: §482.30(b)(1)(i), §482.30(b)(1)(ii), §482.30(b)(1)(ii)(A), §482.30(b)(1)(ii)(B), §482.30(b)(2)
LD.04.01.01, EP 18	For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself if either a Quality Improvement Organization (QIO) has assumed binding review for the hospital or the Centers for Medicare & Medicaid Services (CMS) has determined that the utilization review procedures established by the state under title XIX of the Social Security Act are superior to the procedures required in this section, and has required hospitals in that state to meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to "Appendix A: Medicare Requirements for Hospitals" (AXA). CoPs: §482.30(a)(1), §482.30(a)(2), §482.30(b), §482.30(b)(1)(i), §482.30(b)(1)(ii), §482.30(b)(1)(ii)(A), §482.30(b)(1)(ii)(B), §482.30(b)(2), §482.30(b)(3)(i), §482.30(b)(3)(ii), §482.30(c)(1)(i), §482.30(c)(1)(ii), §482.30(c)(1)(iii), §482.30(c)(2), §482.30(c)(3), §482.30(c)(4)(i), §482.30(c)(4)(ii), §482.30(d)(1)(i), §482.30(d)(1)(ii), §482.30(d)(2), §482.30(d)(3), §482.30(e)(1), §482.30(e)(1)(i), §482.30(e)(1)(ii), §482.30(e)(2), §482.30(e)(3), §482.30(f)	Split to LD.13.01.03, EP 2; LD.13.01.03, EP 3; LD.13.01.03, EP 4; LD.13.01.03, EP 5; LD.13.01.03, EP 6; LD.13.01.03, EP 7; LD.13.01.03, EP 8; LD.13.01.03, EP 9; LD.13.01.03, EP 10	LD.13.01.03, EP 4	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's utilization review committee consists of two or more licensed practitioners, and at least two of the members of the committee are doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in 42 CFR 482.12(c)(1). Note: The committee or group's reviews are not conducted by any individual who has a direct financial interest (for example, an ownership interest) in that hospital or who was professionally involved in the care of the patient whose case is being reviewed. CoPs: §482.30(b), §482.30(b)(3), §482.30(b)(3)(i), §482.30(b)(3)(ii)
LD.04.01.01, EP 18	For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself if either a Quality Improvement Organization (QIO) has assumed binding review for the hospital or the Centers for Medicare & Medicaid Services (CMS) has determined that the utilization review procedures established by the state under title XIX of the Social Security Act are superior to the procedures required in this section, and has required hospitals in that state to meet the utilization review plan requirements under 42 CFR	Split to LD.13.01.03, EP 2; LD.13.01.03, EP 3; LD.13.01.03, EP 4; LD.13.01.03, EP 5; LD.13.01.03, EP 6; LD.13.01.03, EP 7; LD.13.01.03, EP 8; LD.13.01.03,	LD.13.01.03, EP 5	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's utilization review committee reviews professional services provided to determine medical necessity and to promote the most efficient use of available health facilities and services. CoPs: §482.30(f)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	456.50 through 42 CFR 456.245. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to "Appendix A: Medicare Requirements for Hospitals" (AXA). CoPs: §482.30(a)(1), §482.30(a)(2), §482.30(b), §482.30(b)(1)(i), §482.30(b)(1)(ii), §482.30(b)(1)(ii)(A), §482.30(b)(1)(ii)(B), §482.30(b)(2), §482.30(b)(3)(i), §482.30(b)(3)(ii), §482.30(c)(1)(i), §482.30(c)(1)(ii), §482.30(c)(1)(iii), §482.30(c)(2), §482.30(c)(3), §482.30(c)(4)(i), §482.30(c)(4)(ii), §482.30(d)(1)(i), §482.30(d)(1)(ii), §482.30(d)(2), §482.30(d)(3), §482.30(e)(1), §482.30(e)(1)(i), §482.30(e)(1)(ii), §482.30(e)(2), §482.30(e)(3), §482.30(f)	EP 9; LD.13.01.03, EP 10		
LD.04.01.01, EP 18	For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself if either a Quality Improvement Organization (QIO) has assumed binding review for the hospital or the Centers for Medicare & Medicaid Services (CMS) has determined that the utilization review procedures established by the state under title XIX of the Social Security Act are superior to the procedures required in this section, and has required hospitals in that state to meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to "Appendix A: Medicare Requirements for Hospitals" (AXA). CoPs: §482.30(a)(1), §482.30(a)(2), §482.30(b), §482.30(b)(1)(i), §482.30(b)(1)(ii), §482.30(b)(1)(ii)(A), §482.30(b)(1)(ii)(B), §482.30(b)(2), §482.30(b)(3)(i), §482.30(b)(3)(ii), §482.30(c)(1)(i), §482.30(c)(1)(ii), §482.30(c)(1)(iii), §482.30(c)(2), §482.30(c)(3), §482.30(c)(4)(i), §482.30(c)(4)(ii), §482.30(d)(1)(i), §482.30(d)(1)(ii), §482.30(d)(2), §482.30(d)(3), §482.30(e)(1), §482.30(e)(1)(i), §482.30(e)(1)(ii), §482.30(e)(2), §482.30(e)(3), §482.30(f)	Split to LD.13.01.03, EP 2; LD.13.01.03, EP 3; LD.13.01.03, EP 4; LD.13.01.03, EP 5; LD.13.01.03, EP 6; LD.13.01.03, EP 7; LD.13.01.03, EP 8; LD.13.01.03, EP 9; LD.13.01.03, EP 10	LD.13.01.03, EP 6	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital develops and implements a process to determine if an admission or continued stay is not medically necessary. This determination is made by one of the following: - One member of the utilization review committee if the licensed practitioner(s) responsible for the patient's care, as specified in 42 CFR 482.12(c), concurs with the determination or fails to present their views when afforded the opportunity - At least two members of the utilization review committee in all other cases Note: Before determining that an admission or continued stay is not medically necessary, the utilization review committee consults the licensed practitioner(s) responsible for the patient's care, as specified in 42 CFR 482.12(c), and affords the practitioner(s) the opportunity to present their views. CoPs: §482.30(d)(1)(i), §482.30(d)(1)(ii), §482.30(d)(2)
LD.04.01.01, EP 18	For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself if either a Quality Improvement Organization (QIO) has assumed binding review for the hospital or the Centers for Medicare & Medicaid Services (CMS) has determined that the utilization review procedures established by the state under title XIX of the Social Security Act are superior to the procedures required in this section, and has required hospitals in that state to meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to "Appendix A: Medicare Requirements for Hospitals" (AXA). CoPs: §482.30(a)(1), §482.30(a)(2), §482.30(b), §482.30(b)(1)(i), §482.30(b)(1)(ii), §482.30(b)(1)(ii)(A), §482.30(b)(1)(ii)(B), §482.30(b)(2), §482.30(b)(3)(i), §482.30(b)(3)(ii), §482.30(c)(1)(i), §482.30(c)(1)(ii), §482.30(c)(1)(iii), §482.30(c)(2), §482.30(c)(3), §482.30(c)(4)(i), §482.30(c)(4)(ii), §482.30(d)(1)(i), §482.30(d)(1)(ii), §482.30(d)(2), §482.30(d)(3), §482.30(e)(1), §482.30(e)(1)(i), §482.30(e)(1)(ii), §482.30(e)(2), §482.30(e)(3), §482.30(f)	Split to LD.13.01.03, EP 2; LD.13.01.03, EP 3; LD.13.01.03, EP 4; LD.13.01.03, EP 5; LD.13.01.03, EP 6; LD.13.01.03, EP 7; LD.13.01.03, EP 8; LD.13.01.03, EP 9; LD.13.01.03, EP 10	LD.13.01.03, EP 7	For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital is paid for inpatient hospital services under the prospective payment system set forth in 42 CFR Part 412, it conducts a review of duration of stays and a review of professional services as follows: - For duration of stays, the hospital reviews only cases that it determines to be outlier cases based on extended length of stay, as described in 42 CFR 412.80(a)(1)(i). - For professional services, the hospital reviews only cases that it determines to be outlier cases based on extraordinarily high costs, as described in 42 CFR 412.80(a)(1)(ii). CoPs: §482.30(c)(4), §482.30(c)(4)(i), §482.30(c)(4)(ii)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
LD.04.01.01, EP 18	For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself if either a Quality Improvement Organization (QIO) has assumed binding review for the hospital or the Centers for Medicare & Medicaid Services (CMS) has determined that the utilization review procedures established by the state under title XIX of the Social Security Act are superior to the procedures required in this section, and has required hospitals in that state to meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to "Appendix A: Medicare Requirements for Hospitals" (AXA). CoPs: §482.30(a)(1), §482.30(a)(2), §482.30(b), §482.30(b)(1)(i), §482.30(b)(1)(ii), §482.30(b)(1)(ii)(A), §482.30(b)(1)(ii)(B), §482.30(b)(2), §482.30(b)(3)(i), §482.30(b)(3)(ii), §482.30(c)(1)(i), §482.30(c)(1)(ii), §482.30(c)(1)(iii), §482.30(c)(2), §482.30(c)(3), §482.30(c)(4)(i), §482.30(c)(4)(ii), §482.30(d)(1)(i), §482.30(d)(1)(ii), §482.30(d)(2), §482.30(d)(3), §482.30(e)(1), §482.30(e)(1)(i), §482.30(e)(1)(ii), §482.30(e)(2), §482.30(e)(3), §482.30(f)	Split to LD.13.01.03, EP 2; LD.13.01.03, EP 3; LD.13.01.03, EP 4; LD.13.01.03, EP 5; LD.13.01.03, EP 6; LD.13.01.03, EP 7; LD.13.01.03, EP 8; LD.13.01.03, EP 9; LD.13.01.03, EP 10	LD.13.01.03, EP 8	For hospitals that use Joint Commission accreditation for deemed status purposes: In hospitals that are not paid under the prospective payment system, the utilization review (UR) committee periodically reviews, as specified in the UR plan, each current inpatient during a continuous period of extended duration. The scheduling of the periodic reviews may be the same for all cases or differ for different classes of cases. Note: The UR committee conducts its review no later than 7 days after the day required in the UR plan. CoPs: §482.30(e)(1), §482.30(e)(1)(i), §482.30(e)(1)(ii)
LD.04.01.01, EP 18	For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself if either a Quality Improvement Organization (QIO) has assumed binding review for the hospital or the Centers for Medicare & Medicaid Services (CMS) has determined that the utilization review procedures established by the state under title XIX of the Social Security Act are superior to the procedures required in this section, and has required hospitals in that state to meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to "Appendix A: Medicare Requirements for Hospitals" (AXA). CoPs: §482.30(a)(1), §482.30(a)(2), §482.30(b), §482.30(b)(1)(i), §482.30(b)(1)(ii), §482.30(b)(1)(ii)(A), §482.30(b)(1)(ii)(B), §482.30(b)(2), §482.30(b)(3)(i), §482.30(b)(3)(ii), §482.30(c)(1)(i), §482.30(c)(1)(ii), §482.30(c)(1)(iii), §482.30(c)(2), §482.30(c)(3), §482.30(c)(4)(i), §482.30(c)(4)(ii), §482.30(d)(1)(i), §482.30(d)(1)(ii), §482.30(d)(2), §482.30(d)(3), §482.30(e)(1), §482.30(e)(1)(i), §482.30(e)(1)(ii), §482.30(e)(2), §482.30(e)(3), §482.30(f)	Split to LD.13.01.03, EP 2; LD.13.01.03, EP 3; LD.13.01.03, EP 4; LD.13.01.03, EP 5; LD.13.01.03, EP 6; LD.13.01.03, EP 7; LD.13.01.03, EP 8; LD.13.01.03, EP 9; LD.13.01.03, EP 10	LD.13.01.03, EP 9	For hospitals that use Joint Commission accreditation for deemed status purposes: In hospitals paid under the prospective payment system, the utilization review (UR) committee reviews all cases where the extended length of stay exceeds the threshold criteria for the diagnosis, as described in 42 CFR 412.80 (a)(1)(i). The hospital is not required to review an extended stay that does not exceed the outlier threshold for the diagnosis. Note: The UR committee conducts its review no later than 7 days after the day required in the UR plan. CoPs: §482.30(e)(2), §482.30(e)(3)
LD.04.01.01, EP 18	For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan. Note 1: The hospital does not need to implement utilization review activities itself if either a Quality Improvement Organization (QIO) has assumed binding review for the hospital or the Centers for Medicare & Medicaid Services (CMS) has determined that the utilization review procedures established by the state under title XIX of the Social Security Act are superior to the procedures required in this section, and has required hospitals in that state to meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245. Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to	Split to LD.13.01.03, EP 2; LD.13.01.03, EP 3; LD.13.01.03, EP 4; LD.13.01.03, EP 5; LD.13.01.03, EP 6; LD.13.01.03, EP 7; LD.13.01.03, EP 8; LD.13.01.03, EP 9; LD.13.01.03, EP 10	LD.13.01.03, EP 10	For hospitals that use Joint Commission accreditation for deemed status purposes: If the utilization review committee determines that admission to or continued stay in the hospital is not medically necessary, the committee gives written notification to the hospital, the patient, and the licensed practitioner(s) responsible for the patient's care, as specified in 42 CFR 482.12(c), no later than 2 days after the determination. CoPs: §482.30(d)(3)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	"Appendix A: Medicare Requirements for Hospitals" (AXA). CoPs: §482.30(a)(1), §482.30(a)(2), §482.30(b), §482.30(b)(1)(i), §482.30(b)(1)(ii), §482.30(b)(1)(ii)(A), §482.30(b)(1)(ii)(B), §482.30(b)(2), §482.30(b)(3)(i), §482.30(b)(3)(ii), §482.30(c)(1)(i), §482.30(c)(1)(ii), §482.30(c)(1)(iii), §482.30(c)(2), §482.30(c)(3), §482.30(c)(4)(i), §482.30(c)(4)(ii), §482.30(d)(1)(i), §482.30(d)(1)(ii), §482.30(d)(2), §482.30(d)(3), §482.30(e)(1), §482.30(e)(1)(i), §482.30(e)(1)(ii), §482.30(e)(2), §482.30(e)(3), §482.30(f)			
LD.04.01.03, EP 1	Leaders solicit comments from those who work in the hospital when developing the operational and capital budgets. CoPs: §482.12(d)(7)(ii)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.04.01.03, EP 3	The operating budget reflects the hospital's goals and objectives. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the Centers for Medicare & Medicaid Services' (CMS) Institutional Plan and Budget requirements in accordance with 42 CFR 482.12(d). (See Appendix A [AXA] for the language of this CMS requirement.) CoPs: §482.12(d)(2), §482.12(d)(3), §482.12(d)(4), §482.12(d)(4)(i), §482.12(d)(4)(ii), §482.12(d)(4)(iii), §482.12(d)(5) continued, §482.12(d)(5)(i), §482.12(d)(5)(ii), §482.12(d)(5)(iii), §482.12(d)(5)(iv), §482.12(d)(5)(v)	Split to LD.13.01.05, EP 2; LD.13.01.05, EP 3; LD.13.01.05, EP 4	LD.13.01.05, EP 2	For hospitals that use Joint Commission accreditation for deemed status purposes: The institutional plan includes and identifies in detail the objective of, and the anticipated sources of financing for, each anticipated capital expenditure in excess of $600,000 (or a lesser amount that is established, in accordance with section 1122(g)(1) of the Social Security Act [42 U.S.C. 1320a–1(g)(1)], by the state in which the hospital is located) that relates to any of the following: - Acquisition of land - Improvement of land, buildings, and equipment - Replacement, modernization, and expansion of buildings and equipment CoPs: §482.12(d)(4), §482.12(d)(4)(i), §482.12(d)(4)(ii), §482.12(d)(4)(iii)
LD.04.01.03, EP 3	The operating budget reflects the hospital's goals and objectives. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the Centers for Medicare & Medicaid Services' (CMS) Institutional Plan and Budget requirements in accordance with 42 CFR 482.12(d). (See Appendix A [AXA] for the language of this CMS requirement.) CoPs: §482.12(d)(2), §482.12(d)(3), §482.12(d)(4), §482.12(d)(4)(i), §482.12(d)(4)(ii), §482.12(d)(4)(iii), §482.12(d)(5) continued, §482.12(d)(5)(i), §482.12(d)(5)(ii), §482.12(d)(5)(iii), §482.12(d)(5)(iv), §482.12(d)(5)(v)	Split to LD.13.01.05, EP 2; LD.13.01.05, EP 3; LD.13.01.05, EP 4	LD.13.01.05, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes: The institutional plan is prepared by representatives of the hospital's governing body, the administrative staff, and the medical staff under the direction of the governing body. The institutional plan is reviewed and updated annually. CoPs: §482.12(d)(6), §482.12(d)(7)(i), §482.12(d)(7)(ii)
LD.04.01.03, EP 3	The operating budget reflects the hospital's goals and objectives. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the Centers for Medicare & Medicaid Services' (CMS) Institutional Plan and Budget requirements in accordance with 42 CFR 482.12(d). (See Appendix A [AXA] for the language of this CMS requirement.) CoPs: §482.12(d)(2), §482.12(d)(3), §482.12(d)(4), §482.12(d)(4)(i), §482.12(d)(4)(ii), §482.12(d)(4)(iii), §482.12(d)(5) continued, §482.12(d)(5)(i), §482.12(d)(5)(ii), §482.12(d)(5)(iii), §482.12(d)(5)(iv), §482.12(d)(5)(v)	Split to LD.13.01.05, EP 2; LD.13.01.05, EP 3; LD.13.01.05, EP 4	LD.13.01.05, EP 4	For hospitals that use Joint Commission accreditation for deemed status purposes: The institutional plan is submitted for review to the planning agency designated in accordance with section 1122(b) of the Social Security Act (42 U.S.C. 1320a–1(b)), or if an agency is not designated, to the appropriate health planning agency in the state. A capital expenditure is not subject to section 1122 review if 75 percent of the health care facility's patients who are expected to use the service for which the capital expenditure is made are individuals enrolled in a health maintenance organization (HMO) or competitive medical plan (CMP) that meets the requirements of section 1876(b) of the Social Security Act (42 U.S.C. 1395mm(b)), and if the US Department of Health and Human Services determines that the capital expenditure is for services and facilities that are needed by the HMO or CMP in order to operate efficiently and economically and that are not otherwise readily accessible to the HMO or CMP because of one of the following: - The facilities do not provide common services at the same site. - The facilities are not available under a contract of reasonable duration. - Full and equal medical staff privileges in the facilities are not available.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
				- 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. CoPs: §482.12(d)(5), §482.12(d)(5)(i), §482.12(d)(5)(ii), §482.12(d)(5)(iii), §482.12(d)(5)(iv), §482.12(d)(5)(v)
LD.04.01.03, EP 4	The governing body approves an annual operating budget and, when needed, a long-term capital expenditure plan. CoPs: §482.12(d)(1), §482.12(d)(2), §482.12(d)(3), §482.12(d)(4), §482.12(d)(4)(i), §482.12(d)(4)(ii), §482.12(d)(4)(iii), §482.12(d)(6)	Split to LD.13.01.05, EP 2; LD.13.01.05, EP 3; LD.13.01.05, EP 4	LD.13.01.05, EP 2	For hospitals that use Joint Commission accreditation for deemed status purposes: The institutional plan includes and identifies in detail the objective of, and the anticipated sources of financing for, each anticipated capital expenditure in excess of $600,000 (or a lesser amount that is established, in accordance with section 1122(g)(1) of the Social Security Act [42 U.S.C. 1320a–1(g)(1)], by the state in which the hospital is located) that relates to any of the following: - Acquisition of land - Improvement of land, buildings, and equipment - Replacement, modernization, and expansion of buildings and equipment CoPs: §482.12(d)(4), §482.12(d)(4)(i), §482.12(d)(4)(ii), §482.12(d)(4)(iii)
LD.04.01.03, EP 4	The governing body approves an annual operating budget and, when needed, a long-term capital expenditure plan. CoPs: §482.12(d)(1), §482.12(d)(2), §482.12(d)(3), §482.12(d)(4), §482.12(d)(4)(i), §482.12(d)(4)(ii), §482.12(d)(4)(iii), §482.12(d)(6)	Split to LD.13.01.05, EP 2; LD.13.01.05, EP 3; LD.13.01.05, EP 4	LD.13.01.05, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes: The institutional plan is prepared by representatives of the hospital's governing body, the administrative staff, and the medical staff under the direction of the governing body. The institutional plan is reviewed and updated annually. CoPs: §482.12(d)(6), §482.12(d)(7)(i), §482.12(d)(7)(ii)
LD.04.01.03, EP 4	The governing body approves an annual operating budget and, when needed, a long-term capital expenditure plan. CoPs: §482.12(d)(1), §482.12(d)(2), §482.12(d)(3), §482.12(d)(4), §482.12(d)(4)(i), §482.12(d)(4)(ii), §482.12(d)(4)(iii), §482.12(d)(6)	Split to LD.13.01.05, EP 2; LD.13.01.05, EP 3; LD.13.01.05, EP 4	LD.13.01.05, EP 4	For hospitals that use Joint Commission accreditation for deemed status purposes: The institutional plan is submitted for review to the planning agency designated in accordance with section 1122(b) of the Social Security Act (42 U.S.C. 1320a–1(b)), or if an agency is not designated, to the appropriate health planning agency in the state. A capital expenditure is not subject to section 1122 review if 75 percent of the health care facility's patients who are expected to use the service for which the capital expenditure is made are individuals enrolled in a health maintenance organization (HMO) or competitive medical plan (CMP) that meets the requirements of section 1876(b) of the Social Security Act (42 U.S.C. 1395mm(b)), and if the US Department of Health and Human Services determines that the capital expenditure is for services and facilities that are needed by the HMO or CMP in order to operate efficiently and economically and that are not otherwise readily accessible to the HMO or CMP because of one of the following: - The facilities do not provide common services at the same site. - The facilities are not available under a contract of reasonable duration. - Full and equal medical staff privileges in the facilities are not available. - Arrangements with these facilities are not administratively feasible. - The purchase of these services is more costly than if the HMO or CMP provided the services directly. CoPs: §482.12(d)(5), §482.12(d)(5)(i), §482.12(d)(5)(ii), §482.12(d)(5)(iii), §482.12(d)(5)(iv), §482.12(d)(5)(v)
LD.04.01.05, EP 2	Programs, services, sites, or departments providing patient care are directed by one or more qualified professionals or by a qualified licensed practitioner with clinical privileges.	Consolidation of HR.01.06.01, EP 1; LD.04.01.05, EP 2; LD.04.01.05, EP 3	HR.11.02.01, EP 3	The director of rehabilitation services has the knowledge, experience, and capabilities to supervise and administer the services. CoPs: §482.56(a)(1)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.24, §482.28, §482.28(a)(1)(i), §482.28(a)(1)(ii), §482.28(a)(1)(iii), §482.51(a)(1), §482.56(a)(1), §482.62(f)			
LD.04.01.05, EP 3	The hospital defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: This includes the full-time employee who directs and manages dietary services. CoPs: §482.24, §482.25(a), §482.26(c)(1), §482.28, §482.28(a)(1), §482.28(a)(1)(i), §482.28(a)(1)(ii), §482.28(a)(1)(iii), §482.56(a)(1), §482.62(b)(2), §482.62(f)	Split to HR.11.02.01, EP 3; NPG.12.01.01, EP 7; NPG.12.01.01, EP 8	HR.11.02.01, EP 3	The director of rehabilitation services has the knowledge, experience, and capabilities to supervise and administer the services. CoPs: §482.56(a)(1)
LD.04.01.05, EP 3	The hospital defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: This includes the full-time employee who directs and manages dietary services. CoPs: §482.24, §482.25(a), §482.26(c)(1), §482.28, §482.28(a)(1), §482.28(a)(1)(i), §482.28(a)(1)(ii), §482.28(a)(1)(iii), §482.56(a)(1), §482.62(b)(2), §482.62(f)	Split to HR.11.02.01, EP 3; NPG.12.01.01, EP 7; NPG.12.01.01, EP 8	NPG.12.01.01, EP 7	The hospital has dietetic services that are directed and adequately staffed by qualified personnel. Note: For hospitals that provide dietetic services through contracted services, the contracted service has a dietician who serves the hospital full-time, part-time, or on a consultant basis and acts as a liaison to hospital medical staff for recommendations on dietetic policies that affect patient care, treatment, and services. CoPs: §482.28
LD.04.01.05, EP 3	The hospital defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: This includes the full-time employee who directs and manages dietary services. CoPs: §482.24, §482.25(a), §482.26(c)(1), §482.28, §482.28(a)(1), §482.28(a)(1)(i), §482.28(a)(1)(ii), §482.28(a)(1)(iii), §482.56(a)(1), §482.62(b)(2), §482.62(f)	Split to HR.11.02.01, EP 3; NPG.12.01.01, EP 7; NPG.12.01.01, EP 8	NPG.12.01.01, EP 8	The hospital has a full-time employee, qualified through education, training, or experience, who serves as director to oversee the daily management of food and dietetic services. CoPs: §482.28(a)(1)(i), §482.28(a)(1)(ii), §482.28(a)(1)(iii)
LD.04.01.05, EP 4	Staff are held accountable for their responsibilities. CoPs: §482.12, §482.21(e)(4)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.04.01.05, EP 5	Leaders provide for the coordination of care, treatment, and services among the hospital's different programs, services, sites, or departments. CoPs: §482.54(a), §482.55(a)(2)	Moved and Revised	LD.13.03.01, EP 10	If the hospital provides outpatient surgical services, the services are consistent with the quality of inpatient surgical care. CoPs: §482.51
LD.04.01.05, EP 6	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's emergency services are directed and supervised by a qualified member of the medical staff. CoPs: §482.55(a)(1), §482.55(b)(1)	Moved and Revised	LD.13.01.07, EP 1	The hospital's emergency services are supervised by a qualified member of the medical staff. CoPs: §482.55(b)(1)
LD.04.01.05, EP 7	For hospitals that use Joint Commission accreditation for deemed status purposes: A qualified doctor of medicine or osteopathy directs the following services: - Anesthesia - Nuclear medicine - Respiratory care CoPs: §482.52, §482.53(a)(1), §482.57(a)(1)	Moved and Revised	LD.13.01.07, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes: A qualified doctor of medicine or osteopathy directs the following services, when provided: - Anesthesia - Nuclear medicine - Respiratory care Note 1: The anesthesia service is responsible for all anesthesia administered in the hospital.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
				Note 2: For respiratory care services, the director may serve on either a full-time or part-time basis. CoPs: §482.52, §482.53(a)(1), §482.57(a)(1)
LD.04.01.05, EP 8	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital assigns one or more individuals who are responsible for outpatient services. CoPs: §482.54(b)(1)	Moved and Revised	LD.13.01.07, EP 2	The hospital assigns one or more individuals who are responsible for outpatient services. CoPs: §482.54(b)(1)
LD.04.01.05, EP 9	For hospitals that use Joint Commission accreditation for deemed status purposes: The anesthesia service is responsible for all anesthesia administered in the hospital. CoPs: §482.52	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.04.01.05, EP 10	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a director of social work services who monitors and evaluates the social work services furnished. Note: Social work services are furnished in accordance with accepted standards of practice and established policies and procedures. CoPs: §482.62(f), §482.62(g)(1)	Moved and Revised	NPG.12.03.01, EP 6	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a director of social services who monitors and evaluates the quality and appropriateness of social services. Note: Social services are provided in accordance with accepted standards of practice and established policies and procedures. CoPs: §482.62(f)
LD.04.01.05, EP 25	The hospital designates an individual to serve as the radiation safety officer who is responsible for making certain that radiologic services are provided in accordance with law, regulation, and organizational policy. This individual has the necessary authority and leadership support to do the following: - Monitor and verify compliance with established radiation safety practices (including oversight of dosimetry monitoring) - Provide recommendations for improved radiation safety - Intervene as needed to stop unsafe practices - Implement corrective action	Moved and Revised	NPG.13.02.01, EP 1	The hospital designates an individual to serve as the radiation safety officer who is responsible for making certain that radiologic services are provided in accordance with law, regulation, and hospital policy. This individual has the necessary authority and leadership support to do the following: - Monitor and verify compliance with established radiation safety practices (including oversight of dosimetry monitoring) - Provide recommendations for improved radiation safety - Intervene as needed to stop unsafe practices - Implement corrective action
LD.04.01.06, EP 1	For hospitals that elect The Joint Commission Primary Care Medical Home option: Primary care clinicians have the educational background and broad-based knowledge and experience necessary to handle most medical and other health care needs of the patients who selected them. This includes resolving conflicting recommendations for care.	Moved and Revised	MS.16.01.03, EP 5	For hospitals that elect The Joint Commission Primary Care Medical Home option: Primary care clinicians have the educational background and broad-based knowledge and experience necessary to handle most medical and other health care needs of the patients who selected them. This includes resolving conflicting recommendations for care.
LD.04.01.07, EP 1	Leaders review, approve, and manage the implementation of policies and procedures that guide and support patient care, treatment, and services. CoPs: §482.12, §482.23(c)(2), §482.23(c)(4), §482.25, §482.26(b), §482.51(a)(3), §482.51(b), §482.52(b), §482.55(a)(3), §482.57(b), §482.57(b)(1), §482.62(f)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.04.01.10, EP 2	Senior hospital leadership directs implementation of selected hospitalwide improvements in emergency management based on the following: - Examine the emergency management planning reviews at least every two years - Review of the evaluations of all emergency response exercises and all responses to actual emergencies - Determination of which emergency management improvements will be prioritized for implementation, recognizing that some emergency management improvements might be a lower priority and not taken up in the near term	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
LD.04.01.11, EP 3	The interior and exterior space provided for care, treatment, and services meets the needs of patients. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The extent and complexity of facilities must be determined by the services offered. CoPs: §482.41(d), §482.41(d)(1), §482.41(d)(3)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.04.01.11, EP 4	The grounds, equipment, and special activity areas are safe, maintained, and supervised.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.04.01.11, EP 5	The leaders provide for equipment, information systems, supplies, and other resources. CoPs: §482.21(e)(4), §482.41(d)(2), §482.51(b), §482.51(b)(4), §482.52(a), §482.53(a), §482.53(c), §482.54, §482.54, §482.56, §482.56(a), §482.57(a)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.04.02.03, EP 1	The hospital develops and implements a process that allows staff, patients, and families to address ethical issues or issues prone to conflict.	Moved and Revised	NPG.02.02.01, EP 5	The hospital develops and implements a process that allows staff, patients, and families to address ethical issues or issues prone to conflict.
LD.04.02.03, EP 5	Care, treatment, and services are provided based on patient needs, regardless of compensation or financial risk-sharing with those who work in the hospital.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.04.02.03, EP 13	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Each resident who is entitled to Medicaid benefits is informed in writing, either at the time of admission or when the resident becomes eligible for Medicaid, of the following: - The items and services included in the state plan for which the resident may not be charged - Those items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services CoPs: §482.58(b)(1), §483.10(g)(17)(i)(A), §483.10(g)(17)(i)(B)	Moved and Revised	LD.13.02.01, EP 2	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Each Medicaid-eligible resident is informed in writing, either at the time of admission or when the resident becomes eligible for Medicaid, of the following: - Items and services included in the state plan for which the resident may not be charged - Items and services that the hospital offers, those for which the resident may be charged, and the amount of charges for those services Note: The hospital informs residents when changes are made to the items and services. CoPs: §482.58(b)(1), §483.10(g)(17)(i)(A), §483.10(g)(17)(i)(B), §483.10(g)(17)(ii)
LD.04.02.03, EP 14	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Residents are informed when changes are made to the services that are specified in LD.04.02.03, EP 13. CoPs: §482.58(b)(1), §483.10(g)(17)(ii)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.04.02.03, EP 16	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Residents are informed before or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services not covered under Medicare or by the facility's per diem rate. CoPs: §482.58(b)(1), §483.10(g)(18)	Moved and Revised	LD.13.02.01, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital informs residents before or at the time of admission, and periodically during the resident's stay, of services available in the hospital and of charges for those services not covered under Medicare, Medicaid, or by the hospital's per diem rate. CoPs: §482.58(b)(1), §483.10(g)(18)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
LD.04.03.01, EP 1	The needs of the population(s) served guide decisions about which services will be provided directly or through referral, consultation, contractual arrangements, or other agreements. Note: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: If medical and surgical diagnostic and treatment services are not available within the hospital, the hospital has an agreement with an outside source for these services to make sure that the services are immediately available or an agreement needs to be established for transferring patients to a general hospital that participates in the Medicare program. CoPs: §482.26, §482.26(a), §482.27, §482.51(b), §482.54, §482.54, §482.56, §482.57, §482.62(c)	Consolidation of LD.04.03.01, EP 1; LD.04.03.01, EP 3	LD.13.01.05, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has an overall institutional plan that meets the following conditions: - The plan includes an annual operating budget that is prepared according to generally accepted accounting principles and that has all anticipated income and expenses. This provision does not require that the budget identify item by item the components of each anticipated income or expense. - The plan provides for capital expenditures for at least a 3-year period, including the year in which the operating budget is applicable. CoPs: §482.12(d)(1), §482.12(d)(2), §482.12(d)(3)
LD.04.03.01, EP 2	The hospital provides essential services, including the following: - Diagnostic radiology - Dietary - Emergency - Medical records - Nuclear medicine - Nursing care - Pathology and clinical laboratory - Pharmaceutical - Physical rehabilitation - Respiratory care - Social work Note 1: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The diagnostic radiology services provided by the hospital, as well as staff qualifications, meet professionally approved standards. CoPs: §482.12(f)(1), §482.23, §482.24, §482.24(a), §482.25, §482.25, §482.26, §482.26(a), §482.27, §482.27(a), §482.28, §482.53, §482.53, §482.55, §482.56, §482.57	Split to LD.13.03.01, EP 1; LD.13.03.01, EP 2; LD.13.03.01, EP 5; LD.13.03.01, EP 7; LD.13.03.01, EP 8; NPG.12.01.01, EP 6; NPG.12.01.01, EP 7; NPG.13.02.01, EP 2	LD.13.03.01, EP 1	The hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic CoPs: §482.24, §482.24(a), §482.26, §482.26(a), §482.27, §482.27(a), §482.28, §482.51, §482.51(a), §482.51(b), §482.52, §482.52(a), §482.52(b), §482.53, §482.53(a), §482.54, §482.55, §482.55(a)(1), §482.55(a)(2), §482.57, §482.57(a)
LD.04.03.01, EP 2	The hospital provides essential services, including the following: - Diagnostic radiology - Dietary - Emergency - Medical records - Nuclear medicine - Nursing care - Pathology and clinical laboratory - Pharmaceutical - Physical rehabilitation - Respiratory care	Split to LD.13.03.01, EP 1; LD.13.03.01, EP 2; LD.13.03.01, EP 5; LD.13.03.01, EP 7; LD.13.03.01, EP 8; NPG.12.01.01, EP 6; NPG.12.01.01, EP 7; NPG.13.02.01, EP 2	LD.13.03.01, EP 2	The hospital has an organized nursing service, with a plan of administrative authority and delineation of responsibility for patient care, that provides 24-hour nursing services. Note: For hospitals that use The Joint Commission for deemed-status purposes: Rural hospitals with a 24-hour nursing waiver granted under 42 CFR 488.54(c) are not required to have 24-hour nursing services. CoPs: §482.23, §482.23(a), §482.23(b)(1)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	- Social work Note 1: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to "Appendix A: Medicare Requirements for Hospitals" (AXA). Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The diagnostic radiology services provided by the hospital, as well as staff qualifications, meet professionally approved standards. CoPs: §482.12(f)(1), §482.23, §482.24, §482.24(a), §482.25, §482.25, §482.26, §482.26(a), §482.27, §482.27(a), §482.28, §482.53, §482.53, §482.55, §482.56, §482.57			
LD.04.03.01, EP 2	The hospital provides essential services, including the following: - Diagnostic radiology - Dietary - Emergency - Medical records - Nuclear medicine - Nursing care - Pathology and clinical laboratory - Pharmaceutical - Physical rehabilitation - Respiratory care - Social work Note 1: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to "Appendix A: Medicare Requirements for Hospitals" (AXA). Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The diagnostic radiology services provided by the hospital, as well as staff qualifications, meet professionally approved standards. CoPs: §482.12(f)(1), §482.23, §482.24, §482.24(a), §482.25, §482.25, §482.26, §482.26(a), §482.27, §482.27(a), §482.28, §482.53, §482.53, §482.55, §482.56, §482.57	Split to LD.13.03.01, EP 1; LD.13.03.01, EP 2; LD.13.03.01, EP 5; LD.13.03.01, EP 7; LD.13.03.01, EP 8; NPG.12.01.01, EP 6; NPG.12.01.01, EP 7; NPG.13.02.01, EP 2	LD.13.03.01, EP 5	If the hospital provides outpatient services, the services are integrated with inpatient services. CoPs: §482.54(a)
LD.04.03.01, EP 2	The hospital provides essential services, including the following: - Diagnostic radiology - Dietary - Emergency - Medical records - Nuclear medicine - Nursing care - Pathology and clinical laboratory	Split to LD.13.03.01, EP 1; LD.13.03.01, EP 2; LD.13.03.01, EP 5; LD.13.03.01, EP 7; LD.13.03.01, EP 8; NPG.12.01.01, EP 6; NPG.12.01.01,	LD.13.03.01, EP 7	If the hospital provides emergency services, the services are organized under the direction of a qualified member of the medical staff, and are integrated with other departments of the hospital. CoPs: §482.55, §482.55(a)(1), §482.55(a)(2)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	- Pharmaceutical - Physical rehabilitation - Respiratory care - Social work Note 1: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The diagnostic radiology services provided by the hospital, as well as staff qualifications, meet professionally approved standards. CoPs: §482.12(f)(1), §482.23, §482.24, §482.24(a), §482.25, §482.25, §482.26, §482.26(a), §482.27, §482.27(a), §482.28, §482.53, §482.53, §482.55, §482.56, §482.57	EP 7; NPG.13.02.01, EP 2		
LD.04.03.01, EP 2	The hospital provides essential services, including the following: - Diagnostic radiology - Dietary - Emergency - Medical records - Nuclear medicine - Nursing care - Pathology and clinical laboratory - Pharmaceutical - Physical rehabilitation - Respiratory care - Social work Note 1: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to “Appendix A: Medicare Requirements for Hospitals” (AXA). Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The diagnostic radiology services provided by the hospital, as well as staff qualifications, meet professionally approved standards. CoPs: §482.12(f)(1), §482.23, §482.24, §482.24(a), §482.25, §482.25, §482.26, §482.26(a), §482.27, §482.27(a), §482.28, §482.53, §482.53, §482.55, §482.56, §482.57	Split to LD.13.03.01, EP 1; LD.13.03.01, EP 2; LD.13.03.01, EP 5; LD.13.03.01, EP 7; LD.13.03.01, EP 8; NPG.12.01.01, EP 6; NPG.12.01.01, EP 7; NPG.13.02.01, EP 2	LD.13.03.01, EP 8	For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. CoPs: §482.12(f)(1)
LD.04.03.01, EP 2	The hospital provides essential services, including the following: - Diagnostic radiology - Dietary - Emergency - Medical records	Split to LD.13.03.01, EP 1; LD.13.03.01, EP 2; LD.13.03.01, EP 5; LD.13.03.01, EP 7; LD.13.03.01,	NPG.12.01.01, EP 6	The hospital has a medical record service that has administrative responsibility for medical records. The hospital employs adequate staff to support the prompt completion, filing, and retrieval of records. CoPs: §482.24(a)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	- Nuclear medicine - Nursing care - Pathology and clinical laboratory - Pharmaceutical - Physical rehabilitation - Respiratory care - Social work Note 1: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to "Appendix A: Medicare Requirements for Hospitals" (AXA). Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The diagnostic radiology services provided by the hospital, as well as staff qualifications, meet professionally approved standards. CoPs: §482.12(f)(1), §482.23, §482.24, §482.24(a), §482.25, §482.25, §482.26, §482.26(a), §482.27, §482.27(a), §482.28, §482.53, §482.53, §482.55, §482.56, §482.57	EP 8; NPG.12.01.01, EP 6; NPG.12.01.01, EP 7; NPG.13.02.01, EP 2		
LD.04.03.01, EP 2	The hospital provides essential services, including the following: - Diagnostic radiology - Dietary - Emergency - Medical records - Nuclear medicine - Nursing care - Pathology and clinical laboratory - Pharmaceutical - Physical rehabilitation - Respiratory care - Social work Note 1: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to "Appendix A: Medicare Requirements for Hospitals" (AXA). Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The diagnostic radiology services provided by the hospital, as well as staff qualifications, meet professionally approved standards. CoPs: §482.12(f)(1), §482.23, §482.24, §482.24(a), §482.25, §482.25, §482.26, §482.26(a), §482.27, §482.27(a), §482.28, §482.53, §482.53, §482.55, §482.56, §482.57	Split to LD.13.03.01, EP 1; LD.13.03.01, EP 2; LD.13.03.01, EP 5; LD.13.03.01, EP 7; LD.13.03.01, EP 8; NPG.12.01.01, EP 6; NPG.12.01.01, EP 7; NPG.13.02.01, EP 2	NPG.12.01.01, EP 7	The hospital has dietetic services that are directed and adequately staffed by qualified personnel. Note: For hospitals that provide dietetic services through contracted services, the contracted service has a dietician who serves the hospital full-time, part-time, or on a consultant basis and acts as a liaison to hospital medical staff for recommendations on dietetic policies that affect patient care, treatment, and services. CoPs: §482.28
LD.04.03.01, EP 2	The hospital provides essential services, including the following: - Diagnostic radiology	Split to LD.13.03.01, EP 1; LD.13.03.01,	NPG.13.02.01, EP 2	The hospital provides radiology services that meet safety standards approved by nationally recognized professional organizations. At a minimum, diagnostic radiology

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	- Dietary - Emergency - Medical records - Nuclear medicine - Nursing care - Pathology and clinical laboratory - Pharmaceutical - Physical rehabilitation - Respiratory care - Social work Note 1: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: If emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to "Appendix A: Medicare Requirements for Hospitals" (AXA). Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The diagnostic radiology services provided by the hospital, as well as staff qualifications, meet professionally approved standards. CoPs: §482.12(f)(1), §482.23, §482.24, §482.24(a), §482.25, §482.25, §482.26, §482.26(a), §482.27, §482.27(a), §482.28, §482.53, §482.53, §482.55, §482.56, §482.57	EP 2; LD.13.03.01, EP 5; LD.13.03.01, EP 7; LD.13.03.01, EP 8; NPG.12.01.01, EP 6; NPG.12.01.01, EP 7; NPG.13.02.01, EP 2		services are maintained and available at all times the hospital provides services, including emergency services. Note: If the hospital also provides other radiology services, such as therapeutic radiology, the requirements of this element of performance also apply to those services.
LD.04.03.01, EP 3	The hospital provides at least one of the following acute care clinical services: - Child, adolescent, or adult psychiatry - Medicine - Obstetrics and gynecology - Pediatrics - Treatment for addictions - Surgery Note: When the hospital provides surgical or obstetric services, anesthesia services are also available. CoPs: §482.51, §482.51(a)	Consolidation of LD.04.03.01, EP 1; LD.04.03.01, EP 3	LD.13.01.05, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has an overall institutional plan that meets the following conditions: - The plan includes an annual operating budget that is prepared according to generally accepted accounting principles and that has all anticipated income and expenses. This provision does not require that the budget identify item by item the components of each anticipated income or expense. - The plan provides for capital expenditures for at least a 3-year period, including the year in which the operating budget is applicable. CoPs: §482.12(d)(1), §482.12(d)(2), §482.12(d)(3)
LD.04.03.01, EP 14	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The psychiatric hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities. Note: The therapeutic activities program is appropriate to the needs and interests of patients and is directed toward restoring and maintaining optimal levels of physical and psychosocial functioning. CoPs: §482.62(d), §482.62(e), §482.62(f), §482.62(g), §482.62(g)(1)	Moved and Revised	LD.13.03.01, EP 18	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities to meet the needs of its patients. Note: The therapeutic activities program is appropriate to the needs and interests of patients and is directed toward restoring and maintaining optimal levels of physical and psychosocial functioning. CoPs: §482.62(e), §482.62(g), §482.62(g)(1)
LD.04.03.01, EP 26	For hospitals that use Joint Commission accreditation for deemed status purposes: Emergency laboratory services are available 24 hours a day, 7 days a week. CoPs: §482.27(a)(1)	Moved and Revised	LD.13.03.01, EP 13	Emergency laboratory services are available 24 hours a day, 7 days a week. CoPs: §482.27(a)(1)
LD.04.03.07, EP 1	Variances in staff, setting, or payment source do not affect outcomes of care, treatment, and services in a negative way.	Deleted EP - Replaced with more	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.51	direct EP(s) or moved to guidance within SPG		
LD.04.03.09, EP 1	Clinical leaders and medical staff have an opportunity to provide advice about the sources of clinical services to be provided through contractual agreement. CoPs: §482.22(a)(4), §482.28	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.04.03.09, EP 2	The hospital describes, in writing, the nature and scope of services provided through contractual agreements. CoPs: §482.12(a)(8), §482.12(a)(9), §482.12(e), §482.12(e)(2), §482.21, §482.22(a)(4), §482.22(a)(4)(i), §482.23(b)(6), §482.26, §482.26(a), §482.27(a), §482.27(a)(2), §482.27(b)(3), §482.27(b)(3)(i), §482.27(b)(3)(ii), §482.27(b)(3)(iii), §482.28, §482.62(c)	Moved and Revised	LD.13.03.03, EP 1	The hospital maintains a list of all contracted services, including the scope and nature of the services provided. CoPs: §482.12(e), §482.12(e)(2)
LD.04.03.09, EP 3	Designated leaders approve contractual agreements. CoPs: §482.12(a)(9), §482.12(e), §482.22(a)(4), §482.28	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.04.03.09, EP 4	Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: In most cases, each physician and other licensed practitioner providing services through a contractual agreement must be credentialed and privileged by the hospital using their services following the process described in the "Medical Staff" (MS) chapter. Note 2: For hospitals that do not use Joint Commission accreditation for deemed status purposes: When the hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following: - Verify that all physicians and other licensed practitioners who will be providing patient care, treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges. - Specify in the written agreement that the contracted organization will ensure that all contracted services provided by physicians and other licensed practitioners will be within the scope of their privileges. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders who monitor the contracted services are the governing body. CoPs: §482.12(a)(8), §482.12(a)(9), §482.12(e), §482.21, §482.22(a)(4), §482.22(a)(4)(i), §482.26, §482.27(a), §482.27(b)(3), §482.27(b)(3)(i), §482.27(b)(3)(ii), §482.27(b)(3)(iii), §482.28	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.04.03.09, EP 5	Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services. Note: A written description of the expectations can be provided either as part of the written agreement or in addition to it. CoPs: §482.12(a)(9), §482.12(e), §482.21, §482.22(a)(4), §482.26, §482.27(b)(3), §482.27(b)(3)(i), §482.27(b)(3)(ii), §482.27(b)(3)(iii), §482.28	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
LD.04.03.09, EP 6	Leaders monitor contracted services by evaluating these services in relation to the hospital's expectations. CoPs: §482.12(a)(9), §482.12(e), §482.12(e)(1), §482.21, §482.21(e)(1), §482.22(a)(4), §482.23(b)(6), §482.26, §482.28	Consolidation of LD.01.03.01, EP 5; LD.04.03.09, EP 6; LD.04.03.09, EP 7	LD.13.03.03, EP 2	The governing body is responsible for all services provided in the hospital, including contracted services. The governing body assesses that services are provided in a safe and effective manner and takes action to address issues pertaining to quality and performance. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The governing body makes certain that a contractor of services (including one for shared services and joint ventures) provides services that permit the hospital to comply with applicable Centers for Medicare & Medicaid Services (CMS) Conditions of Participation and standards for contract services. CoPs: §482.12(e), §482.12(e)(1)
LD.04.03.09, EP 7	Leaders take steps to improve contracted services that do not meet expectations. Note: Examples of improvement efforts to consider include the following: - Increase monitoring of the contracted services - Provide consultation or training to the contractor - Renegotiate the contract terms - Apply defined penalties - Terminate the contract CoPs: §482.12(e)(1), §482.21, §482.23(b)(6), §482.26, §482.28	Consolidation of LD.01.03.01, EP 5; LD.04.03.09, EP 6; LD.04.03.09, EP 7	LD.13.03.03, EP 2	The governing body is responsible for all services provided in the hospital, including contracted services. The governing body assesses that services are provided in a safe and effective manner and takes action to address issues pertaining to quality and performance. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The governing body makes certain that a contractor of services (including one for shared services and joint ventures) provides services that permit the hospital to comply with applicable Centers for Medicare & Medicaid Services (CMS) Conditions of Participation and standards for contract services. CoPs: §482.12(e), §482.12(e)(1)
LD.04.03.09, EP 8	When contractual agreements are renegotiated or terminated, the hospital maintains the continuity of patient care. CoPs: §482.26, §482.26(a)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.04.03.09, EP 9	For hospitals that do not use Joint Commission accreditation for deemed status purposes: When using the services of physicians or other licensed practitioners from a Joint Commission–accredited ambulatory care organization through a telemedical link for interpretive services, the hospital accepts the credentialing and privileging decisions of a Joint Commission–accredited ambulatory provider only after confirming that those decisions are made using the process described in Standards MS.06.01.03 through MS.06.01.07, excluding MS.06.01.03, EP 2.	Moved and Revised	LD.13.03.03, EP 6	For hospitals that do not use Joint Commission accreditation for deemed status purposes: When using the services of physicians or other licensed practitioners from a Joint Commission–accredited ambulatory care organization through a telemedical link for interpretive services, the hospital accepts the credentialing and privileging decisions of a Joint Commission–accredited ambulatory provider only after confirming that those decisions are made using the process described in Standards MS.17.01.03 through MS.17.02.03.
LD.04.03.09, EP 10	Reference and contract laboratory services meet the federal regulations for clinical laboratories and maintain evidence of the same. Note: For law and regulation guidance on the Clinical Laboratory Improvement Amendments of 1988, refer to 42 CFR 493. CoPs: §482.27(a)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.04.03.09, EP 23	For hospitals that use Joint Commission accreditation for deemed status purposes: When telemedicine services are furnished to the hospital's patients, the originating site has a written agreement with the distant site that specifies the following: - The distant site is a contractor of services to the hospital. - The distant site furnishes services in a manner that permits the originating site to be in compliance with the Medicare Conditions of Participation - The originating site makes certain through the written agreement that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 482.12(a)(1) through	Moved and Revised	LD.13.03.03, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes: When telemedicine services are furnished to the hospital's patients, the originating site has a written agreement with the distant site that specifies the following: - The distant site is a contractor of services to the hospital. - The distant site furnishes services in a manner that permits the originating site to be in compliance with the Medicare Conditions of Participation. - The originating site makes certain through the written agreement that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 482.12(a)(1) through

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	(a)(9) and 482.22(a)(1) through (a)(4). Note: For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A. If the originating site chooses to use the credentialing and privileging decision of the distant-site telemedicine provider, then the following requirements apply: - The governing body of the distant site is responsible for having a process that is consistent with the credentialing and privileging requirements in the "Medical Staff" (MS) chapter (Standards MS.06.01.01 through MS.06.01.13). - The governing body of the originating site grants privileges to a distant site physician or other licensed practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site. CoPs: §482.12(a)(8), §482.12(a)(9), §482.22(a)(3)(i), §482.22(a)(4), §482.22(a)(4)(i), §482.22(c)(6)			(a)(9) and 482.22(a)(1) through (a)(4). Note: For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A. If the originating site chooses to use the credentialing and privileging decision of the distant-site telemedicine provider, then the following requirements apply: - The governing body of the distant site is responsible for having a process that is consistent with the credentialing and privileging requirements in the "Medical Staff" (MS) chapter (Standards MS.17.01.01 through MS.17.04.01). - The governing body of the originating site grants privileges to a distant site physician or other licensed practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site. The written agreement includes that it is the responsibility of the governing body of the distant-site hospital to meet the requirements of this element of performance. CoPs: §482.12(a)(9)
LD.04.03.11, EP 1	The hospital has processes that support the flow of patients throughout the hospital that address the following: - Plans for the care of admitted patients who are in overflow locations or temporary bed locations, such as the postanesthesia care unit or the emergency department - Criteria to guide decisions to initiate ambulance diversion CoPs: §482.55(a)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LD.04.03.11, EP 5	The hospital measures and sets goals for the components of the patient flow process, including the following: - The available supply of patient beds - The throughput of areas where patients receive care, treatment, and services (such as inpatient units, laboratory, operating rooms, telemetry, radiology, and the postanesthesia care unit) - The safety of areas where patients receive care, treatment and services - The efficiency of the nonclinical services that support patient care and treatment (such as housekeeping and transportation) - Access to support services (such as case management and social work)	Moved and Revised	NPG.01.03.01, EP 1	The hospital measures and sets goals for the components of the patient flow process, including the following: - Available supply of patient beds - Throughput of areas where patients receive care, treatment, and services (such as inpatient units, laboratory, operating rooms, telemetry, radiology, and the postanesthesia care unit) - Safety of areas where patients receive care, treatment and services - Efficiency of the nonclinical services that support patient care and treatment (such as housekeeping and transportation) - Access to support services (such as case management and social work)
LD.04.03.11, EP 6	The hospital measures and sets goals for mitigating and managing the boarding of patients who come through the emergency department. (Refer to NPSG.15.01.01, EPs 1 and 2; PC.01.02.03, EP 3; PC.02.01.19, EP 2) Note: Boarding is the practice of holding patients in the emergency department or another temporary location after the decision to admit or transfer has been made. The hospital should set its goals with attention to patient acuity and best practice; it is recommended that boarding time frames not exceed 4 hours in the interest of patient safety and quality of care.	Moved and Revised	NPG.01.03.01, EP 2	The hospital measures and sets goals for mitigating and managing the boarding of patients who come through the emergency department. (Refer to NPG.8.01.01, EPs 1 and 2; NPG.01.05.02, EP 1) Note: Boarding is the practice of holding patients in the emergency department or another temporary location after the decision to admit or transfer has been made. The hospital should set its goals with attention to patient acuity and best practice.
LD.04.03.11, EP 7	The individuals who manage patient flow processes review measurement results to determine whether goals were achieved, and leaders take action to improve patient flow processes when goals are not achieved.) Note: At a minimum, leaders include members of the medical staff and governing body, the chief executive officer and other senior managers, the nurse executive, clinical leaders, and staff members in leadership positions within the organization. (See the Glossary for the definition of leader.)	Moved and Revised	NPG.01.03.01, EP 3	The individuals who manage patient flow processes review measurement results to determine whether goals were achieved, and leaders take action to improve patient flow processes when goals are not achieved. Note: At a minimum, leaders include members of the medical staff and governing body, the chief executive officer and other senior managers, the nurse executive, clinical leaders, and staff members in leadership positions within the organization. (See the Glossary for the definition of leader.)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
LD.04.03.13, EP 1	The hospital has a leader or leadership team that is responsible for pain management and safe opioid prescribing, as well as developing and monitoring performance improvement activities.	Moved	NPG.06.01.01, EP 1	The hospital has a leader or leadership team that is responsible for pain management and safe opioid prescribing, as well as developing and monitoring performance improvement activities.
LD.04.03.13, EP 2	The hospital provides nonpharmacologic pain treatment modalities.	Moved	NPG.06.01.01, EP 2	The hospital provides nonpharmacologic pain treatment modalities.
LD.04.03.13, EP 3	The hospital provides staff with educational resources and programs to improve pain assessment, pain management, and the safe use of opioid medications based on the identified needs of its patient population.	Moved	NPG.06.01.01, EP 3	The hospital provides staff with educational resources and programs to improve pain assessment, pain management, and the safe use of opioid medications based on the identified needs of its patient population.
LD.04.03.13, EP 4	The hospital provides information to staff on available services for consultation and referral of patients with complex pain management needs.	Moved	NPG.06.01.01, EP 4	The hospital provides information to staff on available services for consultation and referral of patients with complex pain management needs.
LD.04.03.13, EP 5	The hospital identifies opioid treatment programs that can be used for patient referrals.	Moved	NPG.06.01.01, EP 5	The hospital identifies opioid treatment programs that can be used for patient referrals.
LD.04.03.13, EP 6	The hospital facilitates licensed practitioner and pharmacist access to the Prescription Drug Monitoring Program databases. Note: This element of performance is applicable in any state that has a Prescription Drug Monitoring Program database, whether querying is voluntary or is mandated by state regulations for all patients prescribed opioids.	Moved and Revised	NPG.06.01.01, EP 6	The hospital facilitates licensed practitioner and pharmacist access to the Prescription Drug Monitoring Program databases. Note: This element of performance is applicable in any state that has a Prescription Drug Monitoring Program database, whether querying is voluntary or is mandated by state regulations for all patients prescribed opioids.
LD.04.03.13, EP 7	Hospital leadership works with its clinical staff to identify and acquire the equipment needed to monitor patients who are at high risk for adverse outcomes from opioid treatment.	Moved and Revised	NPG.06.01.01, EP 7	Hospital leadership works with its clinical staff to identify and acquire the equipment needed to monitor patients who are at high risk for adverse outcomes from opioid treatment.
N/A	N/A	New, more-direct EP for CoP requirement	LD.13.01.09, EP 6	The hospital develops and implements surgical care policies and procedures that maintain high standards for medical practice and patient care. CoPs: §482.51(b)
N/A	N/A	New, more-direct EP for CoP requirement	LD.13.01.09, EP 7	If respiratory care services are provided, services are delivered in accordance with policies and procedures approved by the medical staff. CoPs: §482.57(b)
N/A	N/A	New, more-direct EP for CoP requirement	LD.13.03.01, EP 9	For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital provides nuclear medicine services, and nuclear medicine staff perform laboratory tests, the services meet the applicable requirements for laboratory services specified in 42 CFR 482.27. CoPs: §482.53(b)(3)
N/A	N/A	New, more-direct EP for CoP requirement	LD.13.03.01, EP 12	The hospital has laboratory services available, either directly or through a contractual agreement with a Clinical Laboratory Improvement Amendments (CLIA)–certified laboratory that meets the requirements of 42 CFR 493. CoPs: §482.27, §482.27(a)
N/A	N/A	New, more-direct EP for CoP requirement	LD.13.03.01, EP 15	For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital provides respiratory care services, and respiratory care staff perform blood gasses or other clinical laboratory tests, the applicable requirements for laboratory services specified in 42 CFR 482.27 are met. CoPs: §482.57(b)(2)
N/A	N/A	New, more-direct EP for CoP requirement	LD.13.03.03, EP 5	If the hospital routinely uses the services of an outside blood collecting establishment, it must have an agreement with the blood collecting establishment that governs the procurement, transfer, and availability of blood and blood components. The agreement includes that the blood collecting establishment notify the hospital within the specified timeframes under the following circumstances:

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
				- 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 CoPs: §482.27(b)(3), §482.27(b)(3)(i), §482.27(b)(3)(ii), §482.27(b)(3)(iii)
LS.01.01.01, EP 1	The hospital assigns an individual(s) to assess compliance with the Life Safety Code and manage the Statement of Conditions (SOC) when addressing survey-related deficiencies. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital complies with the 2012 Life Safety Code. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services finds that a fire and safety code imposed by state law adequately protects patients in hospitals. CoPs: §482.41(b)(1)(i), §482.41(b)(3)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.01.01.01, EP 2	In time frames defined by the hospital, the hospital performs a building assessment to determine compliance with the “Life Safety” (LS) chapter. CoPs: §482.41(b)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.01.01.01, EP 3	The hospital maintains current and accurate drawings denoting features of fire safety and related square footage. Fire safety features include the following: - Areas of the building that are fully sprinklered (if the building is partially sprinklered) - Locations of all hazardous storage areas - Locations of all fire-rated barriers - Locations of all smoke-rated barriers - Sleeping and non-sleeping suite boundaries, including the size of the identified suites - Locations of designated smoke compartments - Locations of chutes and shafts - Any approved equivalencies or waivers	Moved	PE.03.01.01, EP 1	The hospital maintains current and accurate drawings denoting features of fire safety and related square footage. Fire safety features include the following: - Areas of the building that are fully sprinklered (if the building is partially sprinklered) - Locations of all hazardous storage areas - Locations of all fire-rated barriers - Locations of all smoke-rated barriers - Sleeping and non-sleeping suite boundaries, including the size of the identified suites - Locations of designated smoke compartments - Locations of chutes and shafts - Any approved equivalencies or waivers
LS.01.01.01, EP 4	When the hospital plans to resolve a deficiency through a Survey-Related Plan for Improvement (SPFI), the hospital meets the 60-day time frame. Note 1: If the corrective action will exceed the 60-day time frame, the hospital must request a time-limited waiver within 30 days from the end of survey. Note 2: If there are alternative systems, methods, or devices considered equivalent, the hospital may submit an equivalency request using its Statement of Conditions (SOC). Note 3: For further information on waiver and equivalency requests, see https://www.jointcommission.org/resources/patient-safety-topics/the-physical-	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	environment/life-safety-code-information-and-resources/ and NFPA 101-2012: 1.4. CoPs: §482.41(b)(2)			
LS.01.01.01, EP 5	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital maintains documentation of any inspections and approvals made by state or local fire control agencies. CoPs: §482.41(b)(6)	Moved and Revised	PE.03.01.01, EP 5	The hospital maintains written evidence of regular inspection and approval by state or local fire control agencies. CoPs: §482.41(b)(6)
LS.01.01.01, EP 6	The hospital does not remove or minimize an existing life safety feature when such feature is a requirement for new construction. Existing life safety features, if not required by the Life Safety Code, can be either maintained or removed. (For full text, refer to NFPA 101-2012: 4.6.12.2; 4.6.12.3; 18/19.7.9)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.01.01.01, EP 7	The hospital maintains current Basic Building Information (BBI) within the Statement of Conditions (SOC).	Moved	PE.03.01.01, EP 2	The hospital maintains current Basic Building Information (BBI) within the Statement of Conditions (SOC).
LS.01.01.01, EP 8	The hospital complies with the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). CoPs: §482.15(e)(1), §482.15(h)(1)(ix), §482.15(h)(1)(vii), §482.15(h)(1)(viii), §482.15(h)(1)(x), §482.15(h)(1)(xi), §482.41(e)(1)(ix), §482.41(e)(1)(vii), §482.41(e)(1)(viii), §482.41(e)(1)(x), §482.41(e)(1)(xi)	Moved and Revised	PE.03.01.01, EP 3	The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in hospitals. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity. CoPs: §482.15(e)(1), §482.15(h)(1)(ix), §482.15(h)(1)(vii), §482.15(h)(1)(viii), §482.15(h)(1)(x), §482.15(h)(1)(xi), §482.41(b), §482.41(b)(1)(i), §482.41(b)(2), §482.41(b)(3), §482.41(e)(1)(ix), §482.41(e)(1)(vii), §482.41(e)(1)(viii), §482.41(e)(1)(x), §482.41(e)(1)(xi)
LS.01.02.01, EP 1	The hospital has a written interim life safety measures (ILSM) policy that covers situations when Life Safety Code deficiencies cannot be immediately corrected or during periods of construction. The policy includes criteria for evaluating when and to what extent the hospital implements LS.01.02.01, EPs 2–15, to compensate for increased life safety risk. The criteria include the assessment process to determine when interim life safety measures are implemented. Note: For any Life Safety Code (LSC) deficiency that cannot be immediately corrected during survey, the hospital identifies which ILSMs in its policy will be implemented until the issue is corrected.	Moved and Revised	PE.03.02.01, EP 1	The hospital has a written interim life safety measures (ILSM) policy that covers situations when Life Safety Code deficiencies cannot be immediately corrected or during periods of construction. The policy includes criteria for evaluating when and to what extent the hospital implements PE.03.02.01, EPs 2–15, to compensate for increased life safety risk. The criteria include the assessment process to determine when interim life safety measures are implemented. Note: For any Life Safety Code (LSC) deficiency that cannot be immediately corrected during survey, the hospital identifies which ILSMs in its policy will be implemented until the issue is corrected.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.41(b)(1)(i)			
LS.01.02.01, EP 2	When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital evacuates the building or notifies the fire department (or other emergency response group) and initiates a fire watch when a fire alarm system is out of service more than 4 out of 24 hours or a sprinkler system is out of service more than 10 hours in a 24-hour period in an occupied building. Notification and fire watch times are documented. (For full text, refer to NFPA 101-2012: 9.6.1.6; 9.7.6; NFPA 25-2011: 15.5.2) CoPs: §482.41(b)(1)(i), §482.41(b)(8), §482.41(b)(8)(i), §482.41(b)(8)(ii)	Moved and Revised	PE.03.01.01, EP 8	When a sprinkler system is shut down for more than 10 hours, the hospital either evacuates the building or portion of the building affected by the system outage until the system is back in service, or the hospital establishes a fire watch until the system is back in service. CoPs: §482.41(b)(8)(i), §482.41(b)(8)(ii)
LS.01.02.01, EP 2	When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital evacuates the building or notifies the fire department (or other emergency response group) and initiates a fire watch when a fire alarm system is out of service more than 4 out of 24 hours or a sprinkler system is out of service more than 10 hours in a 24-hour period in an occupied building. Notification and fire watch times are documented. (For full text, refer to NFPA 101-2012: 9.6.1.6; 9.7.6; NFPA 25-2011: 15.5.2) CoPs: §482.41(b)(1)(i), §482.41(b)(8), §482.41(b)(8)(i), §482.41(b)(8)(ii)	Split to PE.03.01.01, EP 8; PE.03.02.01, EP 2	PE.03.02.01, EP 2	When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital evacuates the building or notifies the fire department (or other emergency response group) and initiates a fire watch when a fire alarm system is out of service more than 4 out of 24 hours in an occupied building. Notification and fire watch times are documented. (For full text, refer to NFPA 101-2012: 9.6.1.6; 9.7.6; NFPA 25-2011: 15.5.2)
LS.01.02.01, EP 3	When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Posts signage identifying the location of alternative exits to everyone affected.	Moved and Revised	PE.03.02.01, EP 3	When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital posts signage identifying the location of alternative exits to everyone affected.
LS.01.02.01, EP 4	When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Inspects exits in affected areas on a daily basis. The need for these inspections is based on criteria in the hospital's interim life safety measures (ILSM) policy.	Moved and Revised	PE.03.02.01, EP 4	When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital inspects exits in affected areas on a daily basis. The need for these inspections is based on criteria in the hospital's interim life safety measures (ILSM) policy.
LS.01.02.01, EP 5	When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Provides temporary but equivalent fire alarm and detection systems for use when a fire system is impaired. The need for equivalent systems is based on criteria in the hospital's interim life safety measures (ILSM) policy.	Moved and Revised	PE.03.02.01, EP 5	When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital provides temporary but equivalent fire alarm and detection systems for use when a fire system is impaired. The need for equivalent systems is based on criteria in the hospital's interim life safety measures (ILSM) policy.
LS.01.02.01, EP 6	When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Provides additional firefighting equipment. The need for this equipment is based on criteria in the hospital's interim life safety measures (ILSM) policy.	Moved and Revised	PE.03.02.01, EP 6	When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital provides additional firefighting equipment. The need for this equipment is based on criteria in the hospital's interim life safety measures (ILSM) policy.
LS.01.02.01, EP 7	When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Uses temporary construction partitions that are smoke-tight, or made of noncombustible or limited-combustible material that will not contribute to the development or spread of fire. The need for these partitions is based on criteria in the hospital's interim life safety measures (ILSM) policy.	Moved and Revised	PE.03.02.01, EP 7	When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital uses temporary construction partitions that are smoke-tight or made of noncombustible or limited-combustible material that will not contribute to the development or spread of fire. The need for these partitions is based on criteria in the hospital's interim life safety measures (ILSM) policy.
LS.01.02.01, EP 8	When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Increases surveillance of buildings, grounds, and equipment, giving special attention to construction areas and storage, excavation, and field offices.	Moved and Revised	PE.03.02.01, EP 8	When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital increases surveillance of buildings, grounds, and equipment, giving special attention to construction areas and storage, excavation, and field offices. The need for increased

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	The need for increased surveillance is based on criteria in the hospital's interim life safety measures (ILSM) policy.			surveillance is based on criteria in the hospital's interim life safety measures (ILSM) policy.
LS.01.02.01, EP 9	When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Enforces storage, housekeeping, and debris-removal practices that reduce the building's flammable and combustible fire load to the lowest feasible level. The need for these practices is based on criteria in the hospital's interim life safety measures (ILSM) policy.	Moved and Revised	PE.03.02.01, EP 9	When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital enforces storage, housekeeping, and debris-removal practices that reduce the building's flammable and combustible fire load to the lowest feasible level. The need for these practices is based on criteria in the hospital's interim life safety measures (ILSM) policy.
LS.01.02.01, EP 10	When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Provides additional training to those who work in the hospital on the use of firefighting equipment. The need for additional training is based on criteria in the hospital's interim life safety measures (ILSM) policy.	Moved and Revised	PE.03.02.01, EP 10	When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital provides additional training to those who work in the hospital on the use of firefighting equipment. The need for additional training is based on criteria in the hospital's interim life safety measures (ILSM) policy.
LS.01.02.01, EP 11	When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Conducts one additional fire drill per shift per quarter. The need for additional drills is based on criteria in the hospital's interim life safety measures (ILSM) policy.	Moved and Revised	PE.03.02.01, EP 11	When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital conducts one additional fire drill per shift per quarter. The need for additional drills is based on criteria in the hospital's interim life safety measures (ILSM) policy.
LS.01.02.01, EP 12	When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital does the following: Inspects and tests temporary systems monthly. The completion date of the tests is documented. The need for these inspections and tests is based on criteria in the hospital's interim life safety measures (ILSM) policy.	Moved and Revised	PE.03.02.01, EP 12	When the hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the hospital inspects and tests temporary systems monthly. The completion date of the tests is documented. The need for these inspections and tests is based on criteria in the hospital's interim life safety measures (ILSM) policy.
LS.01.02.01, EP 13	The hospital conducts education to promote awareness of building deficiencies, construction hazards, and temporary measures implemented to maintain fire safety. The need for education is based on criteria in the hospital's interim life safety measures (ILSM) policy.	Moved	PE.03.02.01, EP 13	The hospital conducts education to promote awareness of building deficiencies, construction hazards, and temporary measures implemented to maintain fire safety. The need for education is based on criteria in the hospital's interim life safety measures (ILSM) policy.
LS.01.02.01, EP 14	The hospital trains those who work in the hospital to compensate for impaired structural or compartmental fire safety features. The need for training is based on criteria in the hospital's interim life safety measures (ILSM) policy. Note: Compartmentalization is the concept of using various building components (for example, fire-rated walls and doors, smoke barriers, fire-rated floor slabs) to prevent the spread of fire and the products of combustion so as to provide a safe means of egress to an approved exit. The presence of these features varies, depending on the building occupancy classification.	Moved	PE.03.02.01, EP 14	The hospital trains those who work in the hospital to compensate for impaired structural or compartmental fire safety features. The need for training is based on criteria in the hospital's interim life safety measures (ILSM) policy. Note: Compartmentalization is the concept of using various building components (for example, fire-rated walls and doors, smoke barriers, fire-rated floor slabs) to prevent the spread of fire and the products of combustion so as to provide a safe means of egress to an approved exit. The presence of these features varies, depending on the building occupancy classification.
LS.01.02.01, EP 15	The hospital's policy allows the use of other ILSMs not addressed in EPs 2–14. Note: The "other" ILSMs used are documented by selecting "other" and annotating the associated text box in the hospital's Survey-Related Plan for Improvement (SPFI) within the Statement of Conditions™ (SOC). CoPs: §482.41(b)(1)(i)	Moved and Revised	PE.03.02.01, EP 15	The hospital's policy allows the use of other interim life safety measures (ILSMs) not addressed in EPs 3–14. Note: The other ILSMs used are documented by selecting "other" and annotating the associated text box in the hospital's Survey-Related Plan for Improvement (SPFI) within the Statement of Conditions™ (SOC).
LS.02.01.10, EP 1	Buildings meet requirements for construction type and height. In Types I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. All new buildings contain approved automatic sprinkler systems. Existing buildings contain approved automatic sprinkler systems as required by the construction type. (For full text, refer to NFPA 101-2012: 18/19.1.6; 18.3.5.1; 19.3.5.3; 18/19.3.5.4; 18/19.3.5.5; 18.3.5.6)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.41(b)(1)(i)			
LS.02.01.10, EP 2	When building rehabilitation occurs, the hospital incorporates NFPA 101-2012: Chapters 18, 19, and 43. (For full text, refer to NFPA 101-2012: Chapter 43; 18/19.1.1.4.3; 18.4.3.1–18.4.3.5; 19.4.3)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.10, EP 3	Any building undergoing change of use or change of occupancy classification complies with NFPA 101-2012: 43.7, unless permitted by NFPA 101-2012: 18/19.1.1.4.2. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.10, EP 4	When an addition is made to a building, the building is in compliance with NFPA 101-2012: 43.8 and Chapter 18. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.10, EP 5	Buildings without protection from automatic sprinkler systems comply with NFPA 101-2012: 18.4.3.2; 18.4.3.3; and 18.4.3.8. When a nonsprinklered smoke compartment has undergone major rehabilitation, the automatic sprinkler requirements of Chapter 18.3.5 will apply. Note: Major rehabilitation involves the modification of more than 50 percent, or 4500 square feet, of the area of the smoke compartment. (For full text, refer to NFPA 101-2012: 18/19.1.1.4.3.3) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.10, EP 6	Fire barriers are continuous from outside wall to outside wall or from one fire barrier to another, or a combination thereof, including continuity through all concealed spaces, such as those found above a ceiling, including interstitial spaces. For those fire barriers terminating at the bottom side of an interstitial space, the construction assembly forming the bottom of the interstitial space must have a fire resistance rating not less than that of the fire barrier. (For full text, refer to NFPA 101-2012: 8.3.1.2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.10, EP 7	Common walls are fire rated for two hours that are within buildings (occupancy separation), between buildings (two health care occupancy buildings), or the building has a common wall with a nonconforming building (for example, a health care occupancy and a business occupancy). (For full text, refer to NFPA 101-2012: 43.8; 18/19.1.1.4; 18/19.1.3.3; 18/19.1.3.4; 8.2.2.2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.10, EP 8	When multiple occupancies are identified, they are in accordance with NFPA 101-2012: 18/19.1.3.2 or 18/19.1.3.4, and the most stringent occupancy requirements are followed throughout the building. Note 1: If a two-hour separation is provided in accordance with NFPA 101-2012: 8.2.1.3, the construction type is determined as follows: - The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with NFPA 101-2012: 18/19.1.6 and Tables 18/19.1.6.1. - The construction type of the areas of the building enclosing the other occupancies are based on NFPA 101-2012: 18/19.1.3.5; 8.2.1.3. Note 2: Outpatient surgical departments must be classified as ambulatory health	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	care occupancy regardless of the number of patients served. (For full text, refer to NFPA 101-2012: 18/19.1.3.4.1) CoPs: §482.41(b)(1)(i)			
LS.02.01.10, EP 9	The fire protection ratings for opening protectives in fire barriers and fire-rated smoke barriers are as follows: - Three hours in three-hour barriers - Ninety minutes in two-hour barriers - Forty-five minutes in one-hour barriers - Twenty minutes in thirty-minute barriers (For full text, refer to NFPA 101-2012: 8.3.3.2; 8.3.4; Table 8.3.4.2) Note 1: Labels on fire door assemblies must be maintained in legible condition. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the applicable provisions of the Life Safety Code Tentative Interim Amendment (TIA) 12-1. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.10, EP 10	In existing buildings that are not a high rise and are protected with automatic sprinkler systems, exit stairs (or new exit stairs connecting three or fewer floors) are fire rated for one hour. In new construction, exit stairs connecting four or more floors are fire rated for two hours. (For full text, refer to NFPA 101-2012: 7.1.3.2.1) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.10, EP 11	Fire-rated doors within walls and floors have functioning hardware, including positive latching devices and self-closing or automatic-closing devices (either kept closed or activated by release device complying with NFPA 101-2012: 7.2.1.8.2). Gaps between meeting edges of door pairs are no more than 1/8 of an inch wide, and undercuts are no larger than 3/4 of an inch. Fire-rated doors within walls do not have unapproved protective plates greater than 16 inches from the bottom of the door. Blocking or wedging open fire-rated doors is prohibited. (For full text, refer to NFPA 101-2012: 8.3.3.1; 7.2.1.8.2; NFPA 80-2010: 4.8.4.1; 5.2.13.3; 6.3.1.7; 6.4.5) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.10, EP 12	Doors requiring a fire rating of 3/4 of an hour or longer are free of coverings, decorations, or other objects applied to the door face, with the exception of informational signs, which are applied with adhesive only. (For full text, refer to NFPA 80-2010: 4.1.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.10, EP 13	Ducts penetrating the walls or floors with a fire resistance rating of less than 3 hours are protected by dampers that are fire rated for 1 1/2 hours; ducts penetrating the walls or floors with a fire resistance rating of 3 hours or greater are protected by dampers that are fire rated for 3 hours. (For full text, refer to NFPA 101-2012: 8.3.5.7; 9.2.1; NFPA 90A-2012: 5.4.1; 5.4.2) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.10, EP 14	The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes penetrating the walls or floors are protected with an approved fire-rated material.	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text, refer to NFPA 101-2012: 8.3.5) CoPs: §482.41(b)(1)(i)	moved to guidance within SPG		
LS.02.01.10, EP 15	The hospital meets all other Life Safety Code requirements related to NFPA 101-2012: 18/19.1. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 1	Doors in a means of egress are not equipped with a latch or lock that requires the use of a tool or key from the egress side, unless a compliant locking configuration is used, such as a delayed-egress locking system as defined in NFPA 101-2012: 7.2.1.6.1 or access-controlled egress door assemblies as defined in NFPA 101-2012: 7.2.1.6.2. Elevator lobby exit access door locking is allowed if compliant with 7.2.1.6.3. (For full text, refer to NFPA 101-2012: 18/19.2.2.2.4; 18/19.2.2.2.5; 18/19.2.2.2.6) Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the applicable provisions of the Life Safety Code Tentative Interim Amendment (TIA) 12-4. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 2	Doors to patient sleeping rooms are not locked unless the clinical needs of patients require specialized security or where patients pose a security threat and staff can readily unlock doors at all times. (For full text, refer to NFPA 101-2012: 18/19.2.2.2.2; 18/19.2.2.2.5.1; 18/19.2.2.2.5.2) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 3	Horizontal sliding doors permitted by NFPA 101-2012: 7.2.1.14 that are not automatic closing are limited to a single leaf and have a latch or other mechanism to prevent the door from rebounding. (For full text, refer to NFPA 101-2012: 18/19.2.2.2.10.1) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 4	Horizontal sliding doors serving an occupant load fewer than 10 are permitted, as long as they comply with NFPA 101-2012: 18/19.2.2.2.10.2 and meet the following criteria: - Area served by the door has no hazards. - Door is operable from either side without special knowledge or effort. - Force required to operate the door in the direction of travel is less than or equal to 30 pounds-force (lbf) to set the door in motion and less than or equal to 15 lbf to close or open to the required width. - Assembly is appropriately fire rated and is self- or automatic-closing by smoke detection per 7.2.1.8; assembly is installed per NFPA 80-2010. - Where required to latch, the door has a latch or other mechanism to prevent the door from rebounding. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 5	Walls containing horizontal exits are fire rated for two or more hours, extend from the lowest floor slab to the floor or roof slab above, and extend continuously from	Deleted EP - Replaced with more	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	exterior wall to exterior wall. (For full text, refer to NFPA 101-2012: 7.2.4.3.1; 18/19.2.2.5) CoPs: §482.41(b)(1)(i)	direct EP(s) or moved to guidance within SPG		
LS.02.01.20, EP 6	Doors in new buildings that are a part of horizontal exits have approved vision panels, are installed without a center mullion, and swing in the opposite direction of one another. Doors in existing construction are not required to swing with egress travel. (For full text, refer to NFPA 101-2012: 18.2.2.5.6; 18.2.2.5.4; 19.2.2.5.3) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 7	When horizontal exit walls in new buildings terminate at outside walls at an angle of less than 180 degrees, the outside walls are fire rated for 1 hour for a distance of 10 or more feet. Openings in the walls in the 10-foot span are fire rated for 3/4 of an hour. (For full text, refer to NFPA 101-2012: 7.2.4.3.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 8	Outside exit stairs are separated from the interior of the building by walls with the same fire rating required for enclosed stairs. The wall extends vertically from the ground to a point 10 feet or more above the top landing of the stairs or roofline (whichever is lower) and extends 10 feet or more horizontally. (For full text, refer to NFPA 101-2012: 18/19.2.2.3; 7.2.2.5.2; 7.2.2.6.3) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 9	Stairs and ramps serving as a required means of egress have handrails and guards on both sides in new buildings and on at least one side in existing buildings. Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with NFPA 101-2012: 7.2.5–7.5.12. (For full text, refer to NFPA 101-2012: 18/19.2.2.3; 18/19.2.2.6–18/19.2.2.10; 7.2.2.4; 7.2.5–7.2.12) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 10	New stairs serving three or more stories and existing stairs serving five or more stories have signs on each floor landing in the stairwell that identify the story, the stairwell, the top and bottom, and the direction to and story of exit discharge. Floor level information is also presented in tactile lettering. The signs are placed five feet above the floor landing in a position that is easily visible when the door is open or closed. (For full text, refer to NFPA 101-2012: 18/19.2.2.3; 7.2.2.5.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 11	The capacity of the means of egress is in accordance with NFPA 101-2012: 7.3. (For full text, refer to NFPA 101-2012: 18/19.2.3.1) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 12	Exits discharge to the outside at grade level or through an approved exit passageway that is continuous and provides a level walking surface. The exit discharge is a hard-packed, all-weather travel surface that is free from obstructions and terminates at a public way or at an exterior exit discharge. (For full text, refer to NFPA 101-2012: 18/19.2.7; 7.1.7; 7.1.10.1; 7.2.6; 7.7.2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.41(b)(1)(i)			
LS.02.01.20, EP 13	An exit enclosure is not used for any purpose that has the potential to interfere with its use as an exit and, if so designated, as an area of refuge. Open space within the exit enclosure is not used for any purpose that has the potential to interfere with egress. (For full text, refer to NFPA 101-2012: 18/19.2.2.3; 7.1.3.2.3; 7.2.2.5.3.1)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 14	Exits, exit accesses, and exit discharges (means of egress) are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text, refer to NFPA 101-2012: 18/19.2.5.1; 7.1.10.1; 7.5.1.1) Note 1: Wheeled equipment (such as equipment and carts currently in use, equipment used for patient lift and transport, and medical emergency equipment not in use) that maintains at least five feet of clear and unobstructed corridor width is allowed, provided there is a fire plan and training program addressing its relocation in a fire or similar emergency. (For full text, refer to NFPA 101-2012: 18/19.2.3.4 (4)) Note 2: Where the corridor width is at least eight feet and the smoke compartment is fully protected by an electrically supervised smoke detection system or is in direct supervision of facility staff, furniture that is securely attached is allowed provided it does not reduce the corridor width to less than six feet, is only on one side of the corridor, does not exceed 50 square feet, is in groupings spaced at least 10 feet apart, and does not restrict access to building service and fire protection equipment. (For full text, refer to NFPA 101-2012: 18/19.2.3.4 (5)) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 15	When stair doors are held open and the sprinkler or fire alarm system activates the release of one door in a stairway, all doors serving that stairway close. (For full text, refer to NFPA 101-2012: 18/19.2.2.2.7; 18/19.2.2.2.8) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 16	Each floor of a building has at least two exits that are remote from each other and accessible from every part of the floor. Each smoke compartment has two distinct egress paths to exits that do not require entry into the same adjacent smoke compartment. (For full text, refer to NFPA 101-2012: 18/19.2.4.1–18/19.2.4.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 17	Every corridor provides access to at least two approved exits in accordance with NFPA 101-2012: 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. (For full text, refer to NFPA 101-2012: 18/19.2.5.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 18	In new buildings, exit corridors are at least eight feet wide, unless otherwise permitted by the Life Safety Code. In new psychiatric buildings, exit corridors are at least six feet wide, unless otherwise permitted by the Life Safety Code. (For full text, refer to NFPA 101-2012: 18.2.3.4; 18.2.3.5) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
LS.02.01.20, EP 19	In existing buildings, exit corridors are at least 48 inches in clear width where serving as a means of egress from patient sleeping rooms. If modifying existing buildings with exit corridors that exceed eight feet, the exit corridors cannot be reduced to less than eight feet. (For full text, refer to NFPA 101-2012: 4.6.12.2; 19.2.3.4)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 20	Existing exit access doors and exit doors are of the swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. (For full text, refer to NFPA 101-2012: 19.2.3.6, 19.2.3.7) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 21	New exit access doors and exit doors are of the swinging type and are at least 41 1/2 inches in clear width. In psychiatric hospitals doors are at least 32 inches wide. Doors not subject to patient use, in exit stairway enclosures, or serving newborn nurseries are at least 32 inches in clear width. If using a pair of doors, the doors have a rabbet, bevel, or astragal at the meeting edge, and at least one of the doors provides 32 inches in clear width, while the inactive leaf of the pair is secured with automatic flush bolts. (For full text, refer to NFPA 101-2012: 18.2.3.6; 18.2.3.7) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 22	Exit access doors and exit doors are free of mirrors, hangings, or draperies that might conceal, obscure, or confuse the direction of exit. (For full text, refer to NFPA 101-2012: 18/19.2.1; 18/19.2.5.1; 7.1.10.2; 7.5.2.2.1) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 23	Doors to new boiler rooms, new heater rooms, and new mechanical equipment rooms located in a means of egress are not held open by an automatic release device. (For full text, refer to NFPA 101-2012: 18.2.2.2.7) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 24	The corridor width is not obstructed by wall projections. Note: When corridors are six feet wide or more, it is allowable for certain objects to project into the corridor, such as hand rub dispensers or computer desks that are retractable. The objects must be no more than 36 inches wide and cannot project more than 6 inches into the corridor. These items must be installed at least 48 inches apart and above the handrail height. (For full text, refer to NFPA 101-2012: 18/19.2.3.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 25	In new buildings, no dead-end corridor is longer than 30 feet, and the common path of travel does not exceed 100 feet. (For full text, refer to NFPA 101-2012: 18.2.5.2) Note: Existing dead-end corridors longer than 30 feet are permitted to be used if it is impractical and unfeasible to alter them. (For full text, refer to NFPA 101-2012: 19.2.5.2) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 26	Patient sleeping rooms open directly onto an exit access corridor. Patient sleeping rooms with less than eight beds may have one intervening room to reach an exit access corridor provided the intervening room is equipped with an approved	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	automatic smoke detection system. (For full text, refer to NFPA 101-2012: 18/19.2.5.6.1–18/19.2.5.6.4) CoPs: §482.41(b)(1)(i)	moved to guidance within SPG		
LS.02.01.20, EP 27	Patient sleeping rooms that are larger than 1,000 square feet have at least two exit access doors remotely located from each other. Rooms not used as patient sleeping rooms that are larger than 2,500 square feet have at least two exit access doors remotely located from each other. (For full text, refer to NFPA 101-2012: 18/19.2.5.5) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 28	Suites are separated from the remainder of the building by corridor walls or existing barriers and doors that limit the transfer of smoke. (For full text, refer to NFPA 101-2012: 18/19.2.5.7.1.2; 18/19.3.6)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 29	Suites are subdivided by means of noncombustible or limited-combustible partitions or partitions constructed with fire retardant–treated wood enclosed with noncombustible or limited-combustible materials. These partitions are not required to be fire rated. (For full text, refer to NFPA 101-2012: 18/19.2.5.7.1.4)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 30	Suites of patient sleeping rooms larger than 1,000 square feet are provided with at least two exit access doors remotely located from each other, with one exiting directly to a corridor. The second exit may go into another suite (provided the two suites are separated with a corridor wall), an exit stair, exit passageway, or exit door to the exterior. (For full text, refer to NFPA 101-2012: 18/19.2.5.7.2.1(B); 18/19.2.5.7.2.2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 31	Suites not used as patient sleeping rooms that are larger than 2,500 square feet have at least two exit access doors remotely located from each other, with one directly exiting to a corridor. The second exit may go into another suite (provided the two suites are separated with a corridor wall), an exit stair, exit passageway, or exit door to the exterior. (For full text, refer to NFPA 101-2012: 18/19.2.5.7.3.2; 18/19.2.5.7.3.1(B))	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 32	For existing buildings, suites of patient sleeping rooms are limited to 5,000 square feet or less. If the existing building has an approved electrically supervised sprinkler system and total coverage automatic smoke detection system, the suite is permitted to be increased to 7,500 square feet. (For full text, refer to NFPA 101-2012: 9.6.2.9; 19.3.4; 19.3.5.7; 19.3.5.8.) If the suite is provided with direct visual supervision, an approved electrically supervised sprinkler system, and a total coverage (complete) smoke detection system, the suite is permitted to be increased to 10,000 square feet. (For full text, refer to NFPA 101-2012: 9.6.2.9; 19.2.5.7.2.1(D)(1)(a); 19.2.5.7.2.3; 19.3.4; 19.3.5.8) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 33	For new buildings, patient sleeping suites are allowed to be 7,500 square feet. If the suite has total coverage smoke detection and direct visual supervision, the suite can be up to 10,000 square feet. (For full text, refer to NFPA 101-2012: 18.2.5.7.2.3; 18.2.5.7.2.1(D)(1)(a); 18.3.4)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
LS.02.01.20, EP 34	Patient care suites not used for sleeping are limited to 10,000 square feet. (For full text, refer to NFPA 101-2012: 18/19.2.5.7.3.3)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 35	For new buildings, sleeping and non-sleeping patient care suites have a travel distance to an exit access door of 100 feet or less from any point in the suite. The travel distance between any point in the suite and an exit is 200 feet. (For full text, refer to NFPA 101-2012: 18.2.5.7.2.4; 18.2.5.7.3.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 36	For existing buildings, sleeping and non-sleeping patient care suites have a travel distance to an exit access door of 100 feet or less from any point in the suite. The travel distance between any point in the suite and an exit is either 150 feet if the building is not protected throughout by an approved electrically supervised sprinkler system or 200 feet if the building is fully protected by an approved electrically supervised sprinkler system. (For full text, refer to NFPA 101-2012: 19.2.5.7.2.4; 19.2.5.7.3.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 37	Travel distances to exits are measured in accordance with NFPA 101-2012: 7.6. - From any point in the room or suite to the exit is 150 feet or less (200 feet or less if the building is fully sprinklered) - From any point in a room to the room door is 50 feet or less (For full text, refer to NFPA 101-2012: 18/19.2.6) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 38	Means of egress are adequately illuminated at all points, including angles and intersections of corridors and passageways, stairways, stairway landings, exit doors, and exit discharges. (For full text, refer to NFPA 101-2012: 18/19.2.8; 7.8.1.1) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 39	Illumination in the means of egress, including exit discharges, is arranged so that failure of any single light fixture or bulb will not leave the area in darkness (less than 0.2 foot candles). Emergency lighting of at least 1½-hours duration is provided automatically in accordance with NFPA 101-2012: 7.9. (For full text, refer to NFPA 101-2012: 18/19.2.8; 18/19.2.9.1; 7.8.1.4; 7.9.2) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 40	Exit signs are visible when the path to the exit is not readily apparent. Signs are adequately lit and have letters that are four or more inches high (or six inches high if externally lit). Exit and directional signs displayed with continuous illumination are also served by the emergency lighting system unless the building is one story with less than 30 occupants, and the line of exit travel is obvious. (For full text, refer to NFPA 101-2012: 18/19.2.10; 7.10.1.4; 7.10.1.5.1; 7.10.5; 7.10.6; 7.10.7) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.20, EP 41	Signs reading "NO EXIT" are posted on any door, passage, or stairway that is neither an exit nor an access to an exit but may be mistaken for an exit. (For full text, refer to	Deleted EP - Replaced with more	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	NFPA 101-2012: 18/19.2.10.1; 7.10.8.3) CoPs: §482.41(b)(1)(i)	direct EP(s) or moved to guidance within SPG		
LS.02.01.20, EP 42	The hospital meets all other Life Safety Code means of egress requirements related to NFPA 101-2012: 18/19.2. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.30, EP 1	In new construction, vertical openings, including exit stairs, are enclosed by one-hour fire-rated walls when connecting three or fewer floors and two-hour fire-rated walls when connecting four or more floors. In existing construction, vertical openings, including exit stairs, are enclosed with a minimum of one-hour fire-rated construction. Note: These vertical openings include, but are not limited to, shafts (including elevator, light and ventilation), communicating stairs, ramps, trash chutes, linen chutes, and utility chases. (For full text, refer to NFPA 101-2012: 8.6; 18/19.3.1; 7.1.3.2.1) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.30, EP 2	All new hazardous areas have doors that are self-closing or automatic-closing, except for laboratories using flammable or combustible materials deemed less than a severe hazard and storage rooms greater than 50 square feet, but less than 100 square feet that are used for storage of combustible material. Hazardous areas have a fire barrier with a one-hour fire-resistive rating. These areas include, but are not limited to, boiler and fuel-fired heater rooms, central/bulk laundries larger than 100 square feet, paint shops, repair shops, soiled linen rooms, trash collection rooms with containers exceeding 64 gallons, laboratories considered a severe hazard, and storage rooms larger than 100 square feet that contain combustible material. (For full text, refer to NFPA 101-2012: 18.3.2.1; 18.3.2.2; 18.3.2.3; 18.3.2.4; Table 18.3.2.1) Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Doors to rooms containing flammable or combustible materials are provided with positive latching hardware. Roller latches are prohibited on such doors. CoPs: §482.41(b)(1)(ii)	Moved and Revised	PE.03.01.01, EP 6	For hospitals that use Joint Commission accreditation for deemed status purposes: Regardless of the provisions of the Life Safety Code, corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited on these doors. CoPs: §482.41(b)(1)(ii)
LS.02.01.30, EP 3	All existing hazardous areas have doors that are self-closing or automatic-closing. These areas are protected by either a fire barrier with one-hour fire-resistive rating or an approved electrically supervised automatic sprinkler system. Hazardous areas include, but are not limited to, boiler and fuel-fired heater rooms, central/bulk laundries larger than 100 square feet, paint shops, repair shops, soiled linen rooms, trash collection rooms with containers exceeding 64 gallons, laboratories employing flammable or combustible materials deemed less than a severe hazard, and storage rooms greater than 50 square feet used for storage of equipment and combustible supplies. (For full text, refer to NFPA 101-2012: 19.3.2.1; 19.3.2.2; 19.3.2.3; 19.3.2.4) Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Doors to rooms containing flammable or combustible materials are provided with positive latching hardware. Roller latches are prohibited on such doors.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.41(b)(1)(ii)			
LS.02.01.30, EP 4	Laboratories using quantities of flammable, combustible, or hazardous materials that are considered a severe hazard are in accordance with NFPA 101-2012: 8.7 and NFPA 99 requirements applicable to administration, maintenance, and testing. (For full text refer to NFPA 101-2012: 18/19.3.2.2; NFPA 99-2012: 15.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.30, EP 5	Where residential or commercial cooking equipment is used to prepare meals for less than 31 people in a smoke compartment, one cooking facility is permitted to be open to the corridor provided all criteria in NFPA 101-2012: 18/19.3.2.5 are met. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the applicable provisions of the Life Safety Code Tentative Interim Amendment (TIA) 12-2. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.30, EP 6	Alcohol-based hand rubs (ABHR) are stored and handled in accordance with NFPA 101-2012: 8.7.3.1, unless all of the following conditions are met: - Corridor is at least six feet wide. - ABHR does not exceed 95% alcohol. - Maximum individual dispenser capacity is 0.32 gallons of fluid (0.53 gallons in suites) or 18 ounces of NFPA Level 1–classified aerosols. - Dispensers have a minimum of four feet of horizontal spacing between them. - Dispensers are not installed within one inch of an ignition source. - If floor is carpeted, the building is fully sprinkler protected. - Operation of the dispenser complies with NFPA 101-2012: 18/19.3.2.6(11). - ABHR is protected against inappropriate access. - Not more than an aggregate of 10 gallons of fluid or 1135 ounces of aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room. - Storing more than five gallons of fluid in a single smoke compartment complies with NFPA 30. CoPs: §482.41(b)(7)	Consolidation of LS.02.01.30, EP 6; LS.03.01.30, EP 5; LS.05.01.30, EP 3	PE.03.01.01, EP 7	When the hospital installs alcohol-based hand rub dispensers, it installs the dispensers in a manner that protects against inappropriate access. CoPs: §482.41(b)(7)
LS.02.01.30, EP 7	Existing wall and ceiling interior finishes are rated Class A or B for limiting smoke development and the spread of flames. Newly installed wall and ceiling interior finishes are rated Class A. (For full text, refer to NFPA 101-2012: 18/19.3.3; 10.2) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.30, EP 8	Newly installed interior floor finishes in corridors of smoke compartments with an approved automatic sprinkler system is at least Class II. Existing floor finishes are not restricted. (For full text, refer to NFPA 101-2012: 18/19.3.3; 10.2.7) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.30, EP 9	Corridors must be separated from all other areas by approved partitions, unless the space is permitted to be open in accordance with NFPA 101-2012: 18/19.3.6.1.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
LS.02.01.30, EP 10	In existing buildings, corridor wall partitions are fire resistance rated for 1/2 hour, continuous from the floor slab to the floor or roof slab above, extended through any concealed spaces (such as those above suspended ceilings and interstitial spaces), properly sealed, and constructed to limit the transfer of smoke. (For full text, refer to NFPA 101-2012: 19.3.6.2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.30, EP 11	Within corridors in smoke compartments that are protected throughout with an approved supervised sprinkler system, partitions are allowed to terminate at the ceiling if the ceiling is constructed to limit the passage of smoke. The passage of smoke can be limited by an exposed, suspended-grid acoustical tile ceiling with penetrating items such as sprinkler piping and sprinklers that penetrate the ceiling, ducted heating, ventilating, and air conditioning (HVAC) supply and return-air diffusers, speakers, and recessed lighting fixtures. (For full text, refer to NFPA 101-2012: 18/19.3.6.2) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.30, EP 12	In new buildings, all corridor doors are constructed to resist the passage of smoke, hinged so that they swing, and the doors do not have ventilating louvers or transfer grills (with the exception of bathrooms, toilets, and sink closets that do not contain flammable or combustible materials). Undercuts are no larger than one inch. Positive latching hardware is required. Roller latches are prohibited. (For full text, refer to NFPA 101-2012: 18.3.6.3.1; 18.3.6.3.5; 18.3.6.4; 18.3.6.5; 18.3.6.3.10; 18.3.6.3.11) CoPs: §482.41(b)(1)(ii)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.30, EP 13	In existing buildings, all corridor doors are constructed to resist the passage of smoke and constructed of 1 3/4-inch or thicker solid bonded wood core or constructed of material that resists fire for not less than 20 minutes, and the doors do not have ventilating louvers or transfer grills (with the exception of bathrooms, toilets, and sink closets that do not contain flammable or combustible materials). Positive latching hardware is required. Roller latches are prohibited. (For full text, refer to NFPA 101-2012: 19.3.6.3.1; 19.3.6.3.2; 19.3.6.3.5) Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: Powered corridor doors are equipped with positive latching hardware unless the organization can verify that this equipment is not an option provided by the door manufacturer. In instances where positive latching hardware is not an available option provided by the manufacturer, the device used must be capable of keeping the door fully closed when a force of 5 lbf is applied at the latch edge and in any direction to a sliding or folding door, whether or not power is applied in accordance with NFPA 101-2012: 19.3.6.3.7. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials are not required to have a device capable of keeping the door fully closed if a force of 5 lbf is applied at the latch edge. In these cases, roller latches are permissible. CoPs: §482.41(b)(1)(ii)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.30, EP 14	In smoke compartments without sprinkler systems, fixed fire windows in corridor walls are 25% or less of the size of the corridor walls in which they are installed. Existing window installations that conform to previously accepted Life Safety Code	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	criteria (such as a size of 1,296 square inches or less, made with wired glass or fire-rated glazing, and set in approved metal frames) are permitted. (For full text, refer to NFPA 101-2012: 19.3.6.2.7; 8.3.3.8; 8.3.3.9; 8.3.3.11) CoPs: §482.41(b)(1)(i)	moved to guidance within SPG		
LS.02.01.30, EP 15	Openings in vision panels or doors in corridor walls (other than in smoke compartments containing patient sleeping rooms) are installed at or below one half the distance from the floor to the ceiling. These openings may not be larger than 80 square inches in new buildings or larger than 20 square inches in existing buildings. Note: Openings may include, but are not limited to, mail slots and pass-through windows in areas such as laboratories, pharmacies, and cashier stations. (For full text, refer to NFPA 101-2012: 18/19.3.6.5) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.30, EP 16	Corridors serving adjoining areas are not used for a portion of an air supply, air return, or exhaust air plenum. Note: Incidental air movement between rooms and corridors (such as isolation rooms) because of the need for pressure differentials in hospitals is permitted. In such cases, the direction of airflow is not the focus for this element of performance. For the purpose of fire protection, air transfer should be limited to the amount necessary to maintain positive or negative pressure differentials. (For full text, refer to NFPA 101-2012: 19.5.2.1; NFPA 90A-2012: 4.3.12.1; 4.3.12.1.3.2) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.30, EP 17	In new buildings, at least two smoke compartments are provided for every story with patient sleeping or treatment rooms and for those stories that have an occupant capacity of 50 or more people, regardless of use. Smoke barriers have a minimum one-hour fire resistance rating; the maximum size of each smoke compartment is limited to 22,500 square feet. Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. The travel distance from any point within the compartment to a smoke barrier door is no more than 200 feet. (For full text, refer to NFPA 101-2012: 18.3.7.1; 18.3.7.3; 18.3.7.5)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.30, EP 18	In existing buildings, at least two smoke compartments are provided for every story that has more than 30 patients in sleeping rooms. Smoke barriers have a minimum ½-hour fire resistance rating; the maximum size of each smoke compartment is limited to 22,500 square feet. Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. The travel distance from any point within the smoke compartment to a smoke barrier door is no more than 200 feet. (For full text, refer to NFPA 101-2012: 19.3.7.1; 19.3.7.3; 19.3.7.5) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.30, EP 19	Smoke barriers extend from the floor slab to the floor or roof slab above, through any concealed spaces (such as those above suspended ceilings and interstitial spaces), and extend continuously from exterior wall to exterior wall. All penetrations are properly sealed. (For full text, refer to NFPA 101-2012: 18/19.3.7.3; 8.2.3; 8.5.2; 8.5.6; 8.7) Note: Polyurethane expanding foam is not an accepted fire-rated material for this	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	purpose. CoPs: §482.41(b)(1)(i)			
LS.02.01.30, EP 20	Doors in smoke barriers are self-closing or automatic-closing, constructed of 1 3/4-inch or thicker solid bonded wood core or constructed to resist fire for not less than 20 minutes, and fitted to resist the passage of smoke. The gap between meeting edges of door pairs is no wider than 1/8 of an inch. In new buildings, undercuts are no larger than 3/4 of an inch, and doors in a means of egress swing in the opposite direction. (For full text, refer to NFPA 101-2012: 18.3.7.6; 18/19.3.7.8; 8.5.4.1; NFPA 80-2010: 4.8.4.1; 6.3.1.7.1) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.30, EP 21	In smoke compartments without sprinkler systems, fixed fire windows in smoke barrier doors are 25% or less of the size of the doors in which they are installed. Existing window installations that conform to previously accepted Life Safety Code criteria (such as 1,296 square inches or less, wired glass or fire-rated glazing, and are set in approved metal frames) are permitted. (For full text, refer to NFPA 101-2012: 19.3.7.6; 8.3.3; 8.5.4.5) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.30, EP 22	In new buildings, the smoke damper is not required in the duct passing through a smoke barrier. In existing buildings, ducts that penetrate smoke barriers are protected by approved smoke dampers that close when a smoke detector is activated. The detector is located either within the duct system or in the area serving the smoke compartment. In existing buildings protected by an approved automatic sprinkler system, the damper is not required in the duct. (For full text, refer to NFPA 101-2012: 18/19.3.7.3; 8.3.5.1; 8.5.5; 8.5.5.7) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.30, EP 23	Approved smoke dampers protect air transfer openings extending through smoke barriers in ceiling spaces that are used as an unducted common plenum for either supply or return air. (For full text, refer to NFPA 101-2012: 18/19.3.7.3; 8.5.5.2) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.30, EP 24	Every patient sleeping room has an outside window or outside door except newborn nurseries or rooms intended for less than 24-hour stays (such as obstetrical labor beds, recovery beds, and observation beds in the emergency department). Note: Windows in atrium walls are considered outside windows. CoPs: §482.41(b)(9), §482.41(b)(9)(i), §482.41(b)(9)(ii)	Moved and Revised	PE.03.01.01, EP 9	Buildings have an outside window or outside door in every sleeping room. For any building constructed after July 5, 2016, the sill height does not exceed 36 inches above the floor. Note 1: Windows in atrium walls are considered outside windows for the purposes of this requirement. Note 2: The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours. Note 3: The sill height in special nursing care areas of new occupancies does not exceed 60 inches. CoPs: §482.41(b)(9), §482.41(b)(9)(i), §482.41(b)(9)(ii)
LS.02.01.30, EP 25	In new buildings constructed after July 5, 2016, the window sill height in patient sleeping rooms does not exceed 36 inches from the floor, except in special nursing care areas (for example, intensive care units, coronary care units, hemodialysis units, and neonatal intensive care units), where window sill height does not exceed	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	60 inches above the floor. CoPs: §482.41(b)(9), §482.41(b)(9)(i), §482.41(b)(9)(ii)	moved to guidance within SPG		
LS.02.01.30, EP 26	The hospital meets all other Life Safety Code fire and smoke protection requirements related to NFPA 101-2012: 18/19.3. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.34, EP 1	A fire alarm system is installed with systems and components to provide effective warning of fire in any part of the building in accordance with NFPA 70-2011, National Electric Code and NFPA 72-2010, National Fire Alarm Code. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.34, EP 2	The master fire alarm control panel is located in an area with a smoke detector or in an area that is continuously occupied and protected, which is an area enclosed with one-hour fire-rated walls and 3/4-hour fire-rated doors. In areas not continuously occupied and protected, a smoke detector is installed at each fire alarm control unit. In a newly designated occupancy, detection is also installed at notification appliance circuit power extenders and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. (For full text, refer to NFPA 101-2012: 18/19.3.4.1; 9.6) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.34, EP 3	Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas are not required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200 feet of travel distance is not exceeded. (For full text, refer to NFPA 101-2012: 18/19.3.4.2.1; 18/19.3.4.2.2; 9.6.2.5) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.34, EP 4	In new buildings, occupant notification is provided automatically in accordance with NFPA 101-2012: 9.6.3 by audible and visual signals. Positive alarm sequence in accordance with 9.6.3.4 is permitted in buildings protected throughout by a sprinkler system. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. Annunciation zoning for the fire alarm and sprinklers is provided by audible and visual indicators; zones are not larger than 22,500 square feet per zone. (For full text, refer to NFPA 101-2012: 18.3.4.3–18.3.4.4.3; 9.6.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.34, EP 5	In existing buildings, occupant notification is provided automatically in accordance with NFPA 101-2012: 9.6.3 by audible and visual signals. Positive alarm sequence in accordance with 9.6.3.4 is permitted in buildings protected throughout by a sprinkler system. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. (For full text, refer to NFPA 101-2012: 19.3.4.3; 9.6.4; 9.7.1.1(1))	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.41(b)(1)(i)			
LS.02.01.34, EP 6	Activation of the required fire alarm control functions occurs automatically and is provided with an alternative power supply in accordance with NFPA 72-2010. (For full text, refer to NFPA 101-2012: 18/19.3.4.4; 9.6.1; 9.6.5) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.34, EP 7	The fire alarm signal automatically transmits using one of the provisions of NFPA 101-2012: 9.6.4. (For full text, refer to NFPA 101-2012: 18/19.3.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.34, EP 8	Smoke detection systems are provided in spaces open to corridors as required by NFPA 101-2012: Chapter 18/19. (For full text, refer to NFPA 101-2012: 18/19.3.4.5.2; 18/19.3.6.1) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.34, EP 9	The ceiling membrane is installed and maintained in a manner that permits activation of the smoke detection system. (For full text, refer to NFPA 101-2012: 18/19.3.4.1)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.34, EP 10	The hospital meets all other Life Safety Code fire alarm requirements related to NFPA 101-2012: 18/19.3.4. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.35, EP 1	The fire alarm system monitors approved automatic sprinkler system components. (For full text, refer to NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.2.1) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.35, EP 2	The fire alarm system is connected to water flow alarms. (For full text, refer to NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.2) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.35, EP 3	Piping supports for approved automatic sprinkler systems are not damaged or loose. (For full text, refer to NFPA 101-2012: 18.3.5.1; 19.3.5.3; NFPA 25-2011: 5.2.3.1; 5.2.3.2) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.35, EP 4	Piping for approved automatic sprinkler systems is not used to support any other item. (For full text, refer to NFPA 25-2011: 5.2.2.2) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.35, EP 5	Sprinklers are not damaged. They are also free from corrosion, foreign materials, and paint and have necessary escutcheon plates installed. (For full text, refer to NFPA	Deleted EP - Replaced with more	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	101-2012: 18.3.5.1; 19.3.5.3; 9.7.5; NFPA 25-2011: 5.2.1.1.1; 5.2.1.1.2; NFPA 13-2010: 6.2.6.2.2; 6.2.7.1) CoPs: §482.41(b)(1)(i)	direct EP(s) or moved to guidance within SPG		
LS.02.01.35, EP 6	There are 18 inches or more of open space maintained below the sprinkler to the top of storage. Note: Perimeter wall and stack shelving may extend up to the ceiling when not located directly below a sprinkler. (For full text, refer to NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.1.1; NFPA 13-2010: 8.5.6) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.35, EP 7	At least six spare sprinkler heads that correspond to the types and temperature rating of the hospital's sprinkler heads, with associated wrenches, are kept in a cabinet that will not exceed 100°F. (For full text, refer to NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.1.1; NFPA 25-2011: 5.4.1.4; 5.4.1.6; NFPA 13-2010: 6.2.9; 6.2.9.1; 6.2.9.3; 6.2.9.6) Note: If the hospital has more than 300 sprinklers, the minimum spare sprinkler head requirement incrementally increases. (For full text, refer to NFPA 13-2010: 6.2.9.5)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.35, EP 8	In both new buildings and existing buildings, the clothing closets in patient sleeping rooms are not required to have sprinkler protection if the closet does not exceed six square feet. (For full text, refer to NFPA 101-2012: 18/19.3.5.10)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.35, EP 9	In new buildings, quick response sprinklers are installed in smoke compartments with patient sleeping rooms. (For full text, refer to NFPA 101-2012: 18.3.5.6)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.35, EP 10	The travel distance from any point to the nearest portable fire extinguisher is 75 feet or less. Portable fire extinguishers have appropriate signage, are installed either in a cabinet or secured on a hanger made for the extinguisher, and are at least four inches off the floor. Those fire extinguishers that are 40 pounds or less are installed so the top is not more than 5 feet above the floor. (For full text, refer to NFPA 101-2012: 18/19.3.5.12; 9.7.4.1; NFPA 10-2010: 6.2.1.1; 6.1.3.3.1; 6.1.3.4; 6.1.3.8) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.35, EP 11	Class K–type portable fire extinguishers are located within 30 feet of grease-producing ranges, griddles, broilers, or cooking appliances that use vegetable or animal oils or fats, such as deep fat fryers. A placard is conspicuously placed near the extinguisher stating that the fire protection system should be activated prior to using the fire extinguisher. (For full text, refer to NFPA 101-2012: 18/19.3.2.5.1; NFPA 96-2011: 10.10.2; NFPA 10-2010: 5.5.5; 6.6.2) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.35, EP 12	Grease-producing cooking devices such as deep fat fryers, ranges, griddles, or broilers have an exhaust hood, an exhaust duct system, and grease removal devices without mesh filters. (For full text, refer to NFPA 101-2012: 18/19.3.2.5.1; NFPA 96-2011: 6.1)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.41(b)(1)(i)			
LS.02.01.35, EP 13	The automatic fire extinguishing system for grease-producing cooking devices does the following: deactivates the fuel source, activates the building fire alarm system, and controls the exhaust fans as designed. (For full text, refer to NFPA 101-2012: 18/19.3.2.5.1; NFPA 96-2011: 10.4; 10.6.1; 10.6.2; 8.2.3) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.35, EP 14	The hospital meets all other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012: 18/19.3.5. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.40, EP 1	High-rise buildings have an approved automatic sprinkler system that meets the requirements of NFPA 101-2012: 18/19.4.2. (For full text, refer to NFPA 101-2012: 11.8) Note: Organizations that do not have approved automatic sprinkler systems in high-rise buildings (over 75 feet tall) as of July 5, 2016, have 12 years to install them. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.50, EP 1	Equipment using gas or gas piping complies with NFPA 54-2012, National Fuel Gas Code; electrical wiring and equipment complies with NFPA 70-2012, National Electric Code. Existing installations can continue in service provided there are no life-threatening hazards. (For full text, refer to NFPA 101-2012: 18/19.5.1.1; 9.1.1; 9.1.2) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.50, EP 2	Heating, ventilation, and air conditioning comply with NFPA 101-2012: 9.2 and are installed in accordance with manufacturers' specifications. (For full text, refer to NFPA 101-2012: 18/19.5.2.1) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.50, EP 3	Any heating device (other than a central heating plant) is designed and installed so combustible materials cannot be ignited by the device and safety features stop fuel and shut down equipment if it experiences excessive temperature or ignition failure. (For full text, refer to NFPA 101-2012: 18/19.5.2.2) Note: If fuel fired, the heating device is designed as follows: - Chimney or vent connected - Takes air for combustion from outside - Combustion system is separate from occupied area atmosphere CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.50, EP 4	A suspended unit heater(s) is permitted provided the following conditions are met: - Not located in means of egress or in patient rooms - Located high enough to be out of reach of people in the area - Has a safety feature to stop fuel and shut down equipment if it experiences excessive temperature or ignition failure (For full text, refer to NFPA 101-2012: 18/19.5.2.3)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.41(b)(1)(i)			
LS.02.01.50, EP 5	Direct-vent fireplaces in patient sleeping areas must meet the provisions of NFPA 101-2012: 18/19.5.2.2; 18/19.5.2.3.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.50, EP 6	Solid fuel–burning fireplaces are permitted in areas other than patient sleeping rooms when the following occurs: - Areas are separated by a one-hour fire-resistant wall - Fireplace complies with NFPA 101-2012: 9.2.2 - Fireplace enclosure resists breakage up to 650°F and has heat-tempered glass - Area has supervised carbon monoxide detection per NFPA 101-2012: 9.8 (For full text, refer to NFPA 101-2012: 18/19.5.2.3(3)) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.50, EP 7	Elevators are equipped with the following: - Firefighters' service key recall - Smoke detector automatic recall - Firefighters' service emergency in-car key operation - Machine room smoke detectors - Elevator lobby smoke detectors Existing elevators that have a travel distance of 25 feet or more above or below the level that best serves the needs of firefighters also meet these requirements. (For full text, refer to NFPA 101-2012: 18/19.5.3; 9.4.2; 9.4.3) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.50, EP 8	Escalators, dumbwaiters, and moving walks comply with NFPA 101-2012: 9.4. In addition, existing escalators, dumbwaiters, and moving walks (including escalator emergency stop buttons and automatic skirt obstruction stop) conform with the requirements of ASME/ANSI A17.1, Safety Code for Elevators and Escalators and ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. (For full text, refer to NFPA 101-2012: 18/19.5.3; 9.4.2; 9.4.6) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.50, EP 9	In new buildings, the inlet door assemblies for linen- and waste-chute services are fire rated for one hour (or for 1 1/2 hours in chutes of four stories or more). In existing buildings, the inlet door assemblies for linen- and waste-chute services are fire rated for 3/4 of an hour (or for one hour if it opens into a corridor). (For full text, refer to NFPA 101-2012: 18/19.5.4; 8.3.3.1; 9.5; NFPA 82-2009: 5.2.3.1.3) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.50, EP 10	All linen and waste chute inlet service doors have both self-closing and positive-latching devices. All linen and waste discharge service doors are self-closing. Note: Discharge doors may be held open with fusible links or electrical hold-open devices. (For full text, refer to NFPA 101-2012: 18/19.5.4; 8.3.3.1; 9.5; NFPA 82-2009: 5.2.3.2.3; Tentative Interim Amendment [TIA] 09-1) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
LS.02.01.50, EP 11	Linen- and waste-chute discharge door assemblies are fire rated the same as the chute. (For full text, refer to NFPA 101-2012: 18/19.5.4; 9.5; NFPA 82-2009: 5.2.4; 5.2.3.2) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.50, EP 12	In buildings more than two stories high, an approved automatic sprinkler system is located above the top of the linen and waste chute service openings on the lowest service levels and above the service door opening on alternate floor levels. (For full text, refer to NFPA 101-2012: 18/19.5.4.3; 9.7; NFPA 82-2009: 5.2.6) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.50, EP 13	Trash chutes discharge into collection rooms that are not used for any other purpose and are separated from the corridor and have a minimum fire resistance rating not less than that specified for the chute. In existing buildings, if the trash collection room is protected with an approved automatic sprinkler system, linen collection may also occur. (For full text, refer to NFPA 101-2012: 18/19.5.4.4; 19.5.4.5; NFPA 82-2009: 5.2.4.1) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.50, EP 14	The hospital meets all other Life Safety Code building service requirements related to NFPA 101-2012: 18/19.5. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.70, EP 1	Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored; these areas have signs that read “NO SMOKING” or display the international symbol for no smoking. In facilities where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs that prohibit smoking in hazardous areas are not required. (For full text, refer to NFPA 101-2012: 18/19.7.4) Note: The secondary sign exception is not applicable to medical gas storage areas.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.70, EP 2	In areas where smoking is permitted, ashtrays are safely designed and made of noncombustible material. Metal containers with self-closing cover devices in which ashtrays can be emptied are readily available to all areas where smoking is permitted. (For full text, refer to NFPA 101-2012: 18/19.7.4)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.70, EP 3	Draperies, curtains (including cubicle and shower curtains), and loosely hanging fabric comply with NFPA 101-2012: 10.3.1. (For full text, refer to NFPA 101-2012: 18/19.7.5.1; 18/19.3.5.11; 10.3.1) Note: Exceptions include shower/bath curtains in addition to window coverings in patient sleeping rooms and non-patient sleeping rooms located in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20% of the wall. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.70, EP 4	In buildings without sprinkler protection, upholstered furniture purchased on or after July 5, 2016, meets Class I or char length and heat release criteria in accordance with NFPA 101-2012: 10.3.2.1 and 10.3.3. Mattresses purchased on or after July 5, 2016, meet char length and heat release criteria in accordance with NFPA 101-2012:	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	10.3.2.2 and 10.3.4. (For full text, refer to NFPA 101-2012: 18/19.7.5.2; 18/19.7.5.4) CoPs: §482.41(b)(1)(i)	moved to guidance within SPG		
LS.02.01.70, EP 5	Decorations (for example, photos, paintings, other art) directly attached to the walls, ceiling, and non-fire-rated doors are permitted provided they do not exceed 20% of the wall, ceiling, or door areas in spaces in nonsprinklered smoke compartments; 30% in spaces in sprinklered smoke compartments; 50% inside patient sleeping rooms that do not exceed four people in sprinklered smoke compartments. (For full text, refer to NFPA 101-2012: 18/19.7.5.6) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.70, EP 6	Soiled linen and trash receptacles larger than 32 gallons are stored in a room protected as a hazardous area. (For full text, refer to NFPA 101-2012: 18/19.7.5.7) Note: Containers that are 96 gallons or less and are labeled and listed as meeting the requirements of FM Approval Standard 6921 (or equivalent) and are used solely for recycling clean waste (including patient records awaiting destruction) are permitted in an unprotected area. Those containers that are greater than 96 gallons are stored in a hazardous storage area. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.70, EP 7	When installed, new engineered smoke control systems are tested in accordance with NFPA 92-2012, Standard for Smoke Control Systems. Existing engineered smoke control systems are tested in accordance with established engineering principles. (For full text, refer to NFPA 101-2012: 18/19.7.7) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.70, EP 8	Portable space heaters are prohibited in smoke compartments containing sleeping rooms and patient treatment areas. Non-sleeping rooms that are occupied by staff and separated from the corridor are permitted to have portable space heaters, but must contain heating elements not exceeding 212°F. (For full text, refer to NFPA 101-2012: 18/19.7.8) Note: For this element of performance, nurses stations are considered patient treatment areas. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.02.01.70, EP 9	The hospital meets all other Life Safety Code operating feature requirements related to NFPA 101-2012: 18.7/19.7. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.10, EP 1	Buildings meet requirements for construction type and height. In Types I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. All new buildings contain approved automatic sprinkler systems. Existing buildings contain approved automatic sprinkler systems as required by the construction type. (For full text, refer to NFPA 101-2012: 20/21.1.6.1–20/21.1.6.6; 20/21.3.5) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
LS.03.01.10, EP 2	Interior nonbearing walls in Types I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls that are required to have a minimum of two-hour fire resistance rating are made with fire retardant–treated wood and enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. (For full text, refer to NFPA 101-2012: 20.1.6.3; 20.1.6.4; 21.1.6.3; 21.1.6.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.10, EP 3	When building rehabilitation occurs, the hospital incorporates NFPA 101-2012: Chapters 20, 21, and 43. (For full text, refer to NFPA 101-2012: Chapter 43; 20/21.1.1.4; 4.6.7) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.10, EP 4	Ambulatory occupancies located in multioccupancy buildings are separated from health care occupancies by two-hour fire-rated walls and from business occupancies by one-hour fire-rated walls. (For full text, refer to NFPA 101-2012: 20/21.1.3; 20/21.1.4; 20/21.3.7.1) Note: Per Centers for Medicare & Medicaid Services' regulation, outpatient surgical departments are classified as ambulatory health care occupancies, regardless of the number of patients served. (For full text, refer to NFPA 101-2012: 20/21.1.3.2; 20/21.3.7.1) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.10, EP 5	Fire barriers are continuous from outside wall to outside wall or from one fire barrier to another, or a combination thereof, including continuity through all concealed spaces, such as those found above a ceiling, including interstitial spaces. For those fire barriers terminating at the bottom side of an interstitial space, the construction assembly forming the bottom of the interstitial space must have a fire resistance rating not less than that of the fire barrier. (For full text, refer to NFPA 101-2012: 8.3.1.2) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.10, EP 6	The fire protection ratings for opening protectives in fire barriers and fire-rated smoke barriers are as follows: - Three hours in three-hour barriers - Ninety minutes in two-hour barriers - Forty-five minutes in one-hour barriers Note: Doors that separate the ambulatory health care occupancy from other tenants or other occupancies (except health care occupancies) do not need to meet the 45-minute rating as long as they are constructed of not less than 1¾-inch thick, solid bonded wood-core or equivalent and must be equipped with positive latches. - Twenty minutes in thirty-minute barriers (For full text, refer to NFPA 101-2012: 8.3.3.2; 8.3.4.2; Table 8.3.4.2; 20/21.3.7.1; NFPA 80-2010: 5.2.13.3) Note 1: Labels on fire door assemblies must be maintained in legible condition. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the applicable provisions of the Life Safety Code Tentative Interim Amendment (TIA) 12-1.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.41(b)(1)(i)			
LS.03.01.10, EP 7	Doors within walls and floors that are required to be fire rated have functioning hardware, including positive latching devices and self-closing or automatic-closing devices. Gaps between meeting edges of door pairs are no more than 1/8-inch wide, and undercuts are no larger than 3/4 of an inch. Blocking or wedging open fire-rated doors is prohibited. Doors required to be fire rated in the walls do not have unapproved protective plates greater than 16 inches from the bottom of the door. (For full text, refer to NFPA 101-2012: 8.3.3.1; NFPA 80-2010: 4.8.4.1; 5.2.13.3; 6.3.1.7; 6.4.5) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.10, EP 8	Doors requiring a minimum fire rating of 3/4 of an hour are free of coverings, decorations, or other objects applied to the door face. Informational signs, which are applied with adhesive only, are allowed provided that the informational signage does not exceed 5% of the door face area. (For full text, refer to NFPA 80-2010: 4.1.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.10, EP 9	Ducts penetrating the walls and floors with a fire-resistance rating of less than three hours are protected by dampers that are fire rated for 1 1/2 hours; penetrations of three hours or greater are protected by fire dampers that are fire rated for three hours. (For full text, refer to NFPA 101-2012: 8.3.5.7; 9.2.1; NFPA 90A-2012: 5.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.10, EP 10	The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes penetrating the walls or floors are protected with an approved fire-rated material. Note: Non-approved polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text, refer to NFPA 101-2012: 8.3.5) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.10, EP 11	The hospital meets all other Life Safety Code requirements related to NFPA 101-2012: 20/21.1. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.20, EP 1	Doors in a means of egress are not equipped with a latch or lock that requires the use of a tool or key from the egress side, unless a compliant locking configuration is used, such as a delayed-egress locking system as defined in NFPA 101-2012: 7.2.1.6.1 or access-controlled egress door assemblies as defined in NFPA 101-2012: 7.2.1.6.2. Elevator lobby exit access door locking is allowed if compliant with 7.2.1.6.3. (For full text, refer to NFPA 101-2012: 20/21.2.2) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.20, EP 2	Any door required to be self-closing, including those in an exit stair enclosure, may be held open provided there is an automatic release device that closes the door in response to the manual fire alarm system, loss of power, and smoke detectors. (For full text, refer to NFPA 101-2012: 20/21.2.2.4; 20/21.2.2.5; 7.2.1.8.2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.41(b)(1)(i)			
LS.03.01.20, EP 3	Exits discharge to the outside at grade level or through an approved exit passageway that is continuous and provides a level walking surface. The exit discharge is a hard-packed, all-weather travel surface that is free from obstructions and terminates at a public way or at an exterior exit discharge. (For full text, refer to NFPA 101-2012: 20/21.2.1; 20/21.2.7; 38/39.2.7; 7.1.7; 7.1.10.1; 7.2.6; 7.7) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.20, EP 4	The capacity of the means of egress complies with NFPA 101-2012: 7.3. (For full text, refer to NFPA 101-2012: 20/21.2.3.1) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.20, EP 5	Exit corridors or passageways serving as a means of egress are 44 (or more) inches wide. Doors opening in the means of egress from diagnostic or treatment areas are 32 (or more) inches wide (unless the existing door opening is 34 inches). (For full text, refer to NFPA 101-2012: 20/21.2.3.2; 2.3.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.20, EP 6	Exits, exit accesses, and exit discharges are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text, refer to NFPA 101-2012: 7.1.10.1) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.20, EP 7	Exit access doors and exit doors are free of mirrors, hangings, or draperies that might conceal, obscure, or confuse the direction of exit. (For full text, refer to NFPA 101-2012: 20/21.2.1; 7.5.2.2.1) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.20, EP 8	Each floor of a building has at least two exits that are remote from each other and accessible from every part of the floor. Each smoke compartment has two distinct egress paths to exits that do not require entry into the same adjacent smoke compartment. Patient care suites larger than 2,500 square feet have two exits remotely located from each other. (For full text, refer to NFPA 101-2012: 20/21.2.4.1; 2.4.2; 7.4; 38/39.2.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.20, EP 9	In new buildings protected throughout by an approved automatic sprinkler system, dead-end corridors are no longer than 50 feet. In new buildings not provided with automatic sprinklers throughout, dead-end corridors are no longer than 20 feet. In existing buildings, dead-end corridors are no longer than 50 feet. (For full text, refer to NFPA 101-2012: 20/21.2.5; 38/39.2.5.2) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.20, EP 10	The travel distance from any point in a room to an exit is 150 feet or less; the travel distance is 200 feet or less in buildings protected throughout by an approved automatic sprinkler system. (For full text, refer to NFPA 101-2012: 20/21.2.6)	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.41(b)(1)(i)	moved to guidance within SPG		
LS.03.01.20, EP 11	Nothing is stored in any exit enclosure. (For full text, refer to NFPA 101-2012: 20/21.2.1; 7.2.2.5) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.20, EP 12	Means of egress are automatically and adequately illuminated at all points, including angles and intersections of corridors and passageways, stairways, stairway landings, exit doors, and exit discharges. (For full text, refer to NFPA 101-2012: 20/21.2.8; 7.8) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.20, EP 13	Illumination in the means of egress, including exit discharge, is arranged so that failure of any single lighting unit will not result in darkness (less than 0.2 foot-candles of illumination). Emergency lighting of at least 1½-hours duration is provided automatically in accordance with NFPA 101-2012: 7.9. (For full text, refer to NFPA 101-2012: 20/21.2.8; 7.8.1.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.20, EP 14	Signs reading "NO EXIT" are posted on doors to stairs in areas that are not conforming exits and that may be mistaken for exits. (For full text, refer to NFPA 101-2012: 20/21.2.10; 7.10.8.3) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.20, EP 15	Exit signs are visible when the path to the exit is not readily apparent. Signs are adequately lit and have letters that are 4 or more inches high or 6 inches high if externally lit. (See NFPA 101-2012: 20/21.2.10; 7.10.5) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.20, EP 16	New buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination for the following: means of egress, emergency lighting equipment, exit, and directional signs supplied by the life safety branch of the electrical system described in NFPA 99-2012. (For full text, refer to NFPA 101-2012: 20.2.9.2; NFPA 99-2012: 6.4.2.2.3) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.20, EP 17	The hospital meets all other Life Safety Code means of egress requirements related to NFPA 101-2012: 20/21.2. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.30, EP 1	In new construction, vertical openings, including exit stairs, are enclosed by one-hour fire-rated walls when connecting three or fewer floors and two-hour fire-rated walls when connecting four or more floors. Existing vertical openings, including exit stairs, are enclosed with a minimum of one-hour fire-rated construction. (For full text, refer to NFPA 101-2012: 20/21.3.1; 8.6; 8.6.5; 38/39.3.1) Note: These vertical openings include, but are not limited to, shafts (including elevator, light, and ventilation), communicating stairs, ramps, trash chutes, linen chutes, and utility chases.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.41(b)(1)(i)			
LS.03.01.30, EP 2	In buildings, exit stairs connecting three or fewer floors are fire rated for one hour; exit stairs connecting four or more floors are fire rated for two hours. (For full text, refer to NFPA 101-2012: 20/21.3.1; 38/39.3.1; 8.6.5) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.30, EP 3	All hazardous areas are enclosed with one-hour fire-rated walls with ¾-hour fire-rated doors; or hazardous areas have sprinkler systems and are constructed to resist the passage of smoke with doors equipped with self-closing or automatic-closing devices. (For full text, refer to NFPA 101-2012: 20/21.3.2; 38/39.3.2; 8.7; NFPA 80-2010: 4.8.4.1; 6.3.1.7; 6.5) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.30, EP 4	Laboratories using quantities of flammable, combustible, or hazardous materials that are considered as a severe hazard are protected in accordance with NFPA 101-2012: 8.7 and NFPA 99-2012 requirements. (For full text, refer to NFPA 101-2012: 20/21.3.2.2) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.30, EP 5	Alcohol-based hand rubs (ABHR) are stored and handled in accordance with NFPA 101-2012: 8.7.3.1, unless all of the following conditions are met: - Corridor is at least six feet wide. - ABHR does not exceed 95% alcohol. - Maximum individual dispenser capacity is 0.32 gallons of fluid (0.53 gallons in suites) or 18 ounces of NFPA Level 1–classified aerosols. - Dispensers have a minimum of four feet of horizontal spacing between them. - Dispensers are not installed within one inch of an ignition source. - If floor is carpeted, the building is fully sprinkler protected. - Operation of the dispenser complies with NFPA 101-2012: 20/21.3.2.6(11). - ABHR is protected against inappropriate access. - Not more than an aggregate of 10 gallons of fluid or 1135 ounces of aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room. - Storing more than five gallons of fluid in a single smoke compartment complies with NFPA 30.	Consolidation of LS.02.01.30, EP 6; LS.03.01.30, EP 5; LS.05.01.30, EP 3	PE.03.01.01, EP 7	When the hospital installs alcohol-based hand rub dispensers, it installs the dispensers in a manner that protects against inappropriate access. CoPs: §482.41(b)(7)
LS.03.01.30, EP 6	Commercial cooking equipment is installed per NFPA 96-2011, unless only used for food warming or limited cooking. (For full text, refer to NFPA 101-2012: 20/21.3.2.4; 20/21.3.2.5; 9.2.3) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.30, EP 7	Wall and ceiling interior finishes of exits and enclosed corridors are rated Class A or B for limiting smoke development and the spread of flames. (For full text, refer to NFPA 101-2012: 20/21.3.3; 38/39.3.3.2; 10.2.3) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.30, EP 8	Newly installed interior floor finishes in exits and enclosed corridors have a Class I or II radiant flux rating. (For full text, refer to NFPA 101-2012: 20/21.3.3; 10.2.7)	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.41(b)(1)(i)	moved to guidance within SPG		
LS.03.01.30, EP 9	In new construction, openings in vision panels or doors are permitted without protection provided the openings are installed at or below one half the distance from the floor to the room ceiling and do not exceed 20 square inches. In rooms protected throughout by an approved automatic sprinkler system, the aggregate area of openings is limited to 80 square inches. In existing construction, openings are not limited. (For full text, refer to NFPA 101-2012: 20.3.6.2) Note: Openings may include, but are not limited to, mail slots and pass-through windows in areas such as laboratory, pharmacy, and cashier stations. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.30, EP 10	In new construction, corridors that provide access to exits are separated from other areas by one-hour fire-rated barriers unless otherwise permitted by NFPA 101-2012: 38.3.6.1. Note: For existing construction, there are no requirements. (For full text, refer to NFPA 101-2012: 20.3.6.2; 38.3.6.1) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.30, EP 11	Ambulatory health care space must be separated from other tenants with a one-hour fire resistance–rated barrier, constructed from the floor slab below to the floor or roof above. Doors in the barrier are 1¾ inch thick, solid bonded (or equivalent), self-closing, and have positive latching. Doors are kept in the closed position except when in use. Windows in the barrier comply with NFPA 101-2012: 8.3. (For full text, refer to NFPA 101-2012: 20/21.3.7.1; 8.3)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.30, EP 12	At least two smoke compartments are provided for every story unless one of the following conditions are met: - Facility is less than 5,000 square feet and protected by an approved smoke detection system - Facility is less than 10,000 square feet and protected by an approved, supervised sprinkler system per NFPA 101-2012: 9.7 - Adjoining occupancy is used as a smoke compartment if all of the following conditions are met: - Separating wall has a fire-resistive rating of one hour - Doors in the one-hour fire-rated wall are 1 3/4-inch thick - Doors in the one-hour fire-rated wall are self-closing - Windows in the one-hour fire-rated wall are fixed fire window assemblies per NFPA 101-2012: 8.3 - The ambulatory health care facility is less than 22,500 square feet - Access from the ambulatory health care facility is unrestricted to another occupancy (For full text, refer to NFPA 101-2012: 20/21.3.7.2) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.30, EP 13	Smoke barriers extend from the floor slab to the upper floor or roof slab above, through any concealed spaces (such as those above suspended ceilings and interstitial spaces), continuously from exterior wall to exterior wall. All penetrations are sealed. New smoke barriers are constructed of one-hour fire-rated materials. (For full text, refer to NFPA 101-2012: 20/21.3.7.5; 20/21.3.7.6)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.41(b)(1)(i)			
LS.03.01.30, EP 14	Ducts that penetrate smoke barriers, are protected by approved smoke dampers that close when a local smoke detector is activated. The detector is located either within the duct system or in the corridor. Note: In buildings with a fully ducted HVAC system and protected throughout by an approved automatic sprinkler system, dampers are not required. (For full text, refer to NFPA 101-2012: 20/21.3.7.6; 8.5.5) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.30, EP 15	Fixed fire window assemblies in smoke barrier walls or doors are fire rated for 20 minutes and are 25% or less of the size of the fire barrier in which they are installed. Note: Existing window installations that have wired glass or fire-rated glazing, are 1,296 square inches in size or smaller, and are set in approved metal frames are acceptable. (For full text, refer to NFPA 101-2012: 20/21.3.7.7, 8.3.3) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.30, EP 16	Doors in smoke barriers are constructed of 1 3/4 inch or thicker solid-bonded wood core (or equivalent) and are self-closing or automatic-closing. For new buildings, doors are required to swing in the direction of egress travel; rabbets, bevels, or astragals are at meeting edges; and stops are at the head and sides of door frames. Center mullions are prohibited in smoke barrier door openings. (For full text, refer to NFPA 101-2012: 20/21.3.7.9; 20/21.2.2.4; 20.3.7.9; 20.3.7.10; 3.7.13; 3.7.14) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.30, EP 17	The hospital meets all other Life Safety Code fire and smoke protection requirements related to NFPA 101-2012: 20/21.3. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.34, EP 1	A fire alarm system is installed with systems and components to provide effective warning of fire in any part of the building in accordance with NFPA 70-2012, National Electric Code, and NFPA 72-2010, National Fire Alarm Code. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.34, EP 2	The master fire alarm control panel is located in an area with a smoke detector or in an area that is continuously occupied and protected, which is an area enclosed with one-hour fire-rated walls and 3/4-hour fire-rated doors. In areas not continuously occupied and protected, a smoke detector is installed at each fire alarm control unit. In a new building, detection is also installed at notification appliance circuit power extenders and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. (For full text, refer to NFPA 101-2012: 20/21.3.4.1; 9.6) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.34, EP 3	Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit and 200 feet of travel distance is not exceeded. (For full text, refer to NFPA 101-2012: 20/21.3.4.2.1; 20/21.3.4.2.2;	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	9.6.2.5) CoPs: §482.41(b)(1)(i)	moved to guidance within SPG		
LS.03.01.34, EP 4	For new buildings, occupant notification is provided automatically in accordance with NFPA 101-2012: 9.6.3 by audible and visual signals. Positive alarm sequence in accordance with 9.6.3.4 is permitted in buildings protected throughout by a sprinkler system. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. Annunciation zoning for the fire alarm and sprinklers is provided by audible and visual indicators; zones are not larger than 22,500 square feet per zone. (For full text, refer to NFPA 101-2012: 20.3.4.3–20.3.4.4; 9.6.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.34, EP 5	For existing buildings, occupant notification is provided automatically in accordance with NFPA 101-2012: 9.6.3 by audible and visual signals. Positive alarm sequence in accordance with 9.6.3.4 is permitted in buildings protected throughout by a sprinkler system. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. (For full text, refer to NFPA 101-2012: 21.3.4.3; 9.6.4; 9.7.1.1(1)) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.34, EP 6	Activation of the required fire alarm control functions occurs automatically and is provided with an alternative power supply in accordance with NFPA 72-2010. (For full text, refer to NFPA 101-2012: 20/21.3.4.4; 9.6.1; 9.6.5) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.34, EP 7	The fire alarm signal automatically transmits to one of the following: - An auxiliary fire alarm system - Central station fire alarm system - A proprietary supervising station fire alarm system - A remote supervising station fire alarm system (For full text, refer to NFPA 101-2012: 20/21.3.4.3.2; NFPA 101-2012: 9.6.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.34, EP 8	The remote ancillary annunciator panel is in a location approved by the local fire department or its equivalent. (For full text, refer to NFPA 101-2012: 20/21.3.4.3, 9.6.3) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.34, EP 9	The fire alarm system contains an audible and visual evacuation signal throughout the building and provides occupant notification without delay. (For full text, refer to NFPA 101-2012: 20/21.3.4.3, 9.6.3) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.34, EP 10	The hospital meets all other Life Safety Code fire alarm requirements related to NFPA 101-2012: 20.3.4/21.3.4. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
LS.03.01.35, EP 1	For new construction, the fire alarm system monitors the components of any required approved automatic sprinkler system. (For full text, refer to NFPA 101-2012: 20/21.3.5.2; 9.7.1.1) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.35, EP 2	The fire alarm system is connected to water flow alarms of any required automatic sprinkler system. (For full text, refer to NFPA 101-2012: 20/21.3.4.4; 20/21.3.5; 9.7.1.1) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.35, EP 3	Piping supports for approved automatic sprinkler systems are not damaged or loose. (For full text, refer to NFPA 101-2012: 20/21.3.4.4; NFPA 25-2011: 5.2.1; 5.2.2; 5.2.3) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.35, EP 4	Approved automatic sprinkler systems piping is not used to support any other item. (For full text, refer to NFPA 101-2012: 20/21.3.4.4; NFPA 25-2011: 5.2.2; NFPA 13-2010: 8.5.5.2; 8.5.5.3) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.35, EP 5	Sprinkler heads are not damaged and are free from corrosion, foreign materials, and paint. (For full text, refer to NFPA 101-2012: 20/21.3.4.4; NFPA 25-2011: 5.2.1; 5.2.2; NFPA 13-2010: 6.2.6.2; 6.2.7.1) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.35, EP 6	There is 18 inches or more of open space maintained below a sprinkler deflector to the top of storage. Note: Perimeter wall shelving may extend up to the ceiling when not located directly below a sprinkler head. (For full text, refer to NFPA 101-2012: 20/21.3.4.4; NFPA 25-2011: 5.2.1; 5.2.2; NFPA 13-2010: 8.5.5; 8.5.6) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.35, EP 7	At least six spare sprinkler heads that correspond to the types and temperature rating of the hospital's sprinkler heads, with associated wrenches, are kept in a cabinet that will not exceed 100°F. (For full text, refer to NFPA 101-2012: 9.7.1.1; NFPA 13-2010: 6.2.9; 6.2.9.1; 6.2.9.3; 6.2.9.6) Note: If the hospital has more than 300 sprinklers, the minimum spare sprinkler head requirement incrementally increases. (For full text, refer to NFPA 13-2010: 6.2.9.5)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.35, EP 10	The travel distance from any point to the nearest portable fire extinguisher is 75 feet or less. Portable fire extinguishers have appropriate signage, are installed in a cabinet or secured on a hanger made for the extinguisher, and are at least four inches off the floor. Those fire extinguishers that are 40 pounds or less are installed so the top is not more than 5 feet above the floor. (For full text, refer to NFPA 101-2012: 20/21.3.5.3; 9.7.4.1; NFPA 10-2010: 6.1.3; 6.2.1) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.35, EP 11	The hospital meets all other Life Safety Code extinguishing requirements related to NFPA 101-2012: 20/21.3.5.	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.41(b)(1)(i)	moved to guidance within SPG		
LS.03.01.40, EP 1	Windowless buildings or portions of windowless buildings meet the requirements of NFPA 101-2012: 20/21.4; 11.7. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.40, EP 2	Existing high-rise buildings have approved automatic sprinkler systems that meet the requirements of NFPA 101-2012: 20/21.4; 11.8; 9.7.1.1(1), or they have an engineered life safety system complying with NFPA 101-2012: 39.4.2.1(2). New high-rise buildings comply with NFPA 101-2012: 11.8. (For full text, refer to NFPA 101-2012: 20/21.4; 11.8; 39.4.2.1) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.40, EP 3	The hospital meets all other Life Safety Code extinguishing requirements related to NFPA 101-2012: 20/21.3.5. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.50, EP 1	Equipment using gas or related gas piping complies with NFPA 54-2012, National Fuel Gas Code; electrical wiring and equipment complies with NFPA 70-2012, National Electric Code. Existing installations can continue in service provided there are no life-threatening hazards. (For full text, refer to NFPA 101-2012: 20/21.5.1; 9.1.1) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.50, EP 2	Heating, ventilation, and air conditioning comply with NFPA 101-2012: 9.2 and are installed in accordance with the manufacturers' specifications. (For full text, refer to NFPA 101-2012: 20/21.5.2.1; 9.2) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.50, EP 3	Any heating device (other than a central heating plant) is designed and installed so combustible materials cannot be ignited by the device, and safety features stop fuel and shut down equipment if it experiences excessive temperature or ignition failure. (For full text, refer to NFPA 101-2012: 20/21.5.2.2) Note: If fuel fired, the heating device is designed as follows: - Chimney or vent connected - Takes air for combustion from outside - Combustion system that is separate from occupied area atmosphere CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.50, EP 4	A suspended unit heater(s) is permitted provided the following conditions are met: - Not located in means of egress or in patient rooms - Located high enough to be out of reach of people in the area - Has a safety feature to stop fuel and shut down equipment if it experiences excessive temperature or ignition failure (For full text, refer to NFPA 101-2012: 20/21.5.2.2) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
LS.03.01.50, EP 5	New elevators are equipped with all of the following: - Firefighters service key recall and smoke detector automatic recall - Firefighters service emergency in-car key operation - Machine room smoke detectors - Elevator lobby smoke detectors Existing elevators meet these requirements when they have a travel distance of 25 feet or more above or below the level that best serves the needs of firefighters. (For full text, refer to NFPA 101-2012: 20/21.5.3; 9.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.50, EP 6	Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks (including escalator emergency stop buttons and automatic skirt obstruction stop) conform to the requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. (For full text, refer to NFPA 101-2012: 20/21.5.3; 9.4.2) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.50, EP 7	The hospital does not allow unvented fuel-fired heaters. (For full text, refer to NFPA 101-2012: 20/21.5.2.2) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.50, EP 8	All heating appliances are provided with safety features to stop the flow of fuel and turn off the appliance during times of excessive temperatures or ignition failure. (For full text, refer to NFPA 101-2012: 20/21.5.2.2) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.50, EP 9	Waste chutes are installed per NFPA 101-2012: 9.5 and meet the following requirements: - Walls, partitions, and inlet openings meet the requirements of NFPA 101-2012: 8.3. - Doors of chutes open to a room designed exclusively for accessing the chute opening. - Rooms used for accessing the chute opening(s) are separated from other spaces per NFPA 101-2012: 8.7. - Chutes are permitted to open into rooms not exceeding 400 cubic feet in size if the room is sprinkler protected and not used for storage. (For full text, refer to NFPA 101-2012: 20/21.5.4; 9.5; NFPA 82-2009) Note: Existing installations having properly enclosed and maintained chute openings are permitted to have inlets open to a corridor or normally occupied space. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.50, EP 10	The hospital meets all other Life Safety Code building service requirements related to NFPA 101-2012: 20/21.5. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.70, EP 1	In areas where smoking is permitted, ashtrays are safely designed and made of noncombustible material. Metal containers with self-closing cover devices in which	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	ashtrays can be emptied are readily available to all areas where smoking is permitted. (For full text, refer to NFPA 101-2012: 20/21.7.4)	moved to guidance within SPG		
LS.03.01.70, EP 2	Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored; these areas have signs that read "NO SMOKING" or display the international symbol for no smoking. In facilities where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs that prohibit smoking in hazardous areas are not required. (For full text, refer to NFPA 101-2012: 18/19.7.4) Note: The secondary sign exception is not applicable to medical gas storage areas.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.70, EP 3	Draperies, curtains (including cubicle curtains) and loosely hanging fabric comply with NFPA 101-2012: 10.3.1. (For full text, refer to NFPA 101-2012: 18/19.7.5.1; 18/19.3.5.11; 10.3.1) Note: Exceptions include shower/bath curtains in addition to window coverings in patient sleeping rooms and in non-patient sleeping rooms located in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20% of the wall. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.70, EP 4	In buildings without sprinkler protection, upholstered furniture purchased on or after July 5, 2016, meets Class I or char length and heat release criteria in accordance with NFPA 101-2012: 10.3.2.1 and 10.3.3. Mattresses purchased on or after July 5, 2016, meet char length and heat release criteria in accordance with NFPA 101-2012: 10.3.2.2 and 10.3.4. (For full text, refer to NFPA 101-2012: 20/21.7.5.2; 20/21.7.5.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.70, EP 5	The hospital prohibits all combustible decorations unless they meet the criteria of NFPA 101-2012: 20/21.7.5.4. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.70, EP 6	Soiled linen and trash receptacles larger than 32 gallons (including recycling containers) are located in a room protected as a hazardous area. (For full text, refer to NFPA 101-2012: 20/21.7.5.5) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.70, EP 7	When installed, new engineered smoke control systems are tested in accordance with NFPA 92-2012, Standard for Smoke Control Systems. Existing engineered smoke control systems are tested in accordance with established engineering principles. (For full text, refer to NFPA 101-2012: 20/21.7.7) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.03.01.70, EP 8	Portable space heaters are prohibited in smoke compartments containing staff sleeping rooms and patient treatment areas. Non-sleeping rooms occupied by staff and employee areas separated from the corridor are permitted to have portable space heaters that contain heating elements not exceeding 212°F. (For full text, refer to NFPA 101-2012: 20/21.7.8) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
LS.03.01.70, EP 9	The hospital meets all other Life Safety Code operating feature requirements related to NFPA 101-2012: 20/21.7. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.05.01.10, EP 1	When building rehabilitation occurs, the hospital incorporates NFPA 101-2012: Chapters 38, 39, and 43. (For full text, refer to NFPA 101-2012: 38/39.1.1.3; 4.6.7) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.05.01.10, EP 2	Business occupancies are separated from parking structures by a 2-hour or greater fire barrier. (For full text, refer to NFPA 101-2012: 38/39.1.3.2.1) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.05.01.10, EP 3	The fire protection ratings for opening protectives in fire barriers are as follows: - Three hours in three-hour barriers - Ninety minutes in two-hour barriers - Forty-five minutes in one-hour barriers - Twenty minutes in thirty-minute barriers Labels on fire door assemblies must be maintained in legible condition. (For full text, refer to NFPA 101-2012: 8.3.4.2; Table 8.3.4.2; 8.3.3.2.3; NFPA 80-2010: 5.2.13.3) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.05.01.10, EP 5	The space around pipes, conduits, bus ducts, cables, wire, air ducts, or pneumatic tubes penetrating fire-rated walls or floors are protected with an approved fire-rated material. (For full text, refer to NFPA 101-2012: 8.3.5) Note: Non-approved polyurethane expanding foam is not an accepted fire-rated material for this purpose. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.05.01.10, EP 6	Doors requiring a fire rating of 3/4 of an hour or longer are free of coverings, decorations, or other objects applied to the door face, with the exception of informational signs, which are applied with adhesive only. (For full text, refer to NFPA 80-2010: 4.1.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.05.01.10, EP 7	The hospital meets all other Life Safety Code requirements, including vertical openings, related to NFPA 101-2012: 38/39.1. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.05.01.20, EP 1	Interior open stairways and ramps are permitted to serve as part of the egress system if not more than one level below the street floor. (For full text, refer to NFPA 101-2012 38/39.2.1.3.2) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.05.01.20, EP 2	In occupancies that serve 50 or more persons, the corridors or passageways must be a minimum of 44 inches of clear width. (For full text, refer to NFPA 101-2012:	Deleted EP - Replaced with more	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	38/39.2.3.2) CoPs: §482.41(b)(1)(i)	direct EP(s) or moved to guidance within SPG		
LS.05.01.20, EP 3	Dead-end corridors cannot exceed 50 feet in existing facilities. In new facilities, dead-end corridors cannot exceed 50 feet if fully sprinklered or cannot exceed 20 feet if they are not fully sprinklered. (For full text, refer to NFPA 101-2012: 38/39.2.5) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.05.01.20, EP 4	Travel distance to an exit must not exceed 200 feet unless the facility is fully sprinklered, in which case the distance may be increased to 300 feet. (For full text, refer to NFPA 101-2012: 38/39.2.6) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.05.01.20, EP 5	Means of egress must be continuously illuminated while occupied. (For full text, refer to NFPA 101-2012: 38/39.2.8) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.05.01.20, EP 6	Emergency lighting for existing construction must be provided if the building is three or more stories in height, if the building has 100 occupants or more in the stories above or below the level of exit discharge, or the building has 1000 or more total occupants. (For full text, refer to NFPA 101-2012: 39.2.9) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.05.01.20, EP 7	Emergency lighting for new construction must be provided if the building is three or more stories in height, if the occupancy has 50 occupants or more in the stories above or below the level of exit discharge, or the building has 300 or more total occupants. (For full text, refer to NFPA 101-2012: 38.2.9) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.05.01.20, EP 8	Doors in a means of egress are not equipped with a latch or lock that requires the use of a tool or key from the egress side unless a compliant locking configuration is used, such as a delayed-egress locking system or an access-controlled egress door assembly. (For full text, refer to NFPA 101-2012: 38/39.2.2.2; 7.2.1.5.3; 7.2.1.6.1; 7.2.1.6.2) Note: An exception to this requirement would be the principal entrance/exit doors with key-operated locks that meet the criteria of NFPA 101-2012 7.2.1.5.5. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.05.01.20, EP 9	The hospital meets all other Life Safety Code means of egress requirements related to NFPA 101-2012: 38/39.2. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.05.01.30, EP 1	All hazardous areas are enclosed with one-hour fire-rated walls with ¾-hour fire-rated doors; or hazardous areas have sprinkler systems and are constructed to resist the passage of smoke with doors equipped with self-closing or automatic-closing devices. (For full text, refer to NFPA 101-2012: 38/39.3.2; 8.7; NFPA 80-2010: 4.8.4.1; 6.3.1.7; 6.5)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.41(b)(1)(ii)			
LS.05.01.30, EP 2	Interior wall and ceiling finishes must be Class A or B for exits and exit access corridors. All other areas should be Class A, B, or C. (For full text, refer to NFPA 101-2012: 38/39.3.3) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.05.01.30, EP 3	Alcohol-based hand rubs (ABHR) are stored and handled in accordance with NFPA 101-2012: 8.7.3.1 and as follows: - Corridor clear width of 44 inches is not compromised by dispenser. - ABHR does not exceed 95% alcohol. - Maximum individual dispenser capacity is 0.32 gallons of fluid (0.53 gallons in suites or rooms separated from corridors) or 18 ounces of NFPA Level 1–classified aerosols. - Dispensers have a minimum of 4 feet of horizontal spacing between them. - Dispensers are not installed within 1 inch of an ignition source. - Operation of the dispensers must comply with the manufacturers' instructions for use. - ABHR is protected against inappropriate access. - Not more than an aggregate of 10 gallons of fluid or 1135 ounces of aerosol are used on a single story or in a single fire compartment outside a storage cabinet, excluding one individual dispenser per room. - Storing more than 5 gallons of fluid on a single story or in a single fire compartment complies with NFPA 30. CoPs: §482.41(b)(7)	Consolidation of LS.02.01.30, EP 6; LS.03.01.30, EP 5; LS.05.01.30, EP 3	PE.03.01.01, EP 7	When the hospital installs alcohol-based hand rub dispensers, it installs the dispensers in a manner that protects against inappropriate access. CoPs: §482.41(b)(7)
LS.05.01.30, EP 4	The hospital meets all other Life Safety Code fire and smoke protection requirements related to NFPA 101-2012: 38/39.3. CoPs: §482.41(b)(1)(i), §482.41(b)(1)(ii), §482.41(b)(7)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.05.01.34, EP 1	Fire alarm systems for existing construction are required if the building is three or more stories in height, there are 100 occupants or more below or above the level of exit discharge, or the building has 1000 or more occupants. The fire alarm system is initiated by manual means, a fire/smoke detection system, or a fire suppression system. The occupant notification system must activate a general alarm; notification can be made using voice communication or a public address system. (For full text, refer to NFPA 101-2012: 39.3.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.05.01.34, EP 2	Fire alarm systems for new construction are required if the building is three or more stories in height, there are 50 occupants or more below or above the level of exit discharge, or the building has 300 or more occupants. The fire alarm system is initiated by manual means, a fire/smoke detection system, or a fire suppression system. The occupant notification system must activate a general alarm. (For full text, refer to 2012 NFPA 101-2012: 38.3.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
LS.05.01.34, EP 3	The hospital meets all other Life Safety Code fire alarm requirements related to NFPA 101-2012: 38/39.4. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.05.01.34, EP 4	For new construction, a process for emergency response notification is provided and includes notifying both of the following: - Fire department in accordance with NFPA 101-2012: 9.6.4 - Local emergency organization, if provided (For full text, refer to NFPA 101-2012: 38.3.4.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.05.01.34, EP 5	For existing construction, notification of emergency forces is accomplished in accordance with NFPA 101-2012: 9.6.4 when the existing fire alarm system is replaced. (For full text, refer to NFPA 101-2012: 39.3.4.4) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.05.01.35, EP 3	The travel distance from any point to the nearest portable fire extinguisher is 75 feet or less. Portable fire extinguishers have appropriate signage, are installed in a cabinet or secured on a hanger made for the extinguisher, and are at least 4 inches off the floor. Those fire extinguishers that are 40 pounds or less are installed so the top is not more than 5 feet above the floor. (For full text, refer to NFPA 101-2012: 38/39.3.5; 9.7.4.1) CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.05.01.35, EP 4	Sprinklers are not damaged. They are also free from corrosion, foreign materials, and paint and have necessary escutcheon plates installed. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.05.01.35, EP 5	There are 18 inches or more of open space maintained below the sprinkler to the top of storage. Note: Perimeter wall and stack shelving may extend up to the ceiling when not located directly below a sprinkler head. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
LS.05.01.35, EP 6	The hospital meets all other Life Safety Code extinguishing requirements related to NFPA 101-2012: 38/39.3.5. CoPs: §482.41(b)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.01.01.01, EP 1	The hospital follows a written policy that describes that the following information about the patient is accessible to staff who participate in the management of the patient's medications: - Age - Sex - Diagnoses - Allergies - Sensitivities	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	- Current medications - Height and weight (when necessary) - Pregnancy and lactation information (when necessary) - Laboratory results (when necessary) - Any additional information required by the organization Note 1: This element of performance does not apply in emergency situations. Note 2: This element of performance is also applicable to sample medications.			
MM.01.01.03, EP 1	The hospital identifies, in writing, its high-alert and hazardous medications. * Note: This element of performance is also applicable to sample medications. Footnote *: For a list of high-alert medications, see https://www.ismp.org/recommendations. For a list of hazardous drugs, see https://www.cdc.gov/niosh/docs/2016-161/pdfs/2016-161.pdf. CoPs: §482.26(b)(1), §482.53(b)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.01.01.03, EP 2	The hospital follows a process for managing high-alert and hazardous medications. Note: This element of performance is also applicable to sample medications. CoPs: §482.26(b)(1), §482.53(b)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.01.01.03, EP 5	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital reports abuses and losses of controlled substances, in accordance with law and regulation, to the individual responsible for the pharmacy department or service and, as appropriate, to the chief executive. Note: This element of performance is also applicable to sample medications. CoPs: §482.25(b)(7)	Moved and Revised	MM.13.01.01, EP 3	The hospital reports abuses and losses of controlled substances, in accordance with federal and state law and regulation, to the individual responsible for the pharmacy department or service and, as appropriate, to the chief executive officer. Note: This element of performance is also applicable to sample medications. CoPs: §482.25(b)(7)
MM.01.02.01, EP 1	The hospital develops a list of look-alike/sound-alike medications it stores, dispenses, or administers. Note 1: One source of look-alike/sound-alike medication name pairs is the Institute for Safe Medication Practices (https://www.ismp.org/recommendations/confused-drug-names-list). Note 2: This element of performance is also applicable to sample medications.	Consolidation of MM.01.02.01, EP 1; MM.01.02.01, EP 2; MM.01.02.01, EP 3; MM.04.01.01, EP 1;	MM.14.01.01, EP 3	The hospital develops and implements a written policy that defines the following: - Specific types of medication orders that it deems acceptable for use - Minimum required elements of a complete medication order, which must include medication name, medication dose, medication route, and medication frequency - When indication for use is required on a medication order - Precautions for ordering medications with look-alike or sound-alike names - Actions to take when medication orders are incomplete, illegible, or unclear - Required elements for medication titration orders, including the medication name, medication route, initial rate of infusion (dose/unit of time), incremental units to which the rate or dose can be increased or decreased, how often the rate or dose can be changed, the maximum rate or dose of infusion, and the objective clinical measure to be used to guide changes Note 1: Examples of objective clinical measures to be used to guide titration changes include blood pressure, Richmond Agitation–Sedation Scale (RASS), and the Confusion Assessment Method (CAM). Note 2: Drugs and biologicals not specifically prescribed as to time or number of doses are automatically stopped after a reasonable time that is predetermined by the medical staff. CoPs: §482.25(a), §482.25(b)(5)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
MM.01.02.01, EP 2	The hospital takes action to prevent errors involving the interchange of the medications on its list of look-alike/sound-alike medications. Note: This element of performance is also applicable to sample medications.	Consolidation of MM.01.02.01, EP 1; MM.01.02.01, EP 2; MM.01.02.01, EP 3; MM.04.01.01, EP 1;	MM.14.01.01, EP 3	The hospital develops and implements a written policy that defines the following: - Specific types of medication orders that it deems acceptable for use - Minimum required elements of a complete medication order, which must include medication name, medication dose, medication route, and medication frequency - When indication for use is required on a medication order - Precautions for ordering medications with look-alike or sound-alike names - Actions to take when medication orders are incomplete, illegible, or unclear - Required elements for medication titration orders, including the medication name, medication route, initial rate of infusion (dose/unit of time), incremental units to which the rate or dose can be increased or decreased, how often the rate or dose can be changed, the maximum rate or dose of infusion, and the objective clinical measure to be used to guide changes Note 1: Examples of objective clinical measures to be used to guide titration changes include blood pressure, Richmond Agitation–Sedation Scale (RASS), and the Confusion Assessment Method (CAM). Note 2: Drugs and biologicals not specifically prescribed as to time or number of doses are automatically stopped after a reasonable time that is predetermined by the medical staff. CoPs: §482.25(a), §482.25(b)(5)
MM.01.02.01, EP 3	The hospital annually reviews and, as necessary, revises its list of look-alike/sound-alike medications. Note: This element of performance is also applicable to sample medications.	Consolidation of MM.01.02.01, EP 1; MM.01.02.01, EP 2; MM.01.02.01, EP 3; MM.04.01.01, EP 1;	MM.14.01.01, EP 3	The hospital develops and implements a written policy that defines the following: - Specific types of medication orders that it deems acceptable for use - Minimum required elements of a complete medication order, which must include medication name, medication dose, medication route, and medication frequency - When indication for use is required on a medication order - Precautions for ordering medications with look-alike or sound-alike names - Actions to take when medication orders are incomplete, illegible, or unclear - Required elements for medication titration orders, including the medication name, medication route, initial rate of infusion (dose/unit of time), incremental units to which the rate or dose can be increased or decreased, how often the rate or dose can be changed, the maximum rate or dose of infusion, and the objective clinical measure to be used to guide changes Note 1: Examples of objective clinical measures to be used to guide titration changes include blood pressure, Richmond Agitation–Sedation Scale (RASS), and the Confusion Assessment Method (CAM). Note 2: Drugs and biologicals not specifically prescribed as to time or number of doses are automatically stopped after a reasonable time that is predetermined by the medical staff. CoPs: §482.25(a), §482.25(b)(5)
MM.02.01.01, EP 1	Members of the medical staff, licensed practitioners, pharmacists, and other staff involved in ordering, dispensing, administering, and/or monitoring the effects of medications develop written criteria for determining which medications are available for dispensing or administering to patients. Note: This element of performance is also applicable to sample medications. CoPs: §482.25(b)(9)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.02.01.01, EP 2	The hospital develops and approves criteria for selecting medications, which, at a minimum, include the following:	Deleted EP - Replaced with more	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	- Indications for use - Effectiveness - Drug interactions - Potential for errors and abuse - Adverse drug events - Sentinel event advisories - Population(s) served (for example, pediatrics, geriatrics) - Other risks - Costs Note: This element of performance is also applicable to sample medications. CoPs: §482.25(b)(9)	direct EP(s) or moved to guidance within SPG		
MM.02.01.01, EP 3	Before using a medication new to the hospital, the hospital determines a method to monitor the response of the patient. Note: This element of performance is also applicable to sample medications.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.02.01.01, EP 4	The hospital maintains a formulary, including medication strength and dosage. The formulary is readily available to those involved in medication management. Note 1: Sample medications are not required to be on the formulary. Note 2: In some settings, the term "list of medications available for use" is used instead of "formulary." The terms are synonymous. CoPs: §482.25(b)(8), §482.25(b)(9)	Moved and Revised	MM.12.01.01, EP 1	The hospital maintains a formulary that includes medication strength and dosage. The formulary is readily available to those involved in medication management. 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. CoPs: §482.25(b)(9)
MM.02.01.01, EP 6	The hospital standardizes and limits the number of drug concentrations available to meet patient care needs.	Moved	NPG.14.02.01, EP 1	The hospital standardizes and limits the number of drug concentrations available to meet patient care needs.
MM.02.01.01, EP 7	The hospital follows a process to select, approve, and procure medications that are not on its formulary. Note: This element of performance is also applicable to sample medications.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.02.01.01, EP 9	Medications designated as available for dispensing or administration are reviewed at least annually based on emerging safety and efficacy information.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.02.01.01, EP 10	The hospital follows a process to communicate medication shortages and outages to staff who participate in medication management.	Moved	NPG.14.02.01, EP 2	The hospital follows a process to communicate medication shortages and outages to staff who participate in medication management.
MM.02.01.01, EP 12	The hospital follows written medication substitution protocols to be used in the event of a medication shortage or outage.	Consolidation of MM.02.01.01, EP 12; MM.02.01.01, EP 14	NPG.14.02.01, EP 3	The hospital follows written medication substitution protocols to be used in the event of a medication shortage or outage and communicates the medication substitution protocols for shortages or outages to all affected staff.
MM.02.01.01, EP 14	The hospital follows a process to communicate the medication substitution protocols for shortages or outages to staff who participate in medication management.	Consolidation of MM.02.01.01, EP 12; MM.02.01.01, EP 14	NPG.14.02.01, EP 3	The hospital follows written medication substitution protocols to be used in the event of a medication shortage or outage and communicates the medication substitution protocols for shortages or outages to all affected staff.
MM.03.01.01, EP 2	The hospital stores medications according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions. Note: This element of performance is also applicable to sample medications.	Consolidation of MM.03.01.01, EP 2; MM.03.01.01, EP 4; MM.03.01.01, EP 7; MM.05.01.11, EP 2	MM.11.01.01, EP 1	Drugs and biologicals are procured, stored, controlled, and distributed in accordance with federal and state laws and accepted standards of practice. Note: The hospital stores medications, including sample medications, according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.23(c)(6)(i)(D), §482.23(c)(6)(ii)(D), §482.25(a)			CoPs: §482.25(a), §482.25(b)
MM.03.01.01, EP 3	The hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area to prevent diversion, and locked when necessary, in accordance with law and regulation. Note 1: Scheduled medications include those listed in Schedules II–V of the Comprehensive Drug Abuse Prevention and Control Act of 1970. Note 2: This element of performance is also applicable to sample medications. CoPs: §482.23(c)(6)(i)(D), §482.23(c)(6)(ii)(D), §482.25(a), §482.25(a)(3), §482.25(b), §482.25(b)(2)(i), §482.25(b)(2)(ii)	Moved and Revised	MM.13.01.01, EP 2	The hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area and locked when necessary to prevent diversion in accordance with law and regulation. Note 1: Scheduled medications include those listed in Schedules II–V of the Comprehensive Drug Abuse Prevention and Control Act of 1970. Note 2: This element of performance is also applicable to sample medications. Note 3: Only authorized staff have access to locked areas. CoPs: §482.25(b)(2)(i), §482.25(b)(2)(ii), §482.25(b)(2)(iii)
MM.03.01.01, EP 4	The hospital follows a written policy addressing the control of medication between receipt by a staff member and administration of the medication, including safe storage, handling, wasting, security, disposition, and return to storage. Note: This element of performance is also applicable to sample medications. CoPs: §482.25(a), §482.25(a)(3), §482.25(b), §482.25(b)(2)(i), §482.53(d)(3)	Split to MM.11.01.01, EP 1; MM.13.01.01, EP 1	MM.11.01.01, EP 1	Drugs and biologicals are procured, stored, controlled, and distributed in accordance with federal and state laws and accepted standards of practice. Note: The hospital stores medications, including sample medications, according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions. CoPs: §482.25(a), §482.25(b)
MM.03.01.01, EP 4	The hospital follows a written policy addressing the control of medication between receipt by a staff member and administration of the medication, including safe storage, handling, wasting, security, disposition, and return to storage. Note: This element of performance is also applicable to sample medications. CoPs: §482.25(a), §482.25(a)(3), §482.25(b), §482.25(b)(2)(i), §482.53(d)(3)	Split to MM.11.01.01, EP 1; MM.13.01.01, EP 1	MM.13.01.01, EP 1	The hospital maintains current and accurate records of the receipt and disposition of all scheduled drugs. CoPs: §482.25(a)(3)
MM.03.01.01, EP 6	The hospital prevents unauthorized individuals from obtaining medications in accordance with its policy and law and regulation. Note: This element of performance is also applicable to sample medications. CoPs: §482.25(b)(2)(i), §482.25(b)(2)(iii)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.03.01.01, EP 7	All stored medications and the components used in their preparation are labeled with the contents, expiration date, and any applicable warnings. Note: This element of performance is also applicable to sample medications. CoPs: §482.25(a)	Consolidation of MM.03.01.01, EP 2; MM.03.01.01, EP 4; MM.03.01.01, EP 7; MM.05.01.11, EP 2	MM.11.01.01, EP 1	Drugs and biologicals are procured, stored, controlled, and distributed in accordance with federal and state laws and accepted standards of practice. Note: The hospital stores medications, including sample medications, according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions. CoPs: §482.25(a), §482.25(b)
MM.03.01.01, EP 8	The hospital removes all expired, damaged, and/or contaminated medications and stores them separately from medications available for administration. Note: This element of performance is also applicable to sample medications. CoPs: §482.25(b)(3), §482.53(d)(3)	Moved and Revised	MM.13.01.01, EP 4	The hospital removes all expired, damaged, mislabeled, contaminated, or otherwise unusable medications and stores them separately from medications available for patient use. Note: This element of performance is also applicable to sample medications. CoPs: §482.25(b)(3)
MM.03.01.01, EP 18	The hospital periodically inspects all medication storage areas. Note: This element of performance is also applicable to sample medications.	Deleted	N/A	N/A
MM.03.01.01, EP 19	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a pharmacy directed by a registered pharmacist or a supervised drug storage area, in accordance with law and regulation. Note: This element of performance is also applicable to sample medications.	Moved and Revised	NPG.12.01.01, EP 10	The hospital has a pharmacy that is directed by a registered pharmacist. If the hospital does not have a pharmacy, it has a drug storage area under competent supervision, as defined by the hospital. Note: The pharmacy or drug storage area is administered in accordance with accepted professional principles.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.25, §482.25			CoPs: §482.25
MM.03.01.01, EP 24	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital maintains records of the receipt and disposition of radiopharmaceuticals. CoPs: §482.53(d)(3)	Moved and Revised	MM.13.01.01, EP 6	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital maintains records of the receipt and distribution of radiopharmaceuticals. CoPs: §482.53(d)(3)
MM.03.01.03, EP 1	Hospital leaders, in conjunction with members of the medical staff and licensed practitioners, decide which emergency medications and their associated supplies will be readily accessible in patient care areas based on the population served. Whenever possible, emergency medications are available in unit-dose, age-specific, and ready-to-administer forms.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.03.01.05, EP 1	The hospital defines when medications brought into the hospital by patients, their families, or licensed practitioners can be administered. Note: This element of performance is also applicable to sample medications. CoPs: §482.23(c)(6)(ii)(A)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.03.01.05, EP 2	Before use or administration of a medication brought into the hospital by a patient, their family, or a licensed practitioner, the hospital identifies the medication and visually evaluates the medication's integrity. Note: This element of performance is also applicable to sample medications. CoPs: §482.23(c)(6)(ii)(C)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.04.01.01, EP 1	The hospital follows a written policy that identifies the specific types of medication orders that it deems acceptable for use. Note: There are several different types of medication orders. Medication orders commonly used include the following: - As needed (PRN) orders: Orders acted on based on the occurrence of a specific indication or symptom - Standing orders: A prewritten medication order and specific instructions from the physician or other licensed practitioner to administer a medication to a person in clearly defined circumstances - Automatic stop orders: Orders that include a date or time to discontinue a medication - Titrating orders: Orders in which the dose is either progressively increased or decreased in response to the patient's status - Taper orders: Orders in which the dose is decreased by a particular amount with each dosing interval - Range orders: Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or patient's status - Signed and held orders: New prewritten (held) medication orders and specific instructions from a physician or other licensed practitioner to administer medication(s) to a patient in clearly defined circumstances that become active upon the release of the orders on a specific date(s) and time(s) - Orders for compounded drugs or drug mixtures not commercially available - Orders for medication-related devices (for example, nebulizers, catheters) - Orders for investigational medications - Orders for herbal products - Orders for medications at discharge or transfer	Consolidation of MM.01.02.01, EP 1; MM.01.02.01, EP 2; MM.01.02.01, EP 3; MM.04.01.01, EP 1;	MM.14.01.01, EP 3	The hospital develops and implements a written policy that defines the following: - Specific types of medication orders that it deems acceptable for use - Minimum required elements of a complete medication order, which must include medication name, medication dose, medication route, and medication frequency - When indication for use is required on a medication order - Precautions for ordering medications with look-alike or sound-alike names - Actions to take when medication orders are incomplete, illegible, or unclear - Required elements for medication titration orders, including the medication name, medication route, initial rate of infusion (dose/unit of time), incremental units to which the rate or dose can be increased or decreased, how often the rate or dose can be changed, the maximum rate or dose of infusion, and the objective clinical measure to be used to guide changes Note 1: Examples of objective clinical measures to be used to guide titration changes include blood pressure, Richmond Agitation–Sedation Scale (RASS), and the Confusion Assessment Method (CAM). Note 2: Drugs and biologicals not specifically prescribed as to time or number of doses are automatically stopped after a reasonable time that is predetermined by the medical staff. CoPs: §482.25(a), §482.25(b)(5)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.23(c)(1), §482.25(b)(5)			
MM.04.01.01, EP 2	The hospital follows a written policy that defines the following: - The minimum required elements of a complete medication order, which must include medication name, medication dose, medication route, and medication frequency - When indication for use is required on a medication order - The precautions for ordering medications with look-alike or sound-alike names - Actions to take when medication orders are incomplete, illegible, or unclear - For medication titration orders, required elements include the medication name, medication route, initial rate of infusion (dose/unit of time), incremental units to which the rate or dose can be increased or decreased, how often the rate or dose can be changed, the maximum rate or dose of infusion, and the objective clinical measure to be used to guide changes Note: Examples of objective clinical measures to be used to guide titration changes include blood pressure, Richmond Agitation–Sedation Scale (RASS), and the Confusion Assessment Method (CAM). CoPs: §482.23(c)(1), §482.23(c)(3)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.04.01.01, EP 6	The hospital minimizes the use of verbal and telephone medication orders. CoPs: §482.23(c)(3)(i)	Moved and Revised	MM.14.01.01, EP 2	The hospital minimizes the use of verbal medication orders. CoPs: §482.23(c)(3)(i)
MM.04.01.01, EP 7	The hospital reviews and updates preprinted order sheets, within time frames it identifies or sooner if necessary, based on current evidence and practice.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.04.01.01, EP 8	The hospital prohibits summary (blanket) orders to resume previous medications.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.04.01.01, EP 10	The hospital defines, in writing, the circumstances for which weight-based dosing is required for pediatric populations. Note: This element of performance is also applicable to sample medications.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.04.01.01, EP 14	The hospital requires an order from a doctor of medicine or osteopathy or, as permitted by law and regulation, a hospital-specific protocol(s) approved by a doctor of medicine or osteopathy to administer influenza and pneumococcal vaccines. CoPs: §482.23(c)(3)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.04.01.01, EP 15	For hospitals that use Joint Commission accreditation for deemed status purposes: Processes for the use of preprinted and electronic standing orders, order sets, and protocols for medication orders include the following: - Review and approval of standing orders and protocols by the medical staff and the hospital's nursing and pharmacy leadership - Evaluation of established standing orders and protocols for consistency with nationally recognized and evidence-based guidelines	Moved and Revised	RC.12.01.01, EP 5	The hospital uses preprinted and electronic standing orders, order sets, and protocols for patient orders only if the following occurs: - Orders and protocols are reviewed and approved by the medical staff and the hospital's nursing and pharmacy leadership. - Orders and protocols are consistent with nationally recognized and evidence-based guidelines. - Orders and protocols are periodically and regularly reviewed by the medical staff

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	- Regular review of such standing orders and protocols by the medical staff and the hospital's nursing and pharmacy leadership to determine the continuing usefulness and safety of the standing orders and protocols - Dating, timing, and authenticating of standing orders and protocols by the ordering physician or other licensed practitioner or another licensed practitioner responsible for the patient's care in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations. CoPs: §482.23(c)(1)(ii), §482.24(c)(3)(i), §482.24(c)(3)(ii), §482.24(c)(3)(iii), §482.24(c)(3)(iv)			and the hospital's nursing and pharmacy leadership to determine the continuing usefulness and safety of the orders and protocols. - Orders and protocols are dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner or by another practitioner responsible for the care of the patient only if such a practitioner is acting in accordance with state law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. CoPs: §482.24(c)(3)(i), §482.24(c)(3)(ii), §482.24(c)(3)(iii), §482.24(c)(3)(iv)
MM.04.01.01, EP 21	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home has an electronic prescribing process.	Moved	MM.14.01.01, EP 4	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home has an electronic prescribing process.
MM.05.01.01, EP 1	Before dispensing or removing medications from floor stock or from an automated storage and distribution device, a pharmacist reviews all medication orders or prescriptions unless a physician or other licensed practitioner controls the ordering, preparation, and administration of the medication or when a delay would harm the patient in an urgent situation (including sudden changes in a patient's clinical status), in accordance with law and regulation. Note 1: The Joint Commission permits emergency departments to broadly apply two exceptions in regard to Standard MM.05.01.01, EP 1. These exceptions are intended to minimize treatment delays and patient backup. The first exception allows medications ordered by a physician or other licensed practitioner to be administered by staff who are permitted to do so by virtue of education, training, and organization policy (such as a registered nurse) and in accordance with law and regulation. A physician or other licensed practitioner is not required to remain at the bedside when the medication is administered. However, a physician or other licensed practitioner must be available to provide immediate intervention should a patient experience an adverse drug event. The second exception allows medications to be administered in urgent situations when a delay in doing so would harm the patient. Note 2: A hospital's radiology service (including hospital-associated ambulatory radiology) will be expected to define, through protocol or policy, the role of the physician or other licensed practitioner in the direct supervision of a patient during and after IV contrast media is administered including the physician or other licensed practitioner's timely intervention in the event of a patient emergency. CoPs: §482.23(c)(1), §482.25(b)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.05.01.01, EP 2	When an on-site pharmacy is not open 24 hours a day, 7 days a week, the following occurs: -A health care professional determined to be qualified by the hospital reviews the medication order in the pharmacist's absence -A pharmacist conducts a retrospective review of all medication orders during this period as soon as a pharmacist is available or the pharmacy opens	Moved and Revised	NPG.14.01.01, EP 1	When an on-site pharmacy is not open 24 hours a day, 7 days a week, the following occurs: - A health care professional, who the hospital determines is qualified, reviews the medication order in the pharmacist's absence - A pharmacist conducts a retrospective review of all medication orders during this period as soon as a pharmacist is available or the pharmacy opens
MM.05.01.01, EP 4	All medication orders are reviewed for the following: - Patient allergies or potential sensitivities - Existing or potential interactions between the medication ordered and food and medications the patient is currently taking - The appropriateness of the medication, dose, frequency, and route of administration - Current or potential impact as indicated by laboratory values	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	- Therapeutic duplication - Other contraindications CoPs: §482.23(c)(1), §482.25(b)(1), §482.25(b)(5)			
MM.05.01.01, EP 11	After the medication order has been reviewed, all concerns, issues, or questions are clarified with the individual prescriber before dispensing. CoPs: §482.23(c)(1), §482.25(b)(1)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.05.01.07, EP 1	A pharmacist supervises all compounding, packaging, and dispensing of drugs and biologicals except in urgent situations in which a delay could harm the patient or when the product's stability is short. All compounding, packaging, and dispensing of drugs and biologicals are performed in accordance with state and federal law and regulation. CoPs: §482.25(b)(1)	Moved	MM.15.01.01, EP 1	A pharmacist supervises all compounding, packaging, and dispensing of drugs and biologicals except in urgent situations in which a delay could harm the patient or when the product's stability is short. All compounding, packaging, and dispensing of drugs and biologicals are performed in accordance with state and federal law and regulation. CoPs: §482.25(b)(1)
MM.05.01.07, EP 2	The hospital develops and implements policies and procedures for sterile medication compounding of nonhazardous and hazardous medications in accordance with state and federal law and regulation. Note: All compounded medications are prepared in accordance with the orders of a physician or other licensed practitioner. CoPs: §482.25(b)(1)	Moved	MM.15.01.01, EP 2	The hospital develops and implements policies and procedures for sterile medication compounding of nonhazardous and hazardous medications in accordance with state and federal law and regulation. Note: All compounded medications are prepared in accordance with the orders of a physician or other licensed practitioner. CoPs: §482.25(b)(1)
MM.05.01.07, EP 3	The hospital assesses competency of staff who conduct sterile medication compounding of nonhazardous and hazardous medications in accordance with state and federal law and regulation and hospital policies. CoPs: §482.25(b)(1)	Moved	MM.15.01.01, EP 3	The hospital assesses competency of staff who conduct sterile medication compounding of nonhazardous and hazardous medications in accordance with state and federal law and regulation and hospital policies. CoPs: §482.25(b)(1)
MM.05.01.07, EP 4	The hospital conducts sterile medication compounding of nonhazardous and hazardous medications within a proper environment in accordance with federal law and regulation and hospital policies. Note: Aspects of a proper environment include but are not limited to air exchanges and pressures, ISO designations, viable testing, and cleaning/disinfecting. CoPs: §482.25(b)(1)	Moved	MM.15.01.01, EP 4	The hospital conducts sterile medication compounding of nonhazardous and hazardous medications within a proper environment in accordance with federal law and regulation and hospital policies. Note: Aspects of a proper environment include but are not limited to air exchanges and pressures, ISO designations, viable testing, and cleaning/disinfecting. CoPs: §482.25(b)(1)
MM.05.01.07, EP 5	The hospital properly stores compounded sterile preparations of nonhazardous and hazardous medications and labels them with beyond-use dates in accordance with state and federal law and regulation and hospital policies. CoPs: §482.25(b)(1)	Moved	MM.15.01.01, EP 5	The hospital properly stores compounded sterile preparations of nonhazardous and hazardous medications and labels them with beyond-use dates in accordance with state and federal law and regulation and hospital policies. CoPs: §482.25(b)(1)
MM.05.01.07, EP 6	The hospital conducts quality assurance of compounded sterile preparations of nonhazardous and hazardous medications in accordance with state and federal law and regulation and organization policy. CoPs: §482.25(b)(1)	Moved	MM.15.01.01, EP 6	The hospital conducts quality assurance of compounded sterile preparations of nonhazardous and hazardous medications in accordance with state and federal law and regulation and organization policy. CoPs: §482.25(b)(1)
MM.05.01.07, EP 7	For hospitals that use Joint Commission accreditation for deemed status purposes: An appropriately trained registered pharmacist or doctor of medicine or osteopathy performs or supervises in-house preparation of radiopharmaceuticals.	Moved	MM.15.01.01, EP 7	For hospitals that use Joint Commission accreditation for deemed status purposes: An appropriately trained registered pharmacist or doctor of medicine or osteopathy performs or supervises in-house preparation of radiopharmaceuticals.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.25(b)(1)			CoPs: §482.25(b)(1), §482.53(b)(1)
MM.05.01.09, EP 1	Medication containers are labeled whenever medications are prepared but not immediately administered. Note 1: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process. Note 2: This element of performance is also applicable to sample medications.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.05.01.09, EP 2	Information on medication labels is displayed in a standardized format, in accordance with law and regulation and standards of practice. Note: This element of performance is also applicable to sample medications. CoPs: §482.23(c), §482.25(b)(1)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.05.01.09, EP 3	All medications prepared in the hospital are correctly labeled with the following: - Medication name, strength, and amount (if not apparent from the container) Note: This is also applicable to sample medications. - Expiration date when not used within 24 hours - Expiration date and time when expiration occurs in less than 24 hours - The date prepared and the diluent for all compounded intravenous admixtures and parenteral nutrition formulas CoPs: §482.23(c), §482.25(b)(1)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.05.01.09, EP 7	When preparing individualized medications for multiple patients, the label also includes the following: - The patient's name - The location where the medication is to be delivered - Directions for use and applicable accessory and cautionary instructions	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.05.01.09, EP 10	When an individualized medication(s) is prepared by someone other than the person administering the medication, the label includes the following: - The patient's name - The location where the medication is to be delivered - Directions for use and applicable accessory and cautionary instructions CoPs: §482.23(c), §482.25(b)(1)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.05.01.11, EP 2	The hospital dispenses medications and maintains records in accordance with law and regulation, licensure, and professional standards of practice. Note 1: Dispensing practices and recordkeeping include antidiversion strategies. Note 2: This element of performance is also applicable to sample medications. CoPs: §482.23(c), §482.25(a), §482.25(a)(3), §482.25(b)	Split to MM.11.01.01, EP 1; MM.13.01.01, EP 1	MM.11.01.01, EP 1	Drugs and biologicals are procured, stored, controlled, and distributed in accordance with federal and state laws and accepted standards of practice. Note: The hospital stores medications, including sample medications, according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions. CoPs: §482.25(a), §482.25(b)
MM.05.01.11, EP 2	The hospital dispenses medications and maintains records in accordance with law and regulation, licensure, and professional standards of practice. Note 1: Dispensing practices and recordkeeping include antidiversion strategies. Note 2: This element of performance is also applicable to sample medications. CoPs: §482.23(c), §482.25(a), §482.25(a)(3), §482.25(b)	Split to MM.11.01.01, EP 1; MM.13.01.01, EP 1	MM.13.01.01, EP 1	The hospital maintains current and accurate records of the receipt and disposition of all scheduled drugs. CoPs: §482.25(a)(3)
MM.05.01.11, EP 3	The hospital dispenses medications within time frames it defines to meet patient needs.	Deleted EP - Replaced with more	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.23(c)	direct EP(s) or moved to guidance within SPG		
MM.05.01.11, EP 4	Medications are dispensed in the most ready-to-administer forms commercially available and, if feasible, in unit doses that have been repackaged by the pharmacy or licensed repackager.	Deleted	N/A	N/A
MM.05.01.13, EP 1	The hospital follows a process for providing medications to meet patient needs when the pharmacy is closed. CoPs: §482.25(b)(4)	Consolidation of MM.05.01.13, EP 1; MM.05.01.13, EP 2	MM.13.01.01, EP 5	When a pharmacist is not available, only designated staff obtain drugs and biologicals from the pharmacy or storage area in accordance with policies and procedures of medical staff and pharmaceutical service, and applicable federal and state law and regulation. CoPs: §482.25(b)(4)
MM.05.01.13, EP 2	When non-pharmacist health care professionals are allowed by law or regulation to obtain medications after the pharmacy is closed, the following occurs: - Medications available are limited to those approved by the hospital. - The hospital stores and secures the medications approved for use outside of the pharmacy. - Only trained, designated prescribers and nurses are permitted access to approved medications - Quality control procedures (such as an independent second check by another individual or a secondary verification built into the system such as bar coding) are in place to prevent medication retrieval errors. - The hospital arranges for a qualified pharmacist to be available either on-call or at another location (for example, at another organization that has 24-hour pharmacy service) to answer questions or provide medications beyond those accessible to non-pharmacy staff. CoPs: §482.25(b)(4)	Consolidation of MM.05.01.13, EP 1; MM.05.01.13, EP 2	MM.13.01.01, EP 5	When a pharmacist is not available, only designated staff obtain drugs and biologicals from the pharmacy or storage area in accordance with policies and procedures of medical staff and pharmaceutical service, and applicable federal and state law and regulation. CoPs: §482.25(b)(4)
MM.05.01.17, EP 1	The hospital follows a written policy describing how it will retrieve and handle medications within the hospital that are recalled or discontinued for safety reasons by the manufacturer or the US Food and Drug Administration (FDA). Note: This element of performance is also applicable to sample medications. CoPs: §482.25(b)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.05.01.17, EP 3	When a medication is recalled or discontinued for safety reasons by the manufacturer or the US Food and Drug Administration (FDA), the hospital notifies the prescribers and those who dispense or administer the medication. Note: This element of performance is also applicable to sample medications. CoPs: §482.25(b)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.05.01.17, EP 4	When required by law and regulation or hospital policy, the hospital informs patients that their medication has been recalled or discontinued for safety reasons by the manufacturer or the US Food and Drug Administration (FDA). Note: This element of performance is also applicable to sample medications. CoPs: §482.25(b)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.05.01.19, EP 2	When the hospital accepts unused, expired, or returned medications, it follows a process for returning medications to the pharmacy's control which includes procedures for preventing diversion.	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	Note: This element of performance is also applicable to sample medications. CoPs: §482.25(b)	moved to guidance within SPG		
MM.06.01.01, EP 1	Only authorized clinical staff administer medications. The hospital defines, in writing, those who are authorized to administer medication, with or without supervision, in accordance with law and regulation. Note: This does not prohibit self-administration of medications by patients, when indicated. CoPs: §482.23(c), §482.23(c)(2), §482.23(c)(4)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.06.01.01, EP 3	Before administration, the individual administering the medication does the following: - Verifies that the medication selected matches the medication order and product label - Visually inspects the medication for particulates, discoloration, or other loss of integrity - Verifies that the medication has not expired - Verifies that no contraindications exist - Verifies that the medication is being administered at the proper time, in the prescribed dose, and by the correct route - Discusses any unresolved concerns about the medication with the patient's physician or other licensed practitioner, prescriber (if different from the physician or other licensed practitioner), and/or staff involved with the patient's care, treatment, and services CoPs: §482.23(c)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.06.01.01, EP 9	Before administering a new medication, the patient or family is informed about any potential clinically significant adverse drug reactions or other concerns regarding administration of a new medication. CoPs: §482.23(c)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.06.01.01, EP 13	Before administering a radioactive pharmaceutical for diagnostic purposes, staff verify that the dose to be administered is within 20% of the prescribed dose, or, if the dose is prescribed as a range, staff verify that the dose to be administered is within the prescribed range.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.06.01.03, EP 1	If self-administration of medications is allowed, the hospital follows written processes that guide the safe and accurate self-administration of medications or the administration of medications by a family member (refer to the Glossary for the definition of family). The processes address training, supervision, and documentation. CoPs: §482.23(c)(6), §482.23(c)(6)(i)(A), §482.23(c)(6)(i)(D), §482.23(c)(6)(i)(E), §482.23(c)(6)(ii)(B), §482.23(c)(6)(ii)(D), §482.23(c)(6)(ii)(E)	Moved and Revised	MM.16.01.01, EP 3	The hospital develops and implements policies and procedures that guide the safe and accurate self-administration of medications by the patient or their caregiver or support person, where appropriate. Note 1: This applies to hospital-issued medications and the patient's own medications brought into the hospital. Note 2: The term "self-administered medication(s)" may refer to medications administered by a family member. CoPs: §482.23(c)(6)
MM.06.01.03, EP 3	The hospital educates patients and families involved in self-administration about the following: - Medication name, type, and reason for use - How to administer medication, including process, time, frequency, route, and dose	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	- Anticipated actions and potential side effects of the medication administered - Monitoring the effects of the medication CoPs: §482.23(c)(6)(i)(C)	moved to guidance within SPG		
MM.06.01.03, EP 7	The hospital determines that the patient or the family member who administers the medication is competent at medication administration before allowing them to administer medications. CoPs: §482.23(c)(6)(i)(B), §482.23(c)(6)(ii)(B)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.06.01.05, EP 2	The hospital's written process for the use of investigational medications specifies that the pharmacy controls the storage, dispensing, labeling, and distribution of investigational medications.	Deleted	N/A	N/A
MM.07.01.03, EP 1	The hospital follows a written process to respond to actual or potential adverse drug events, significant adverse drug reactions, and medication errors. Note: This element of performance is also applicable to sample medications. CoPs: §482.23(c)(5), §482.25(b)(6)	Moved and Revised	LD.13.01.09, EP 5	The hospital develops and implements policies and procedures that minimizes drug errors. The medical staff develops these policies and procedures unless delegated to the pharmaceutical service. CoPs: §482.25
MM.07.01.03, EP 2	The hospital follows a written process addressing prescriber notification in the event of an adverse drug event, significant adverse drug reaction, or medication error. Note: This element of performance is also applicable to sample medications. CoPs: §482.25(b)(6)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.07.01.03, EP 3	The hospital complies with internal and external reporting requirements for actual or potential adverse drug events, significant adverse drug reactions, and medication errors. Note: This element of performance is also applicable to sample medications. CoPs: §482.23(c)(5), §482.25(b)(6)	Moved and Revised	MM.17.01.01, EP 1	The hospital develops and implements policies and procedures for reporting transfusion reactions, adverse drug reactions, and errors in administration of drugs. Note: This element of performance is also applicable to sample medications. CoPs: §482.23(c)(5)
MM.07.01.03, EP 6	For hospitals that use Joint Commission accreditation for deemed status purposes: Medication administration errors, adverse drug reactions, and medication incompatibilities as defined by the hospital are immediately reported to the attending physician and as appropriate to the organizationwide quality assessment and performance improvement program. Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). CoPs: §482.25(b)(6)	Moved and Revised	MM.17.01.01, EP 2	Medication administration errors, adverse drug reactions, and medication incompatibilities, as defined by the hospital, are immediately reported to the attending physician or other licensed practitioner and, as appropriate, to the hospitalwide quality assessment and performance improvement program. CoPs: §482.25(b)(6)
MM.08.01.01, EP 1	As part of its evaluation of the effectiveness of medication management, the hospital does the following: - Collects data on the performance of its medication management system - Analyzes data on its medication management system - Compares data over time to identify risk points, levels of performance, patterns, trends, and variations of its medication management system Note: This element of performance is also applicable to sample medications. CoPs: §482.21(e)(1)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.08.01.01, EP 5	Based on analysis of its data, as well as review of the literature for new technologies and best practices, the hospital identifies opportunities for improvement in its	Deleted EP - Replaced with more	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	medication management system. CoPs: §482.21(e)(1)	direct EP(s) or moved to guidance within SPG		
MM.08.01.01, EP 6	When opportunities are identified for improvement of the medication management system, the hospital does the following: - Takes action on improvement opportunities identified as priorities for its medication management system - Evaluates its actions to confirm that they resulted in improvements Note: This element of performance is also applicable to sample medications. CoPs: §482.21(e)(1)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.08.01.01, EP 8	The hospital takes additional action when planned improvements for its medication management processes are either not achieved or not sustained. CoPs: §482.21(e)(1)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.08.01.01, EP 16	When automatic dispensing cabinets (ADCs) are used, the hospital has a policy that describes the types of medication overrides that will be reviewed for appropriateness and the frequency of the reviews. A 100% review of overrides is not required.	Moved and Revised	NPG.14.01.01, EP 2	When automatic dispensing cabinets (ADCs) are used, the hospital develops and implements a policy that describes the types of medication overrides that will be reviewed for appropriateness and the frequency of the reviews. A 100% review of overrides is not required.
MM.09.01.01, EP 10	The hospital allocates financial resources for staffing and information technology to support the antibiotic stewardship program. CoPs: §482.42	Moved and Revised	MM.18.01.01, EP 1	The antibiotic stewardship program reflects the scope and complexity of the hospital services provided. CoPs: §482.42, §482.42(b)(4)
MM.09.01.01, EP 11	The governing body appoints a physician and/or pharmacist who is qualified through education, training, or experience in infectious diseases and/or antibiotic stewardship as the leader(s) of the antibiotic stewardship program. Note: The appointment(s) is based on recommendations of medical staff leaders and pharmacy leaders. CoPs: §482.42(b)(1)	Moved and Revised	MM.18.01.01, EP 2	The hospital demonstrates that an individual (or individuals), who is qualified through education, training, or experience in infectious diseases and/or antibiotic stewardship, is appointed by the governing body as the leader(s) of the antibiotic stewardship program and that the appointment is based on the recommendations of medical staff leadership and pharmacy leadership. CoPs: §482.42(b)(1)
MM.09.01.01, EP 12	The leader(s) of the antibiotic stewardship program is responsible for the following: - Developing and implementing a hospitalwide antibiotic stewardship program that is based on nationally recognized guidelines to monitor and improve the use of antibiotics - Documenting antibiotic stewardship activities, including any new or sustained improvements - Communicating and collaborating with the medical staff, nursing leaders, and pharmacy leaders, as well as with the hospital's infection prevention and control and quality assessment and performance improvement programs on antibiotic use issues - Providing competency-based training and education for staff on the practical applications of antibiotic stewardship guidelines, policies, and procedures CoPs: §482.42, §482.42(b)(2)(iii), §482.42(b)(4), §482.42(c)(1)(i), §482.42(c)(1)(ii), §482.42(c)(3)(i), §482.42(c)(3)(ii), §482.42(c)(3)(iii), §482.42(c)(3)(iv)	Moved and Revised	MM.18.01.01, EP 3	The leader(s) of the antibiotic stewardship program is responsible for the following: - Development and implementation a hospitalwide antibiotic stewardship program, based on nationally recognized guidelines, to monitor and improve the use of antibiotics. - All documentation, written or electronic, of antibiotic stewardship program activities. - Communication and collaboration with medical staff, nursing, and pharmacy leadership, as well as with the hospital's infection prevention and control and QAPI programs, on antibiotic use issues. - Competency-based training and education of hospital personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the hospital, on the practical applications of antibiotic stewardship guidelines, policies, and procedures. CoPs: §482.42, §482.42(c)(3)(i), §482.42(c)(3)(ii), §482.42(c)(3)(iii), §482.42(c)(3)(iv)
MM.09.01.01, EP 13	The hospital has a multidisciplinary committee that oversees the antibiotic stewardship program. Note 1: The committee may be composed of representatives from the medical staff,	Moved and Revised	NPG.14.06.01, EP 1	The hospital has a multidisciplinary committee that oversees the antibiotic stewardship program. Note 1: The committee may be composed of representatives from the medical staff,

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	pharmacy services, the infection prevention and control program, nursing services, microbiology, information technology, and the quality assessment and performance improvement program. Note 2: The committee may include part-time or consultant staff. Participation may occur on site or remotely.			pharmaceutical services, the infection prevention and control program, nursing services, microbiology, information technology, and the quality assessment and performance improvement program. Note 2: The committee may include part-time or consultant staff. Participation may occur on site or remotely.
MM.09.01.01, EP 14	The antibiotic stewardship program demonstrates coordination among all components of the hospital responsible for antibiotic use and resistance, including, but not limited to, the infection prevention and control program, the quality assessment and performance improvement program, the medical staff, nursing services, and pharmacy services. CoPs: §482.42(b)(2)(i), §482.42(c)(1)(ii)	Moved and Revised	MM.18.01.01, EP 4	The governing body ensures all antibiotic use issues identified by the antibiotic stewardship program are addressed in collaboration with the hospital's QAPI leadership. CoPs: §482.42(c)(1)(ii)
MM.09.01.01, EP 15	The antibiotic stewardship program documents the evidence-based use of antibiotics in all departments and services of the hospital. CoPs: §482.42(b)(2)(ii), §482.42(b)(4)	Moved and Revised	MM.18.01.01, EP 5	The hospitalwide antibiotic stewardship program: - Demonstrates coordination among all components of the hospital responsible for antibiotic use and resistance, including, but not limited to, the infection prevention and control program, the QAPI program, the medical staff, nursing services, and pharmacy services. - Documents the evidence-based use of antibiotics in all departments and services of the hospital. - Documents any improvements, including sustained improvements, in proper antibiotic use. CoPs: §482.42(b)(2)(i), §482.42(b)(2)(ii), §482.42(b)(2)(iii)
MM.09.01.01, EP 16	The antibiotic stewardship program monitors the hospital's antibiotic use by analyzing data on days of therapy per 1,000 days present or 1,000 patient days or by reporting antibiotic use data to the National Healthcare Safety Network's Antimicrobial Use Option of the Antimicrobial Use and Resistance Module.	Moved	NPG.14.06.01, EP 2	The antibiotic stewardship program monitors the hospital's antibiotic use by analyzing data on days of therapy per 1,000 days present or 1,000 patient days or by reporting antibiotic use data to the National Healthcare Safety Network's Antimicrobial Use Option of the Antimicrobial Use and Resistance Module.
MM.09.01.01, EP 17	The antibiotic stewardship program implements one or both of the following strategies to optimize antibiotic prescribing: - Preauthorization for specific antibiotics that includes an internal review and approval process prior to use - Prospective review and feedback regarding antibiotic prescribing practices, including the treatment of positive blood cultures, by a member of the antibiotic stewardship program CoPs: §482.42(b)(3)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.09.01.01, EP 18	The antibiotic stewardship program implements at least two evidence-based guidelines to improve antibiotic use for the most common indications. Note 1: Examples include, but are not limited to, the following: - Community-acquired pneumonia - Urinary tract infections - Skin and soft tissue infections - Clostridioides difficile colitis - Asymptomatic bacteriuria - Plan for parenteral to oral antibiotic conversion - Use of surgical prophylactic antibiotics Note 2: Evidence-based guidelines must be based on national guidelines and also reflect local susceptibilities, formulary options, and the patients served, as needed.	Moved and Revised	MM.18.01.01, EP 6	The antibiotic stewardship program adheres to nationally recognized guidelines, as well as best practices, for improving antibiotic use. CoPs: §482.42(b)(3)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.42(b)(3)			
MM.09.01.01, EP 19	The antibiotic stewardship program evaluates adherence (including antibiotic selection and duration of therapy, where applicable) to at least one of the evidence-based guidelines the hospital implements. Note 1: The hospital may measure adherence at the group level (that is, departmental, unit, clinician subgroup) or at the individual prescriber level. Note 2: The hospital may obtain adherence data for a sample of patients from relevant clinical areas by analyzing electronic health records or by conducting chart reviews. CoPs: §482.42(b)(3)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MM.09.01.01, EP 20	The antibiotic stewardship program collects, analyzes, and reports data to hospital leaders and prescribers. Note: Examples of antibiotic stewardship program data include antibiotic resistance patterns, antibiotic prescribing practices, or an evaluation of antibiotic stewardship activities. CoPs: §482.42(b)(2)(iii), §482.42(c)(1)(i)	Moved and Revised	MM.18.01.01, EP 7	The governing body ensures that systems are in place and operational for the tracking of all antibiotic use activities in order to demonstrate the implementation, success, and sustainability of such activities. CoPs: §482.42(c)(1)(i)
MM.09.01.01, EP 21	The hospital takes action on improvement opportunities identified by the antibiotic stewardship program. CoPs: §482.42(b)(2)(iii), §482.42(c)(1)(i)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
N/A	N/A	New, more-direct EP for CoP requirement	MM.11.01.03, EP 1	Information relating to drug interactions, drug therapy, side effects, toxicology, dosage, indications for use, and routes of administration is available to the professional staff. CoPs: §482.25(b)(8)
N/A	N/A	New, more-direct EP for CoP requirement	MM.14.01.01, EP 1	Orders for drugs and biologicals are documented and signed by any practitioner who is authorized to write orders in accordance with state law, hospital policy, and medical staff bylaws, rules, and regulations. Note: Influenza and pneumococcal vaccines may be administered per physician-approved hospital policy after an assessment of contraindications. CoPs: §482.23(c)(3), §482.23(c)(3)(iii)
N/A	N/A	New, more-direct EP for CoP requirement	MM.16.01.01, EP 1	Drugs and biologicals are prepared and administered in accordance with federal and state laws, the orders of the licensed practitioner or practitioners responsible for the patient's care, and accepted standards of practice. For hospitals that use Joint Commission Accreditation for deemed status purposes: Drugs and biologicals may be prepared and administered as follows: - On the orders of other practitioners not specified under 42 CFR 482.12(c) only if such practitioners are acting in accordance with state law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. - On the orders contained within preprinted and electronic standing orders, order sets, and protocols for patient orders only if such orders meet the requirements of 42 CFR 482.24(c)(3). CoPs: §482.23(c)(1), §482.23(c)(1)(i), §482.23(c)(1)(ii)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
N/A	N/A	New, more-direct EP for CoP requirement	MM.16.01.01, EP 2	Drugs and biologicals are administered by, or under supervision of, nursing or other staff in accordance with federal and state laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. CoPs: §482.23(c)(2)
N/A	N/A	New, more-direct EP for CoP requirement	MM.16.01.01, EP 4	If the hospital allows a patient to self-administer specific hospital-issued medications, the hospital has policies and procedures in place that address the following: - Making certain that an order is issued by a licensed practitioner responsible for the patient's care and that it is consistent with the hospital's self-administration policy - Determining that the patient or the patient's caregiver or support person is capable of administering the specified medication(s) - Instructing the patient or the patient's caregiver or support person, where appropriate, in the safe and accurate administration of the specified medication(s) - Addressing the security of the medications for each patient Note: The term "self-administered medication(s)" may refer to medications administered by a family member. CoPs: §482.23(c)(6)(i)(A), §482.23(c)(6)(i)(B), §482.23(c)(6)(i)(C), §482.23(c)(6)(i)(D)
N/A	N/A	New, more-direct EP for CoP requirement	MM.16.01.01, EP 5	If the hospital allows a patient to self-administer medications not issued by the hospital, the hospital has policies and procedures in place that address the following: - Making certain that an order is issued by a practitioner responsible for the patient's care and that it is consistent with the hospital's self-administration policy - Determining that the patient or the patient's caregiver or support person is capable of administering the specified medication(s) - Instructing the patient or the patient's caregiver or support person, where appropriate, in the safe and accurate administration of the specified medication(s) - Addressing the security of the medications for each patient - Identifying the specified medication(s) and visually evaluating the medication(s) for integrity Note: The term "self-administered medication(s)" may refer to medications administered by a family member. CoPs: §482.23(c)(6)(ii)(A), §482.23(c)(6)(ii)(B), §482.23(c)(6)(ii)(C), §482.23(c)(6)(ii)(D)
N/A	N/A	New, more-direct EP for CoP requirement	MM.17.01.01, EP 3	The hospital has a method (such as using established benchmarks for the size and scope of services provided by the hospital or studies on reporting rates published in peer-reviewed journals) by which to measure the effectiveness of its process for identifying and reporting medication errors and adverse drug reactions to the quality assessment and performance improvement program. CoPs: §482.25(b)(6)
MS.01.01.01, EP 1	The organized medical staff develops medical staff bylaws, rules and regulations, and policies. CoPs: §482.12(a)(3), §482.22, §482.22(c)	Consolidation of MS.01.01.01, EP 1; MS.01.01.01, EP 2; MS.01.01.01, EP 6; MS.01.01.01, EP 12; MS.01.01.01, EP 14;	MS.14.01.01, EP 1	The organized medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following: - Statement of the duties and privileges of each category of medical staff (for example, active, courtesy) - Description of the organization of the medical staff, including those members who

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
		MS.01.01.01, EP 15; MS.01.01.01, EP 17; MS.01.01.01, EP 18; MS.01.01.01, EP 19; MS.01.01.01, EP 21; MS.01.01.01, EP 24; MS.01.01.01, EP 25; MS.01.01.01, EP 26; MS.01.01.01, EP 27; MS.01.01.01, EP 36		are eligible to vote - Description of the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body - Criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges, including the process for reprivileging physicians and other licensed practitioners - Process for credentialing and recredentialing physicians and other licensed practitioners - List of all the officer positions for the medical staff - Process by which the organized medical staff selects and/or elects and removes the medical staff officers - Process for adopting and amending the medical staff bylaws, medical staff rules and regulations, and policies - The qualifications and roles and responsibilities of the department chair, when applicable Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the hospital are also subject to the requirements in 42 CFR 482.12(a)(8) and (a)(9), and 42 CFR 482.22(a)(3) and (a)(4). CoPs: §482.22(c)(1), §482.22(c)(2), §482.22(c)(3), §482.22(c)(4), §482.22(c)(6)
MS.01.01.01, EP 2	The organized medical staff adopts and amends medical staff bylaws. Adoption or amendment of medical staff bylaws cannot be delegated. After adoption or amendment by the organized medical staff, the proposed bylaws are submitted to the governing body for action. Bylaws become effective only upon governing body approval. (See the "Leadership" [LD] chapter for requirements regarding the governing body's authority and conflict management processes. See Element of Performance 17 for information on which medical staff members are eligible to vote.) CoPs: §482.12(a)(1), §482.12(a)(3), §482.12(a)(4), §482.22, §482.22(c), §482.22(c)(1)	Consolidation of MS.01.01.01, EP 1; MS.01.01.01, EP 2; MS.01.01.01, EP 6; MS.01.01.01, EP 12; MS.01.01.01, EP 14; MS.01.01.01, EP 15; MS.01.01.01, EP 17; MS.01.01.01, EP 18; MS.01.01.01, EP 19; MS.01.01.01, EP 21; MS.01.01.01, EP 24; MS.01.01.01, EP 25; MS.01.01.01, EP 26; MS.01.01.01, EP 27; MS.01.01.01, EP 36	MS.14.01.01, EP 1	The organized medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following: - Statement of the duties and privileges of each category of medical staff (for example, active, courtesy) - Description of the organization of the medical staff, including those members who are eligible to vote - Description of the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body - Criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges, including the process for reprivileging physicians and other licensed practitioners - Process for credentialing and recredentialing physicians and other licensed practitioners - List of all the officer positions for the medical staff - Process by which the organized medical staff selects and/or elects and removes the medical staff officers - Process for adopting and amending the medical staff bylaws, medical staff rules and regulations, and policies - The qualifications and roles and responsibilities of the department chair, when applicable Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the hospital are also subject to the requirements in 42 CFR 482.12(a)(8) and (a)(9), and 42 CFR 482.22(a)(3) and (a)(4). CoPs: §482.22(c)(1), §482.22(c)(2), §482.22(c)(3), §482.22(c)(4), §482.22(c)(6)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
MS.01.01.01, EP 4	The medical staff bylaws, rules and regulations, and policies, the governing body bylaws, and the hospital policies are compatible with each other and are compliant with law and regulation.	Moved and Revised	MS.14.01.01, EP 4	The medical staff bylaws, rules and regulations, and policies; the governing body bylaws; and the hospital policies are compatible with each other and are compliant with law and regulation.
MS.01.01.01, EP 5	The medical staff complies with the medical staff bylaws, rules and regulations, and policies. CoPs: §482.22, §482.22(a)(1), §482.22(b)(4)(ii), §482.22(c)	Split to MS.16.01.01, EP 1; MS.17.01.03, EP 4	MS.16.01.01, EP 1	The hospital has an organized medical staff that operates under bylaws approved by the governing body and that is responsible for the quality of medical care provided by the hospital. CoPs: §482.22
MS.01.01.01, EP 5	The medical staff complies with the medical staff bylaws, rules and regulations, and policies. CoPs: §482.22, §482.22(a)(1), §482.22(b)(4)(ii), §482.22(c)	Split to MS.16.01.01, EP 1; MS.17.01.03, EP 4	MS.17.01.03, EP 4	The medical staff examines the credentials of all candidates eligible for medical staff membership and makes recommendations to the governing body on the appointment of these candidates, in accordance with state law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations. A candidate who has been recommended by the medical staff and who has been appointed by the governing body is subject to all medical staff bylaws, rules, and regulations. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: A candidate who has been recommended by the medical staff and who has been appointed by the governing body is also subject to 42 CFR 482.22(a). CoPs: §482.22(a)(2)
MS.01.01.01, EP 6	The organized medical staff enforces the medical staff bylaws, rules and regulations, and policies by recommending action to the governing body in certain circumstances and taking action in others. CoPs: §482.22, §482.22(a)(1), §482.22(b)(4)(ii), §482.22(c)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
MS.01.01.01, EP 7	The governing body upholds the medical staff bylaws, rules and regulations, and policies that have been approved by the governing body. CoPs: §482.12(a)(1), §482.12(a)(3), §482.12(a)(4), §482.22, §482.22(b)(4)(ii), §482.22(c)(1)	Consolidation of MS.01.01.01, EP 5; MS.01.01.01, EP 7; MS.07.01.01, EP 2	MS.16.01.01, EP 1	The hospital has an organized medical staff that operates under bylaws approved by the governing body and that is responsible for the quality of medical care provided by the hospital. CoPs: §482.22
MS.01.01.01, EP 8	The organized medical staff has the ability to adopt medical staff bylaws, rules and regulations, and policies, and amendments thereto, and to propose them directly to the governing body.	Moved	MS.14.01.01, EP 5	The organized medical staff has the ability to adopt medical staff bylaws, rules and regulations, and policies, and amendments thereto, and to propose them directly to the governing body.
MS.01.01.01, EP 9	If the voting members of the organized medical staff propose to adopt a rule, regulation, or policy, or an amendment thereto, they first communicate the proposal to the medical executive committee. If the medical executive committee proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the medical staff; when it adopts a policy or an amendment thereto, it communicates this to the medical staff. This element of performance applies only when the organized medical staff, with the approval of the governing body, has delegated authority over such rules, regulations, or policies to the medical executive committee.	Moved	MS.14.02.01, EP 2	If the voting members of the organized medical staff propose to adopt a rule, regulation, or policy, or an amendment thereto, they first communicate the proposal to the medical executive committee. If the medical executive committee proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the medical staff; when it adopts a policy or an amendment thereto, it communicates this to the medical staff. This element of performance applies only when the organized medical staff, with the approval of the governing body, has delegated authority over such rules, regulations, or policies to the medical executive committee.
MS.01.01.01, EP 10	The organized medical staff has a process which is implemented to manage conflict between the medical staff and the medical executive committee on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto. Nothing in the foregoing is intended to prevent medical staff members from communicating with the governing body on a rule, regulation, or policy adopted by the organized medical staff or the medical executive committee. The governing body determines the method of communication.	Moved and Revised	MS.14.02.01, EP 3	The organized medical staff has a process that is implemented to manage conflict between the medical staff and the medical executive committee on issues including but not limited to proposals to adopt a rule, regulation, or policy or an amendment thereto. This is not intended to prevent medical staff members from communicating with the governing body on a rule, regulation, or policy adopted by the organized medical staff or the medical executive committee. The governing body determines the method of communication.

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MS.01.01.01, EP 11	In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, there is a process by which the medical executive committee, if delegated to do so by the voting members of the organized medical staff, may provisionally adopt and the governing body may provisionally approve an urgent amendment without prior notification of the medical staff. In such cases, the medical staff will be immediately notified by the medical executive committee. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and the medical executive committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the medical executive committee is implemented. If necessary, a revised amendment is then submitted to the governing body for action. Note: Please see the Introduction to this standard for further discussion of the relationship of the voting members of the organized medical staff to the medical executive committee.	Moved and Revised	MS.14.02.01, EP 4	In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, there is a process by which the medical executive committee, if delegated to do so by the voting members of the organized medical staff, may provisionally adopt and the governing body may provisionally approve an urgent amendment without prior notification of the medical staff. In such cases, the medical staff will be immediately notified by the medical executive committee. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and the medical executive committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the medical executive committee is implemented. If necessary, a revised amendment is then submitted to the governing body for action.
MS.01.01.01, EP 12	The medical staff bylaws include the following requirements: The structure of the medical staff. CoPs: §482.12(a)(1), §482.22(a), §482.22(b)(1), §482.22(b)(4)(i), §482.22(b)(4)(ii), §482.22(c)(3)	Consolidation of MS.01.01.01, EP 1; MS.01.01.01, EP 2; MS.01.01.01, EP 6; MS.01.01.01, EP 12; MS.01.01.01, EP 14; MS.01.01.01, EP 15; MS.01.01.01, EP 17; MS.01.01.01, EP 18; MS.01.01.01, EP 19; MS.01.01.01, EP 21; MS.01.01.01, EP 24; MS.01.01.01, EP 25; MS.01.01.01, EP 26; MS.01.01.01, EP 27; MS.01.01.01, EP 36	MS.14.01.01, EP 1	The organized medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following: - Statement of the duties and privileges of each category of medical staff (for example, active, courtesy) - Description of the organization of the medical staff, including those members who are eligible to vote - Description of the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body - Criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges, including the process for reprivileging physicians and other licensed practitioners - Process for credentialing and recredentialing physicians and other licensed practitioners - List of all the officer positions for the medical staff - Process by which the organized medical staff selects and/or elects and removes the medical staff officers - Process for adopting and amending the medical staff bylaws, medical staff rules and regulations, and policies - The qualifications and roles and responsibilities of the department chair, when applicable Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the hospital are also subject to the requirements in 42 CFR 482.12(a)(8) and (a)(9), and 42 CFR 482.22(a)(3) and (a)(4). CoPs: §482.22(c)(1), §482.22(c)(2), §482.22(c)(3), §482.22(c)(4), §482.22(c)(6)
MS.01.01.01, EP 13	The medical staff bylaws include the following requirements: Qualifications for appointment to the medical staff. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff must be composed of doctors of medicine or osteopathy. In accordance with state law, including scope of practice laws, the medical staff may also include other categories of physicians as listed at	Consolidation of MS.01.01.01, EP 13; MS.06.01.05, EP 3; MS.07.01.01, EP 4	MS.14.01.01, EP 2	The medical staff bylaws include the qualifications for appointment and reappointment to the medical staff. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff is composed of doctors of medicine or osteopathy. In accordance with state law, including scope of practice laws, the medical staff may also include other categories of physicians, as listed at 42 CFR 482.12(c)(1), and

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	482.12(c)(1) and other licensed practitioners who are determined to be eligible for appointment by the governing body. CoPs: §482.12(a)(1), §482.22(a), §482.22(a)(2), §482.22(b)(4)(ii), §482.22(c)(4)			other licensed practitioners who the governing body determines are eligible for appointment. Note 2: Gender, race, creed, and national origin are not used in making decisions regarding the granting or denying of medical staff membership. CoPs: §482.22(a)
MS.01.01.01, EP 14	The medical staff bylaws include the following requirements: The process for privileging and re-privileging physicians and other licensed practitioners. CoPs: §482.22(a)(1), §482.22(b)(4)(ii), §482.22(c)(6)	Consolidation of MS.01.01.01, EP 1; MS.01.01.01, EP 2; MS.01.01.01, EP 6; MS.01.01.01, EP 12; MS.01.01.01, EP 14; MS.01.01.01, EP 15; MS.01.01.01, EP 17; MS.01.01.01, EP 18; MS.01.01.01, EP 19; MS.01.01.01, EP 21; MS.01.01.01, EP 24; MS.01.01.01, EP 25; MS.01.01.01, EP 26; MS.01.01.01, EP 27; MS.01.01.01, EP 36	MS.14.01.01, EP 1	The organized medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following: - Statement of the duties and privileges of each category of medical staff (for example, active, courtesy) - Description of the organization of the medical staff, including those members who are eligible to vote - Description of the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body - Criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges, including the process for reprivileging physicians and other licensed practitioners - Process for credentialing and recredentialing physicians and other licensed practitioners - List of all the officer positions for the medical staff - Process by which the organized medical staff selects and/or elects and removes the medical staff officers - Process for adopting and amending the medical staff bylaws, medical staff rules and regulations, and policies - The qualifications and roles and responsibilities of the department chair, when applicable Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the hospital are also subject to the requirements in 42 CFR 482.12(a)(8) and (a)(9), and 42 CFR 482.22(a)(3) and (a)(4). CoPs: §482.22(c)(1), §482.22(c)(2), §482.22(c)(3), §482.22(c)(4), §482.22(c)(6)
MS.01.01.01, EP 15	For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff bylaws include the following requirements: A statement of the duties and privileges related to each category of the medical staff (for example, active, courtesy). Note: Solely for the purposes of this element of performance, The Joint Commission interprets the word "privileges" to mean the duties and prerogatives of each category, and not the clinical privileges to provide patient care, treatment, and services related to each category. Each member of the medical staff is to have specific clinical privileges to provide care, treatment, and services authorized through the processes specified in Standards MS.06.01.03, MS.06.01.05, and MS.06.01.07. CoPs: §482.22(b)(4)(ii), §482.22(c)(2)	Consolidation of MS.01.01.01, EP 1; MS.01.01.01, EP 2; MS.01.01.01, EP 6; MS.01.01.01, EP 12; MS.01.01.01, EP 14; MS.01.01.01, EP 15; MS.01.01.01, EP 17; MS.01.01.01, EP 18; MS.01.01.01, EP 19; MS.01.01.01, EP 21; MS.01.01.01, EP 24; MS.01.01.01, EP 25; MS.01.01.01, EP 26; MS.01.01.01, EP 27; MS.01.01.01, EP 36	MS.14.01.01, EP 1	The organized medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following: - Statement of the duties and privileges of each category of medical staff (for example, active, courtesy) - Description of the organization of the medical staff, including those members who are eligible to vote - Description of the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body - Criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges, including the process for reprivileging physicians and other licensed practitioners - Process for credentialing and recredentialing physicians and other licensed practitioners - List of all the officer positions for the medical staff - Process by which the organized medical staff selects and/or elects and removes

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				the medical staff officers - Process for adopting and amending the medical staff bylaws, medical staff rules and regulations, and policies - The qualifications and roles and responsibilities of the department chair, when applicable Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the hospital are also subject to the requirements in 42 CFR 482.12(a)(8) and (a)(9), and 42 CFR 482.22(a)(3) and (a)(4). CoPs: §482.22(c)(1), §482.22(c)(2), §482.22(c)(3), §482.22(c)(4), §482.22(c)(6)
MS.01.01.01, EP 16	For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff bylaws include the following requirements: The requirements for completing and documenting medical histories and physical examinations. The medical history and physical examination are completed and documented by a physician (as defined in section 1861(r) of the Social Security Act), an oral and maxillofacial surgeon, or other qualified licensed practitioner in accordance with state law and hospital policy. Note: For more information on performing the medical history and physical examination, refer to MS.03.01.01, EPs 6–11. For more information on completion time of the history and physical examination, refer to Standard PC.01.02.03, EPs 4 and 5. CoPs: §482.22(c)(5)(i), §482.22(c)(5)(ii)	Consolidation of MS.01.01.01, EP 16; MS.01.01.01, EP 38	MS.14.01.01, EP 3	The medical staff bylaws include requirements for the following: - Medical history and physical examination for each patient as described in PC.11.02.01, EP 2 - Updated patient examinations as described in PC.11.02.01, EP 3 - Assessments in lieu of medical history and physical examinations for patients as described in PC.11.02.01, EP 4 Note: The medical history and physical examination are completed and documented by a physician (as defined in section 1861(r) of the Social Security Act), an oral and maxillofacial surgeon, or other qualified licensed practitioner in accordance with state law and hospital policy. CoPs: §482.22(c)(5)(i), §482.22(c)(5)(ii), §482.22(c)(5)(iii)
MS.01.01.01, EP 17	The medical staff bylaws include the following requirements: A description of those members of the medical staff who are eligible to vote. CoPs: §482.22(b)(4)(i), §482.22(b)(4)(ii)	Consolidation of MS.01.01.01, EP 1; MS.01.01.01, EP 2; MS.01.01.01, EP 6; MS.01.01.01, EP 12; MS.01.01.01, EP 14; MS.01.01.01, EP 15; MS.01.01.01, EP 17; MS.01.01.01, EP 18; MS.01.01.01, EP 19; MS.01.01.01, EP 21; MS.01.01.01, EP 24; MS.01.01.01, EP 25; MS.01.01.01, EP 26; MS.01.01.01, EP 27; MS.01.01.01, EP 36	MS.14.01.01, EP 1	The organized medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following: - Statement of the duties and privileges of each category of medical staff (for example, active, courtesy) - Description of the organization of the medical staff, including those members who are eligible to vote - Description of the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body - Criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges, including the process for reprivileging physicians and other licensed practitioners - Process for credentialing and recredentialing physicians and other licensed practitioners - List of all the officer positions for the medical staff - Process by which the organized medical staff selects and/or elects and removes the medical staff officers - Process for adopting and amending the medical staff bylaws, medical staff rules and regulations, and policies - The qualifications and roles and responsibilities of the department chair, when applicable Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the hospital are also subject to the requirements in 42 CFR 482.12(a)(8) and (a)(9), and 42 CFR 482.22(a)(3) and (a)(4).

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
				CoPs: §482.22(c)(1), §482.22(c)(2), §482.22(c)(3), §482.22(c)(4), §482.22(c)(6)
MS.01.01.01, EP 18	The medical staff bylaws include the following requirements: The process, as determined by the organized medical staff and approved by the governing body, by which the organized medical staff selects and/or elects and removes the medical staff officers.	Consolidation of MS.01.01.01, EP 1; MS.01.01.01, EP 2; MS.01.01.01, EP 6; MS.01.01.01, EP 12; MS.01.01.01, EP 14; MS.01.01.01, EP 15; MS.01.01.01, EP 17; MS.01.01.01, EP 18; MS.01.01.01, EP 19; MS.01.01.01, EP 21; MS.01.01.01, EP 24; MS.01.01.01, EP 25; MS.01.01.01, EP 26; MS.01.01.01, EP 27; MS.01.01.01, EP 36	MS.14.01.01, EP 1	The organized medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following: - Statement of the duties and privileges of each category of medical staff (for example, active, courtesy) - Description of the organization of the medical staff, including those members who are eligible to vote - Description of the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body - Criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges, including the process for reprivileging physicians and other licensed practitioners - Process for credentialing and recredentialing physicians and other licensed practitioners - List of all the officer positions for the medical staff - Process by which the organized medical staff selects and/or elects and removes the medical staff officers - Process for adopting and amending the medical staff bylaws, medical staff rules and regulations, and policies - The qualifications and roles and responsibilities of the department chair, when applicable Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the hospital are also subject to the requirements in 42 CFR 482.12(a)(8) and (a)(9), and 42 CFR 482.22(a)(3) and (a)(4). CoPs: §482.22(c)(1), §482.22(c)(2), §482.22(c)(3), §482.22(c)(4), §482.22(c)(6)
MS.01.01.01, EP 19	The medical staff bylaws include the following requirements: A list of all the officer positions for the medical staff.	Consolidation of MS.01.01.01, EP 1; MS.01.01.01, EP 2; MS.01.01.01, EP 6; MS.01.01.01, EP 12; MS.01.01.01, EP 14; MS.01.01.01, EP 15; MS.01.01.01, EP 17; MS.01.01.01, EP 18; MS.01.01.01, EP 19; MS.01.01.01, EP 21; MS.01.01.01, EP 24; MS.01.01.01, EP 25; MS.01.01.01, EP 26; MS.01.01.01, EP 27; MS.01.01.01, EP 36	MS.14.01.01, EP 1	The organized medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following: - Statement of the duties and privileges of each category of medical staff (for example, active, courtesy) - Description of the organization of the medical staff, including those members who are eligible to vote - Description of the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body - Criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges, including the process for reprivileging physicians and other licensed practitioners - Process for credentialing and recredentialing physicians and other licensed practitioners - List of all the officer positions for the medical staff - Process by which the organized medical staff selects and/or elects and removes the medical staff officers - Process for adopting and amending the medical staff bylaws, medical staff rules and regulations, and policies - The qualifications and roles and responsibilities of the department chair, when

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
				applicable Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the hospital are also subject to the requirements in 42 CFR 482.12(a)(8) and (a)(9), and 42 CFR 482.22(a)(3) and (a)(4). CoPs: §482.22(c)(1), §482.22(c)(2), §482.22(c)(3), §482.22(c)(4), §482.22(c)(6)
MS.01.01.01, EP 20	The medical staff bylaws include the following requirements: The medical executive committee's function, size, and composition, as determined by the organized medical staff and approved by the governing body; the authority delegated to the medical executive committee by the organized medical staff to act on the medical staff's behalf; and how such authority is delegated or removed. (For more information on the role of the medical executive committee, refer to Standard MS.02.01.01.)	Split to MS.15.01.01, EP 1; MS.15.01.01, EP 4	MS.15.01.01, EP 1	The structure and function of the medical staff executive committee conforms to the medical staff bylaws.
MS.01.01.01, EP 20	The medical staff bylaws include the following requirements: The medical executive committee's function, size, and composition, as determined by the organized medical staff and approved by the governing body; the authority delegated to the medical executive committee by the organized medical staff to act on the medical staff's behalf; and how such authority is delegated or removed. (For more information on the role of the medical executive committee, refer to Standard MS.02.01.01.)	Split to MS.15.01.01, EP 1; MS.15.01.01, EP 4	MS.15.01.01, EP 4	The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on all of the following, at a minimum: - Organized medical staff's structure - Process used to review credentials and delineate privileges - Executive committee's review of and actions on reports of medical staff committees, departments, and other assigned activity groups
MS.01.01.01, EP 21	The medical staff bylaws include the following requirements: The process, as determined by the organized medical staff and approved by the governing body, for selecting and/or electing and removing the medical executive committee members.	Consolidation of MS.01.01.01, EP 1; MS.01.01.01, EP 2; MS.01.01.01, EP 6; MS.01.01.01, EP 12; MS.01.01.01, EP 14; MS.01.01.01, EP 15; MS.01.01.01, EP 17; MS.01.01.01, EP 18; MS.01.01.01, EP 19; MS.01.01.01, EP 21; MS.01.01.01, EP 24; MS.01.01.01, EP 25; MS.01.01.01, EP 26; MS.01.01.01, EP 27; MS.01.01.01, EP 36	MS.14.01.01, EP 1	The organized medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following: - Statement of the duties and privileges of each category of medical staff (for example, active, courtesy) - Description of the organization of the medical staff, including those members who are eligible to vote - Description of the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body - Criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges, including the process for reprivileging physicians and other licensed practitioners - Process for credentialing and recredentialing physicians and other licensed practitioners - List of all the officer positions for the medical staff - Process by which the organized medical staff selects and/or elects and removes the medical staff officers - Process for adopting and amending the medical staff bylaws, medical staff rules and regulations, and policies - The qualifications and roles and responsibilities of the department chair, when applicable Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the hospital are also subject to the requirements in 42 CFR 482.12(a)(8) and (a)(9), and 42 CFR 482.22(a)(3) and (a)(4). CoPs: §482.22(c)(1), §482.22(c)(2), §482.22(c)(3), §482.22(c)(4), §482.22(c)(6)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
MS.01.01.01, EP 22	The medical staff bylaws include the following requirements: That the medical executive committee includes physicians and may include other licensed practitioners. CoPs: §482.22(b)(4)(ii)	Consolidation of MS.01.01.01, EP 22; MS.02.01.01, EP 3; MS.02.01.01, EP 4	MS.15.01.01, EP 3	The majority of voting medical staff executive committee members are fully licensed doctors of medicine or osteopathy actively practicing in the hospital. Note: All members of the organized medical staff, of any discipline or specialty, are eligible for membership on the medical staff executive committee. CoPs: §482.22(b)(2)
MS.01.01.01, EP 23	The medical staff bylaws include the following requirements: That the medical executive committee acts on the behalf of the medical staff between meetings of the organized medical staff, within the scope of its responsibilities as defined by the organized medical staff.	Moved and Revised	MS.14.01.01, EP 6	The medical staff bylaws include the following requirements regarding the medical executive committee: - The function, size, and composition, as determined by the organized medical staff and approved by the governing body; - The authority delegated to the medical executive committee by the organized medical staff to act on the medical staff's behalf and how such authority is delegated or removed. (For more information on the role of the medical executive committee, refer to Standard MS.14.02.01.) - The process, as determined by the organized medical staff and approved by the governing body, for selecting and/or electing and removing the medical executive committee members. Note: The medical executive committee includes physicians and may include other licensed practitioners.
MS.01.01.01, EP 24	The medical staff bylaws include the following requirements: The process for adopting and amending the medical staff bylaws.	Consolidation of MS.01.01.01, EP 1; MS.01.01.01, EP 2; MS.01.01.01, EP 6; MS.01.01.01, EP 12; MS.01.01.01, EP 14; MS.01.01.01, EP 15; MS.01.01.01, EP 17; MS.01.01.01, EP 18; MS.01.01.01, EP 19; MS.01.01.01, EP 21; MS.01.01.01, EP 24; MS.01.01.01, EP 25; MS.01.01.01, EP 26; MS.01.01.01, EP 27; MS.01.01.01, EP 36	MS.14.01.01, EP 1	The organized medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following: - Statement of the duties and privileges of each category of medical staff (for example, active, courtesy) - Description of the organization of the medical staff, including those members who are eligible to vote - Description of the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body - Criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges, including the process for reprivileging physicians and other licensed practitioners - Process for credentialing and recredentialing physicians and other licensed practitioners - List of all the officer positions for the medical staff - Process by which the organized medical staff selects and/or elects and removes the medical staff officers - Process for adopting and amending the medical staff bylaws, medical staff rules and regulations, and policies - The qualifications and roles and responsibilities of the department chair, when applicable Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the hospital are also subject to the requirements in 42 CFR 482.12(a)(8) and (a)(9), and 42 CFR 482.22(a)(3) and (a)(4). CoPs: §482.22(c)(1), §482.22(c)(2), §482.22(c)(3), §482.22(c)(4), §482.22(c)(6)
MS.01.01.01, EP 25	The medical staff bylaws include the following requirements: The process for adopting and amending the medical staff rules and regulations, and policies.	Consolidation of MS.01.01.01, EP 1; MS.01.01.01, EP 2;	MS.14.01.01, EP 1	The organized medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following:

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
		MS.01.01.01, EP 6; MS.01.01.01, EP 12; MS.01.01.01, EP 14; MS.01.01.01, EP 15; MS.01.01.01, EP 17; MS.01.01.01, EP 18; MS.01.01.01, EP 19; MS.01.01.01, EP 21; MS.01.01.01, EP 24; MS.01.01.01, EP 25; MS.01.01.01, EP 26; MS.01.01.01, EP 27; MS.01.01.01, EP 36		- Statement of the duties and privileges of each category of medical staff (for example, active, courtesy) - Description of the organization of the medical staff, including those members who are eligible to vote - Description of the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body - Criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges, including the process for reprivileging physicians and other licensed practitioners - Process for credentialing and recredentialing physicians and other licensed practitioners - List of all the officer positions for the medical staff - Process by which the organized medical staff selects and/or elects and removes the medical staff officers - Process for adopting and amending the medical staff bylaws, medical staff rules and regulations, and policies - The qualifications and roles and responsibilities of the department chair, when applicable Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the hospital are also subject to the requirements in 42 CFR 482.12(a)(8) and (a)(9), and 42 CFR 482.22(a)(3) and (a)(4). CoPs: §482.22(c)(1), §482.22(c)(2), §482.22(c)(3), §482.22(c)(4), §482.22(c)(6)
MS.01.01.01, EP 26	The medical staff bylaws include the following requirements: The process for credentialing and re-credentialing physicians and other licensed practitioners. CoPs: §482.22(b)(4)(ii)	Consolidation of MS.01.01.01, EP 1; MS.01.01.01, EP 2; MS.01.01.01, EP 6; MS.01.01.01, EP 12; MS.01.01.01, EP 14; MS.01.01.01, EP 15; MS.01.01.01, EP 17; MS.01.01.01, EP 18; MS.01.01.01, EP 19; MS.01.01.01, EP 21; MS.01.01.01, EP 24; MS.01.01.01, EP 25; MS.01.01.01, EP 26; MS.01.01.01, EP 27; MS.01.01.01, EP 36	MS.14.01.01, EP 1	The organized medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following: - Statement of the duties and privileges of each category of medical staff (for example, active, courtesy) - Description of the organization of the medical staff, including those members who are eligible to vote - Description of the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body - Criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges, including the process for reprivileging physicians and other licensed practitioners - Process for credentialing and recredentialing physicians and other licensed practitioners - List of all the officer positions for the medical staff - Process by which the organized medical staff selects and/or elects and removes the medical staff officers - Process for adopting and amending the medical staff bylaws, medical staff rules and regulations, and policies - The qualifications and roles and responsibilities of the department chair, when applicable Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the hospital are also subject to the requirements in 42 CFR 482.12(a)(8) and (a)(9), and 42 CFR 482.22(a)(3) and (a)(4).

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
				CoPs: §482.22(c)(1), §482.22(c)(2), §482.22(c)(3), §482.22(c)(4), §482.22(c)(6)
MS.01.01.01, EP 27	The medical staff bylaws include the following requirements: The process for appointment and re-appointment to membership on the medical staff. CoPs: §482.12(a)(1), §482.22(b)(4)(ii)	Consolidation of MS.01.01.01, EP 1; MS.01.01.01, EP 2; MS.01.01.01, EP 6; MS.01.01.01, EP 12; MS.01.01.01, EP 14; MS.01.01.01, EP 15; MS.01.01.01, EP 17; MS.01.01.01, EP 18; MS.01.01.01, EP 19; MS.01.01.01, EP 21; MS.01.01.01, EP 24; MS.01.01.01, EP 25; MS.01.01.01, EP 26; MS.01.01.01, EP 27; MS.01.01.01, EP 36	MS.14.01.01, EP 1	The organized medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following: - Statement of the duties and privileges of each category of medical staff (for example, active, courtesy) - Description of the organization of the medical staff, including those members who are eligible to vote - Description of the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body - Criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges, including the process for reprivileging physicians and other licensed practitioners - Process for credentialing and recredentialing physicians and other licensed practitioners - List of all the officer positions for the medical staff - Process by which the organized medical staff selects and/or elects and removes the medical staff officers - Process for adopting and amending the medical staff bylaws, medical staff rules and regulations, and policies - The qualifications and roles and responsibilities of the department chair, when applicable Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the hospital are also subject to the requirements in 42 CFR 482.12(a)(8) and (a)(9), and 42 CFR 482.22(a)(3) and (a)(4). CoPs: §482.22(c)(1), §482.22(c)(2), §482.22(c)(3), §482.22(c)(4), §482.22(c)(6)
MS.01.01.01, EP 28	The medical staff bylaws include the following requirements: Indications for automatic suspension of a physician's or other licensed practitioner’s medical staff membership or clinical privileges.	Consolidation of MS.01.01.01, EP 28; MS.01.01.01, EP 29; MS.01.01.01, EP 30; MS.01.01.01, EP 31; MS.01.01.01, EP 32; MS.01.01.01, EP 33	MS.14.01.01, EP 7	The medical staff bylaws include the following requirements regarding the suspension or termination of a physician’s or other licensed practitioner’s medical staff membership or privileges: - Indications and process for automatic suspension of a physician's or other licensed practitioner’s medical staff membership or clinical privileges - Indications and process for summary suspension of a physician's or other licensed practitioner’s medical staff membership or clinical privileges - Indications and process for recommending termination or suspension of medical staff membership, and/or termination, suspension, or reduction of clinical privileges
MS.01.01.01, EP 29	The medical staff bylaws include the following requirements: Indications for summary suspension of a physician's or other licensed practitioner’s medical staff membership or clinical privileges.	Consolidation of MS.01.01.01, EP 28; MS.01.01.01, EP 29; MS.01.01.01, EP 30; MS.01.01.01, EP 31; MS.01.01.01, EP 32; MS.01.01.01, EP 33	MS.14.01.01, EP 7	The medical staff bylaws include the following requirements regarding the suspension or termination of a physician’s or other licensed practitioner’s medical staff membership or privileges: - Indications and process for automatic suspension of a physician's or other licensed practitioner’s medical staff membership or clinical privileges - Indications and process for summary suspension of a physician's or other licensed practitioner’s medical staff membership or clinical privileges - Indications and process for recommending termination or suspension of medical staff membership, and/or termination, suspension, or reduction of clinical privileges

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
MS.01.01.01, EP 30	The medical staff bylaws include the following requirements: Indications for recommending termination or suspension of medical staff membership, and/or termination, suspension, or reduction of clinical privileges.	Consolidation of MS.01.01.01, EP 28; MS.01.01.01, EP 29; MS.01.01.01, EP 30; MS.01.01.01, EP 31; MS.01.01.01, EP 32; MS.01.01.01, EP 33	MS.14.01.01, EP 7	The medical staff bylaws include the following requirements regarding the suspension or termination of a physician's or other licensed practitioner's medical staff membership or privileges: - Indications and process for automatic suspension of a physician's or other licensed practitioner's medical staff membership or clinical privileges - Indications and process for summary suspension of a physician's or other licensed practitioner's medical staff membership or clinical privileges - Indications and process for recommending termination or suspension of medical staff membership, and/or termination, suspension, or reduction of clinical privileges
MS.01.01.01, EP 31	The medical staff bylaws include the following requirements: The process for automatic suspension of a physician's or other licensed practitioner's medical staff membership or clinical privileges.	Consolidation of MS.01.01.01, EP 28; MS.01.01.01, EP 29; MS.01.01.01, EP 30; MS.01.01.01, EP 31; MS.01.01.01, EP 32; MS.01.01.01, EP 33	MS.14.01.01, EP 7	The medical staff bylaws include the following requirements regarding the suspension or termination of a physician's or other licensed practitioner's medical staff membership or privileges: - Indications and process for automatic suspension of a physician's or other licensed practitioner's medical staff membership or clinical privileges - Indications and process for summary suspension of a physician's or other licensed practitioner's medical staff membership or clinical privileges - Indications and process for recommending termination or suspension of medical staff membership, and/or termination, suspension, or reduction of clinical privileges
MS.01.01.01, EP 32	The medical staff bylaws include the following requirements: The process for summary suspension of a physician's or other licensed practitioner's medical staff membership or clinical privileges.	Consolidation of MS.01.01.01, EP 28; MS.01.01.01, EP 29; MS.01.01.01, EP 30; MS.01.01.01, EP 31; MS.01.01.01, EP 32; MS.01.01.01, EP 33	MS.14.01.01, EP 7	The medical staff bylaws include the following requirements regarding the suspension or termination of a physician's or other licensed practitioner's medical staff membership or privileges: - Indications and process for automatic suspension of a physician's or other licensed practitioner's medical staff membership or clinical privileges - Indications and process for summary suspension of a physician's or other licensed practitioner's medical staff membership or clinical privileges - Indications and process for recommending termination or suspension of medical staff membership, and/or termination, suspension, or reduction of clinical privileges
MS.01.01.01, EP 33	The medical staff bylaws include the following requirements: The process for recommending termination or suspension of medical staff membership and/or termination, suspension, or reduction of clinical privileges.	Consolidation of MS.01.01.01, EP 28; MS.01.01.01, EP 29; MS.01.01.01, EP 30; MS.01.01.01, EP 31; MS.01.01.01, EP 32; MS.01.01.01, EP 33	MS.14.01.01, EP 7	The medical staff bylaws include the following requirements regarding the suspension or termination of a physician's or other licensed practitioner's medical staff membership or privileges: - Indications and process for automatic suspension of a physician's or other licensed practitioner's medical staff membership or clinical privileges - Indications and process for summary suspension of a physician's or other licensed practitioner's medical staff membership or clinical privileges - Indications and process for recommending termination or suspension of medical staff membership, and/or termination, suspension, or reduction of clinical privileges
MS.01.01.01, EP 34	The medical staff bylaws include the following requirements: The fair hearing and appeal process (refer to Standard MS.10.01.01), which at a minimum shall include: - The process for scheduling hearings and appeals - The process for conducting hearings and appeals CoPs: §482.22(b)(4)(ii)	Split to MS.18.04.01, EP 2; MS.18.04.01, EP 3	MS.18.04.01, EP 2	The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has a mechanism to schedule a hearing of such requests.
MS.01.01.01, EP 34	The medical staff bylaws include the following requirements: The fair hearing and appeal process (refer to Standard MS.10.01.01), which at a minimum shall include: - The process for scheduling hearings and appeals - The process for conducting hearings and appeals CoPs: §482.22(b)(4)(ii)	Split to MS.18.04.01, EP 2; MS.18.04.01, EP 3	MS.18.04.01, EP 3	The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has identified the procedures for the hearing to follow.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
MS.01.01.01, EP 35	The medical staff bylaws include the following requirements: The composition of the fair hearing committee.	Moved and Revised	MS.14.01.01, EP 8	The medical staff bylaws include requirements for the composition of the fair hearing committee.
MS.01.01.01, EP 36	The medical staff bylaws include the following requirements: If departments of the medical staff exist, the qualifications and roles and responsibilities of the department chair, which are defined by the organized medical staff, include the following: Qualifications: - Certification by an appropriate specialty board or comparable competence affirmatively established through the credentialing process Roles and responsibilities: - Clinically related activities of the department - Administratively related activities of the department, unless otherwise provided by the hospital - Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges - Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department - Recommending clinical privileges for each member of the department - Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization - Integration of the department or service into the primary functions of the organization - Coordination and integration of interdepartmental and intradepartmental services - Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services - Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services - Determination of the qualifications and competence of department or service staff who provide patient care, treatment, and services but are not licensed to practice independently - Continuous assessment and improvement of the quality of care, treatment, and services - Maintenance of quality control programs, as appropriate - Orientation and continuing education of all persons in the department or service - Recommending space and other resources needed by the department or service Note: For hospitals that use Joint Commission accreditation for deemed status purposes: When departments of the medical staff do not exist, the medical staff is responsible for the development of policies and procedures that minimize medication errors. The medical staff may delegate this responsibility to the organized pharmaceutical service. CoPs: §482.26(c)(1), §482.55(a)(3), §482.57(b), §482.62(b)(2)	Consolidation of MS.01.01.01, EP 1; MS.01.01.01, EP 2; MS.01.01.01, EP 6; MS.01.01.01, EP 12; MS.01.01.01, EP 14; MS.01.01.01, EP 15; MS.01.01.01, EP 17; MS.01.01.01, EP 18; MS.01.01.01, EP 19; MS.01.01.01, EP 21; MS.01.01.01, EP 24; MS.01.01.01, EP 25; MS.01.01.01, EP 26; MS.01.01.01, EP 27; MS.01.01.01, EP 36	MS.14.01.01, EP 1	The organized medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following: - Statement of the duties and privileges of each category of medical staff (for example, active, courtesy) - Description of the organization of the medical staff, including those members who are eligible to vote - Description of the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body - Criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges, including the process for reprivileging physicians and other licensed practitioners - Process for credentialing and recredentialing physicians and other licensed practitioners - List of all the officer positions for the medical staff - Process by which the organized medical staff selects and/or elects and removes the medical staff officers - Process for adopting and amending the medical staff bylaws, medical staff rules and regulations, and policies - The qualifications and roles and responsibilities of the department chair, when applicable Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the hospital are also subject to the requirements in 42 CFR 482.12(a)(8) and (a)(9), and 42 CFR 482.22(a)(3) and (a)(4). CoPs: §482.22(c)(1), §482.22(c)(2), §482.22(c)(3), §482.22(c)(4), §482.22(c)(6)
MS.01.01.01, EP 37	For hospitals that use Joint Commission accreditation for deemed status purposes: When a multihospital system has a unified and integrated medical staff, the medical staff bylaws include the following requirements: A description of the process by which medical staff members at each separately accredited hospital (that is, all	Moved	MS.14.03.01, EP 4	For hospitals that use Joint Commission accreditation for deemed status purposes: When a multihospital system has a unified and integrated medical staff, the medical staff bylaws include the following requirements: A description of the process by which medical staff members at each separately accredited hospital (that is, all

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	medical staff members who hold privileges to practice at that specific hospital) are advised of their right to opt out of the unified and integrated medical staff structure after a majority vote by the members to maintain a separate and distinct medical staff for their respective hospital. CoPs: §482.22(b)(4)(ii)			medical staff members who hold privileges to practice at that specific hospital) are advised of their right to opt out of the unified and integrated medical staff structure after a majority vote by the members to maintain a separate and distinct medical staff for their respective hospital. CoPs: §482.22(b)(4)(ii)
MS.01.01.01, EP 38	For hospitals that use Joint Commission accreditation for deemed status purposes: When the medical staff has chosen to allow an assessment, in lieu of a comprehensive medical history and physical examination, for patients receiving specific outpatient surgical or procedural services, the medical staff bylaws specify that an assessment of the patient is completed and documented after registration, but prior to surgery or a procedure requiring anesthesia services, when the patient is receiving specific outpatient surgical or procedural services. Note: For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(i), (ii), (iii), and (v). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text. CoPs: §482.22(c)(5)(iii)	Consolidation of MS.01.01.01, EP 16; MS.01.01.01, EP 38	MS.14.01.01, EP 3	The medical staff bylaws include requirements for the following: - Medical history and physical examination for each patient as described in PC.11.02.01, EP 2 - Updated patient examinations as described in PC.11.02.01, EP 3 - Assessments in lieu of medical history and physical examinations for patients as described in PC.11.02.01, EP 4 Note: The medical history and physical examination are completed and documented by a physician (as defined in section 1861(r) of the Social Security Act), an oral and maxillofacial surgeon, or other qualified licensed practitioner in accordance with state law and hospital policy. CoPs: §482.22(c)(5)(i), §482.22(c)(5)(ii), §482.22(c)(5)(iii)
MS.01.01.03, EP 1	The medical staff bylaws, rules, and regulations are not unilaterally amended.	Moved and Revised	MS.14.02.01, EP 1	The medical staff bylaws, rules, and regulations are not unilaterally amended.
MS.01.01.05, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes: If a multihospital system with separately accredited hospitals chooses to establish a unified and integrated medical staff, the following occurs: Each separately accredited hospital within a multihospital system that elects to have a unified and integrated medical staff demonstrates that the medical staff members of each hospital (that is, all medical staff members who hold privileges to practice at that specific hospital) have voted by majority either to accept the unified and integrated medical staff structure or to opt out of such a structure and maintain a separate and distinct medical staff for their hospital. CoPs: §482.22(b)(4)(i)	Moved and Revised	MS.14.03.01, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes: If a multihospital system with separately accredited hospitals chooses to establish a unified and integrated medical staff, in accordance with state and local laws, the following occurs: Each separately accredited hospital within a multihospital system that elects to have a unified and integrated medical staff demonstrates that the medical staff members of each hospital (that is, all medical staff members who hold privileges to practice at that specific hospital) have voted by majority, in accordance with medical staff bylaws, either to accept the unified and integrated medical staff structure or to opt out of such a structure and maintain a separate and distinct medical staff for their hospital. CoPs: §482.22(b)(4)(i)
MS.01.01.05, EP 2	For hospitals that use Joint Commission accreditation for deemed status purposes: If a multihospital system with separately accredited hospitals chooses to establish a unified and integrated medical staff, the following occurs: The unified and integrated medical staff takes into account each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital. CoPs: §482.22(b)(4)(iii)	Moved	MS.14.03.01, EP 2	For hospitals that use Joint Commission accreditation for deemed status purposes: If a multihospital system with separately accredited hospitals chooses to establish a unified and integrated medical staff, the following occurs: The unified and integrated medical staff takes into account each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital. CoPs: §482.22(b)(4)(iii)
MS.01.01.05, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes: If a multihospital system with separately accredited hospitals chooses to establish a unified and integrated medical staff, the following occurs: The unified and integrated medical staff establishes and implements policies and procedures to make certain that the needs and concerns expressed by members of the medical staff at each of its separately accredited hospitals, regardless of practice or location, are given due consideration. CoPs: §482.22(b)(4)(iv)	Consolidation of MS.01.01.05, EP 3; MS.01.01.05, EP 4	MS.14.03.01, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes: If a multihospital system with separately accredited hospitals chooses to establish a unified and integrated medical staff, the following occurs: The unified and integrated medical staff develops and implements policies and procedures and mechanisms to make certain that the needs and concerns expressed by members of the medical staff at each of its separately accredited hospitals, regardless of practice or location, are duly considered and addressed. CoPs: §482.22(b)(4)(iv)

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MS.01.01.05, EP 4	For hospitals that use Joint Commission accreditation for deemed status purposes: If a multihospital system with separately accredited hospitals chooses to establish a unified and integrated medical staff, the following occurs: The unified and integrated medical staff has mechanisms in place to make certain that issues localized to particular hospitals within the system are duly considered and addressed. CoPs: §482.22(b)(4)(iv)	Consolidation of MS.01.01.05, EP 3; MS.01.01.05, EP 4	MS.14.03.01, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes: If a multihospital system with separately accredited hospitals chooses to establish a unified and integrated medical staff, the following occurs: The unified and integrated medical staff develops and implements policies and procedures and mechanisms to make certain that the needs and concerns expressed by members of the medical staff at each of its separately accredited hospitals, regardless of practice or location, are duly considered and addressed. CoPs: §482.22(b)(4)(iv)
MS.02.01.01, EP 1	The structure and function of the medical staff executive committee conforms to the medical staff bylaws.	Moved	MS.15.01.01, EP 1	The structure and function of the medical staff executive committee conforms to the medical staff bylaws.
MS.02.01.01, EP 2	The chief executive officer (CEO) of the hospital or their designee attends each medical staff executive committee meeting on an ex-officio basis, with or without a vote.	Moved	MS.15.01.01, EP 2	The chief executive officer (CEO) of the hospital or their designee attends each medical staff executive committee meeting on an ex-officio basis, with or without a vote.
MS.02.01.01, EP 3	All members of the organized medical staff, of any discipline or specialty, are eligible for membership on the medical staff executive committee.	Consolidation of MS.01.01.01, EP 22; MS.02.01.01, EP 3; MS.02.01.01, EP 4	MS.15.01.01, EP 3	The majority of voting medical staff executive committee members are fully licensed doctors of medicine or osteopathy actively practicing in the hospital. Note: All members of the organized medical staff, of any discipline or specialty, are eligible for membership on the medical staff executive committee. CoPs: §482.22(b)(2)
MS.02.01.01, EP 4	The majority of voting medical staff executive committee members are fully licensed doctors of medicine or osteopathy actively practicing in the hospital. CoPs: §482.22(b)(2)	Consolidation of MS.01.01.01, EP 22; MS.02.01.01, EP 3; MS.02.01.01, EP 4	MS.15.01.01, EP 3	The majority of voting medical staff executive committee members are fully licensed doctors of medicine or osteopathy actively practicing in the hospital. Note: All members of the organized medical staff, of any discipline or specialty, are eligible for membership on the medical staff executive committee. CoPs: §482.22(b)(2)
MS.02.01.01, EP 5	The medical staff executive committee acts on behalf of the organized medical staff between medical staff meetings.	Consolidation of MS.02.01.01, EP 5; MS.02.01.01, EP 6; MS.02.01.01, EP 7; MS.02.01.01, EP 8; MS.02.01.01, EP 9; MS.02.01.01, EP 10; MS.02.01.01, EP 12	MS.15.01.01, EP 4	The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on all of the following, at a minimum: - Organized medical staff's structure - Process used to review credentials and delineate privileges - Executive committee's review of and actions on reports of medical staff committees, departments, and other assigned activity groups
MS.02.01.01, EP 6	The medical staff executive committee has a mechanism to recommend medical staff membership termination.	Consolidation of MS.02.01.01, EP 5; MS.02.01.01, EP 6; MS.02.01.01, EP 7; MS.02.01.01, EP 8; MS.02.01.01, EP 9; MS.02.01.01, EP 10; MS.02.01.01, EP 12	MS.15.01.01, EP 4	The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on all of the following, at a minimum: - Organized medical staff's structure - Process used to review credentials and delineate privileges - Executive committee's review of and actions on reports of medical staff committees, departments, and other assigned activity groups
MS.02.01.01, EP 7	The medical staff executive committee requests evaluations of physicians and other licensed practitioners privileged through the medical staff process in instances where there is doubt about an applicant's ability to perform the privileges requested.	Consolidation of MS.02.01.01, EP 5; MS.02.01.01, EP 6; MS.02.01.01, EP 7; MS.02.01.01, EP 8; MS.02.01.01, EP 9;	MS.15.01.01, EP 4	The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on all of the following, at a minimum: - Organized medical staff's structure - Process used to review credentials and delineate privileges - Executive committee's review of and actions on reports of medical staff committees, departments, and other assigned activity groups

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		MS.02.01.01, EP 10; MS.02.01.01, EP 12		
MS.02.01.01, EP 8	The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on, at least, all of the following: Medical staff membership. CoPs: §482.12(a)(2)	Consolidation of MS.02.01.01, EP 5; MS.02.01.01, EP 6; MS.02.01.01, EP 7; MS.02.01.01, EP 8; MS.02.01.01, EP 9; MS.02.01.01, EP 10; MS.02.01.01, EP 12	MS.15.01.01, EP 4	The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on all of the following, at a minimum: - Organized medical staff's structure - Process used to review credentials and delineate privileges - Executive committee's review of and actions on reports of medical staff committees, departments, and other assigned activity groups
MS.02.01.01, EP 9	The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on, at least, all of the following: The organized medical staff's structure.	Consolidation of MS.02.01.01, EP 5; MS.02.01.01, EP 6; MS.02.01.01, EP 7; MS.02.01.01, EP 8; MS.02.01.01, EP 9; MS.02.01.01, EP 10; MS.02.01.01, EP 12	MS.15.01.01, EP 4	The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on all of the following, at a minimum: - Organized medical staff's structure - Process used to review credentials and delineate privileges - Executive committee's review of and actions on reports of medical staff committees, departments, and other assigned activity groups
MS.02.01.01, EP 10	The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on, at least, all of the following: The process used to review credentials and delineate privileges.	Consolidation of MS.02.01.01, EP 5; MS.02.01.01, EP 6; MS.02.01.01, EP 7; MS.02.01.01, EP 8; MS.02.01.01, EP 9; MS.02.01.01, EP 10; MS.02.01.01, EP 12	MS.15.01.01, EP 4	The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on all of the following, at a minimum: - Organized medical staff's structure - Process used to review credentials and delineate privileges - Executive committee's review of and actions on reports of medical staff committees, departments, and other assigned activity groups
MS.02.01.01, EP 11	The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on, at least, all of the following: The delineation of privileges for each physician and other licensed practitioner privileged through the medical staff process. CoPs: §482.12(a)(8), §482.12(a)(9), §482.22(a)(2)	Consolidation of MS.01.01.01, EP 5; MS.02.01.01, EP 11; MS.06.01.03, EP 1; MS.06.01.03, EP 2; MS.06.01.03, EP 4; MS.06.01.07, EP 8; MS.06.01.09, EP 1; MS.06.01.09, EP 2; MS.06.01.09, EP 3; MS.06.01.09, EP 4	MS.17.01.03, EP 4	The medical staff examines the credentials of all candidates eligible for medical staff membership and makes recommendations to the governing body on the appointment of these candidates, in accordance with state law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations. A candidate who has been recommended by the medical staff and who has been appointed by the governing body is subject to all medical staff bylaws, rules, and regulations. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: A candidate who has been recommended by the medical staff and who has been appointed by the governing body is also subject to 42 CFR 482.22(a). CoPs: §482.22(a)(2)
MS.02.01.01, EP 12	The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on, at least, all of the following: The executive committee's review of and actions on reports of medical staff committees, departments, and other assigned activity groups.	Consolidation of MS.02.01.01, EP 5; MS.02.01.01, EP 6; MS.02.01.01, EP 7; MS.02.01.01, EP 8; MS.02.01.01, EP 9; MS.02.01.01, EP 10; MS.02.01.01, EP 12	MS.15.01.01, EP 4	The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on all of the following, at a minimum: - Organized medical staff's structure - Process used to review credentials and delineate privileges - Executive committee's review of and actions on reports of medical staff committees, departments, and other assigned activity groups
MS.03.01.01, EP 1	Physician members of the organized medical staff are designated to perform the oversight activities of the organized medical staff.	Consolidation of MS.03.01.01, EP 1; MS.03.01.01, EP 3	MS.16.01.01, EP 2	Physician members of the organized medical staff are designated to perform the oversight activities of the organized medical staff.

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MS.03.01.01, EP 2	Physicians and other licensed practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff. CoPs: §482.12(c)(2), §482.12(c)(4)(ii)(A), §482.22(a)(1), §482.23(c)(1)(i), §482.23(c)(1)(ii), §482.23(c)(2), §482.51(a)(4), §482.52(a)(1), §482.52(a)(2), §482.52(a)(3), §482.52(a)(4), §482.52(a)(5), §482.52(c)(1), §482.53(d)(2), §482.53(d)(4)	Moved	MS.16.01.01, EP 3	Physicians and other licensed practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.
MS.03.01.01, EP 3	Physicians are responsible for the oversight activities of the organized medical staff.	Consolidation of MS.03.01.01, EP 1; MS.03.01.01, EP 3	MS.16.01.01, EP 2	Physician members of the organized medical staff are designated to perform the oversight activities of the organized medical staff.
MS.03.01.01, EP 4	The organized medical staff through its designated mechanisms provides leadership in activities related to patient safety.	Moved and Revised	MS.16.01.01, EP 4	The organized medical staff, through its designated mechanisms, provides leadership in activities related to patient safety.
MS.03.01.01, EP 5	The organized medical staff provides oversight in the process of analyzing and improving patient satisfaction.	Moved	MS.16.01.01, EP 5	The organized medical staff provides oversight in the process of analyzing and improving patient satisfaction.
MS.03.01.01, EP 6	The organized medical staff specifies the minimal content of medical histories and physical examinations, which may vary by setting or level of care, treatment, and services. CoPs: §482.24(b)	Consolidation of MS.03.01.01, EP 6; MS.03.01.01, EP 7; MS.03.01.01, EP 8; MS.03.01.01, EP 9; MS.03.01.01, EP 10; MS.03.01.01. EP 11	MS.16.01.01, EP 7	The organized medical staff does the following: - Defines when a medical history and physical examination must be validated and countersigned by a physician with appropriate privileges - Specifies the minimal content and scope of medical histories and physical examinations, which may vary by setting or level of care, treatment, and services, including non-inpatient services - Monitors the quality of medical histories and physical examinations
MS.03.01.01, EP 7	The organized medical staff monitors the quality of medical histories and physical examinations. CoPs: §482.24(b)	Consolidation of MS.03.01.01, EP 6; MS.03.01.01, EP 7; MS.03.01.01, EP 8; MS.03.01.01, EP 9; MS.03.01.01, EP 10; MS.03.01.01. EP 11	MS.16.01.01, EP 7	The organized medical staff does the following: - Defines when a medical history and physical examination must be validated and countersigned by a physician with appropriate privileges - Specifies the minimal content and scope of medical histories and physical examinations, which may vary by setting or level of care, treatment, and services, including non-inpatient services - Monitors the quality of medical histories and physical examinations
MS.03.01.01, EP 8	The medical staff requires that a physician or other licensed practitioner who has been granted privileges by the hospital to do so performs a patient's medical history and physical examination and required updates.	Consolidation of MS.03.01.01, EP 6; MS.03.01.01, EP 7; MS.03.01.01, EP 8; MS.03.01.01, EP 9; MS.03.01.01, EP 10; MS.03.01.01. EP 11	MS.16.01.01, EP 7	The organized medical staff does the following: - Defines when a medical history and physical examination must be validated and countersigned by a physician with appropriate privileges - Specifies the minimal content and scope of medical histories and physical examinations, which may vary by setting or level of care, treatment, and services, including non-inpatient services - Monitors the quality of medical histories and physical examinations
MS.03.01.01, EP 9	As permitted by state law and policy, the organized medical staff may choose to allow practitioners who are not licensed to practice independently to perform part or all of a patient's medical history and physical examination under the supervision of, or through appropriate delegation by, a specific qualified doctor of medicine or osteopathy who is accountable for the patient's medical history and physical examination. CoPs: §482.22(c)(5)(i)	Consolidation of MS.03.01.01, EP 6; MS.03.01.01, EP 7; MS.03.01.01, EP 8; MS.03.01.01, EP 9; MS.03.01.01, EP 10; MS.03.01.01. EP 11	MS.16.01.01, EP 7	The organized medical staff does the following: - Defines when a medical history and physical examination must be validated and countersigned by a physician with appropriate privileges - Specifies the minimal content and scope of medical histories and physical examinations, which may vary by setting or level of care, treatment, and services, including non-inpatient services - Monitors the quality of medical histories and physical examinations
MS.03.01.01, EP 10	The organized medical staff defines when a medical history and physical examination must be validated and countersigned by a physician with appropriate privileges.	Consolidation of MS.03.01.01, EP 6; MS.03.01.01, EP 7; MS.03.01.01, EP 8; MS.03.01.01, EP 9;	MS.16.01.01, EP 7	The organized medical staff does the following: - Defines when a medical history and physical examination must be validated and countersigned by a physician with appropriate privileges - Specifies the minimal content and scope of medical histories and physical examinations, which may vary by setting or level of care, treatment, and services,

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		MS.03.01.01, EP 10; MS.03.01.01. EP 11		including non-inpatient services - Monitors the quality of medical histories and physical examinations
MS.03.01.01, EP 11	The organized medical staff defines the scope of the medical history and physical examination when required for non-inpatient services.	Consolidation of MS.03.01.01, EP 6; MS.03.01.01, EP 7; MS.03.01.01, EP 8; MS.03.01.01, EP 9; MS.03.01.01, EP 10; MS.03.01.01. EP 11	MS.16.01.01, EP 7	The organized medical staff does the following: - Defines when a medical history and physical examination must be validated and countersigned by a physician with appropriate privileges - Specifies the minimal content and scope of medical histories and physical examinations, which may vary by setting or level of care, treatment, and services, including non-inpatient services - Monitors the quality of medical histories and physical examinations
MS.03.01.01, EP 13	For hospitals that use Joint Commission accreditation for deemed status purposes: When emergency services are provided at the hospital but not at one or more off-campus locations, the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the off-campus locations. CoPs: §482.12(f)(3)	Consolidation of MS.03.01.01, EP 13; MS.03.01.01, EP 14; MS.07.01.01, EP 1; MS.07.01.01, EP 5	LD.11.01.01, EP 2	The governing body does the following: - Approves and is responsible for the effective operation of the grievance process - Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee - Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff - Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff - Makes certain that the medical staff has bylaws - Approves medical staff bylaws and other medical staff rules and regulations - Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients - Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment - Makes certain that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society - Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the locations without emergency services when emergency services are not provided at the hospital, or are provided at the hospital but not at one or more off-campus locations CoPs: §482.12(a)(1), §482.12(a)(2), §482.12(a)(3), §482.12(a)(4), §482.12(a)(5), §482.12(a)(6), §482.12(a)(7), §482.12(f)(2), §482.12(f)(3), §482.13(a)(2)
MS.03.01.01, EP 14	For hospitals that use Joint Commission accreditation for deemed status purposes: When emergency services are not provided at the hospital, the medical staff has written policies and procedures for appraisal of emergencies, initial treatment of patients, and referral of patients when needed. CoPs: §482.12(f)(2)	Consolidation of MS.03.01.01, EP 13; MS.03.01.01, EP 14; MS.07.01.01, EP 1; MS.07.01.01, EP 5	LD.11.01.01, EP 2	The governing body does the following: - Approves and is responsible for the effective operation of the grievance process - Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee - Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff - Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff - Makes certain that the medical staff has bylaws - Approves medical staff bylaws and other medical staff rules and regulations - Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients - Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment - Makes certain that under no circumstances is the accordance of staff membership

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				or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society - Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the locations without emergency services when emergency services are not provided at the hospital, or are provided at the hospital but not at one or more off-campus locations CoPs: §482.12(a)(1), §482.12(a)(2), §482.12(a)(3), §482.12(a)(4), §482.12(a)(5), §482.12(a)(6), §482.12(a)(7), §482.12(f)(2), §482.12(f)(3), §482.13(a)(2)
MS.03.01.01, EP 16	For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff determines the qualifications of the radiology staff who use equipment and administer procedures. Note: Technologists who perform diagnostic computed tomography exams will, at a minimum, meet the requirements specified at HR.01.01.01, EP 32. CoPs: §482.26(c)(2)	Moved and Revised	MS.16.01.01, EP 11	For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff determines the qualifications of the radiology staff who use equipment and administer procedures. Note: Technologists who perform diagnostic computed tomography exams will, at a minimum, meet the requirements specified at NPG.13.01.01, EP 1. CoPs: §482.26(c)(2)
MS.03.01.01, EP 17	For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff approves the nuclear services director's specifications for the qualifications, training, functions, and responsibilities of the nuclear medicine staff. CoPs: §482.53(a)(2)	Moved	MS.16.01.01, EP 12	For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff approves the nuclear services director's specifications for the qualifications, training, functions, and responsibilities of the nuclear medicine staff. CoPs: §482.53(a)(2)
MS.03.01.01, EP 18	For hospitals that elect The Joint Commission Primary Care Medical Home option: Through the privileging process, the organized medical staff determines which licensed practitioners are qualified to serve in the role of primary care clinician.	Moved	MS.16.01.01, EP 13	For hospitals that elect The Joint Commission Primary Care Medical Home option: Through the privileging process, the organized medical staff determines which licensed practitioners are qualified to serve in the role of primary care clinician.
MS.03.01.01, EP 19	For hospitals that use Joint Commission accreditation for deemed status purposes: If the medical staff chooses to develop and maintain a policy for the identification of specific patients to whom the assessment requirements would apply, in lieu of a comprehensive medical history and physical examination, the policy is based on the following: - Patient age, diagnoses, the type and number of surgeries and procedures scheduled to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure - Nationally recognized guidelines and standards of practice for assessment of particular types of patients prior to specific outpatient surgeries and procedures - Applicable state and local health and safety laws Note: For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(iii). Refer to “Appendix A: Medicare Requirements for Hospitals” (AXA) for full text. CoPs: §482.22(c)(5)(iv), §482.22(c)(5)(v), §482.22(c)(5)(v)(A), §482.22(c)(5)(v)(B), §482.22(c)(5)(v)(C)	Moved and Revised	MS.16.01.01, EP 10	If the medical staff chooses to develop and maintain a policy for the identification of specific patients to whom the assessment requirements would apply in lieu of a comprehensive medical history and physical examination, the policy is based on the following: - Patient age, diagnoses, the type and number of surgeries and procedures scheduled to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure - Nationally recognized guidelines and standards of practice for assessment of particular types of patients prior to specific outpatient surgeries and procedures - Applicable state and local health and safety laws The hospital demonstrates evidence that the policy applies only to those patients receiving specific outpatient surgical or procedural services. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: For law and regulation guidance pertaining to the medical history and physical examination at 42 CFR 482.22(c)(5)(iii), refer to https://www.ecfr.gov/. CoPs: §482.22(c)(5)(iv), §482.22(c)(5)(v), §482.22(c)(5)(v)(A), §482.22(c)(5)(v)(B), §482.22(c)(5)(v)(C)
MS.03.01.03, EP 1	Physicians and clinical psychologists with appropriate privileges manage and coordinate the patient’s care, treatment, and services. Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). CoPs: §482.12(c)(1)(i), §482.12(c)(1)(ii), §482.12(c)(1)(iii), §482.12(c)(1)(iv),	Split to LD.11.01.01, EP 7	LD.11.01.01, EP 7	The governing body makes certain that patients are under the care of the appropriate licensed practitioners. CoPs: §482.12(c)(1)(i), §482.12(c)(1)(ii), §482.12(c)(1)(iii), §482.12(c)(1)(iv), §482.12(c)(1)(v), §482.12(c)(1)(vi), §482.12(c)(2), §482.12(c)(3), §482.12(c)(4),

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	§482.12(c)(1)(v), §482.12(c)(1)(vi), §482.12(c)(2), §482.12(c)(2) continued, §482.12(c)(4), §482.12(c)(4)(i), §482.12(c)(4)(ii), §482.12(c)(4)(ii)(A), §482.12(c)(4)(ii)(B), §482.12(c)(4)(ii)(C), §482.62(b)			§482.12(c)(4)(i), §482.12(c)(4)(ii), §482.12(c)(4)(ii)(A), §482.12(c)(4)(ii)(B), §482.12(c)(4)(ii)(C)
MS.03.01.03, EP 3	A patient's general medical condition is managed and coordinated by a doctor of medicine or osteopathy. For hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy manages and coordinates the care of any Medicare or Medicaid patient's psychiatric problem that is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor, as limited under 42 CFR 482.12(c)(1)(v); or a clinical psychologist. CoPs: §482.12(c)(1)(i), §482.12(c)(1)(ii), §482.12(c)(1)(iii), §482.12(c)(1)(iv), §482.12(c)(1)(v), §482.12(c)(1)(vi), §482.12(c)(2), §482.12(c)(2) continued, §482.12(c)(4), §482.12(c)(4)(i), §482.12(c)(4)(ii), §482.12(c)(4)(ii)(A), §482.12(c)(4)(ii)(B), §482.12(c)(4)(ii)(C), §482.62(b), §482.62(c)	Moved and Revised	MS.16.01.03, EP 3	A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization and is not specifically within the scope of practice, as defined by the medical staff and in accordance with state law, of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor, as limited under 42 CFR 12(c)(1)(v); or clinical psychologist. CoPs: §482.12(c)(4), §482.12(c)(4)(i), §482.12(c)(4)(ii), §482.12(c)(4)(ii)(A), §482.12(c)(4)(ii)(B), §482.12(c)(4)(ii)(C)
MS.03.01.03, EP 4	The organized medical staff, through its designated mechanism, determines the circumstances under which consultation or management by a doctor of medicine or osteopathy, or other licensed practitioner, is required. CoPs: §482.62(c)	Moved and Revised	NPG.12.03.01, EP 5	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Doctors of medicine or osteopathy and other appropriate professional staff are available to provide necessary medical and surgical diagnostic and treatment services. If medical and surgical diagnostic and treatment services are not available within the hospital, the hospital has an agreement with an outside source for these services to ensure that they are immediately available, or the hospital establishes an agreement for transferring patients to a general hospital that participates in the Medicare program. CoPs: §482.62(c)
MS.03.01.03, EP 5	Consultation is obtained for the circumstances defined by the organized medical staff.	Consolidation of LD.04.03.01, EP 2; MS.03.01.03, EP 5; MS.03.01.03, EP 6	LD.13.03.01, EP 1	The hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic CoPs: §482.24, §482.24(a), §482.26, §482.26(a), §482.27, §482.27(a), §482.28, §482.51, §482.51(a), §482.51(b), §482.52, §482.52(a), §482.52(b), §482.53, §482.53(a), §482.54, §482.55, §482.55(a)(1), §482.55(a)(2), §482.57, §482.57(a)
MS.03.01.03, EP 6	There is coordination of the care, treatment, and services among the staff involved in a patient's care, treatment, and services. CoPs: §482.55(a)(2)	Consolidation of LD.04.03.01, EP 2; MS.03.01.03, EP 5; MS.03.01.03, EP 6	LD.13.03.01, EP 1	The hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following:

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
				- Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic CoPs: §482.24, §482.24(a), §482.26, §482.26(a), §482.27, §482.27(a), §482.28, §482.51, §482.51(a), §482.51(b), §482.52, §482.52(a), §482.52(b), §482.53, §482.53(a), §482.54, §482.55, §482.55(a)(1), §482.55(a)(2), §482.57, §482.57(a)
MS.03.01.03, EP 12	For hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy is on duty or on call at all times. CoPs: §482.12(c)(3), §482.62(c)	Moved and Revised	MS.16.01.03, EP 2	A doctor of medicine or osteopathy is on duty or on call at all times. CoPs: §482.12(c)(3)
MS.03.01.03, EP 13	For hospitals that use Joint Commission accreditation for deemed status purposes: Patients are admitted to the hospital only on the decision of a licensed practitioner permitted by the state to admit patients to a hospital. CoPs: §482.12(c)(2)	Split to LD.11.01.01, EP 7; MS.16.01.03, EP 1	LD.11.01.01, EP 7	The governing body makes certain that patients are under the care of the appropriate licensed practitioners. CoPs: §482.12(c)(1)(i), §482.12(c)(1)(ii), §482.12(c)(1)(iii), §482.12(c)(1)(iv), §482.12(c)(1)(v), §482.12(c)(1)(vi), §482.12(c)(2), §482.12(c)(3), §482.12(c)(4), §482.12(c)(4)(i), §482.12(c)(4)(ii), §482.12(c)(4)(ii)(A), §482.12(c)(4)(ii)(B), §482.12(c)(4)(ii)(C)
MS.03.01.03, EP 13	For hospitals that use Joint Commission accreditation for deemed status purposes: Patients are admitted to the hospital only on the decision of a licensed practitioner permitted by the state to admit patients to a hospital. CoPs: §482.12(c)(2)	Split to LD.11.01.01, EP 7; MS.16.01.03, EP 1	MS.16.01.03, EP 1	Patients are admitted to the hospital only on the recommendation of a licensed practitioner permitted by the state to admit patients to a hospital. For hospitals that use Joint Commission accreditation for deemed status purposes: If a Medicare patient is admitted by a practitioner not specified in MS.16.01.03, EP 4, that patient is under the care of a doctor of medicine or osteopathy. CoPs: §482.12(c)(2)
MS.04.01.01, EP 1	The organized medical staff has a defined process for supervision by a physician with appropriate clinical privileges of each participant in the program in carrying out patient care responsibilities.	Moved and Revised	MS.16.02.01, EP 1	The organized medical staff has a defined process for supervision of each participant in the program in carrying out patient care responsibilities by a physician with appropriate clinical privileges.
MS.04.01.01, EP 2	Written descriptions of the roles, responsibilities, and patient care activities of the participants of graduate education programs are provided to the organized medical staff and hospital staff.	Moved and Revised	MS.16.02.01, EP 2	The organized medical staff and hospital staff receive written descriptions of the roles, responsibilities, and patient care activities of graduate education program participants.
MS.04.01.01, EP 3	The descriptions include identification of mechanisms by which the supervisor(s) and graduate education program director make decisions about each participant's progressive involvement and independence in specific patient care activities.	Moved and Revised	MS.16.02.01, EP 3	The written descriptions of the roles, responsibilities, and patient care activities of graduate education program participants include identification of mechanisms by which the supervisor(s) and graduate education program director make decisions about each participant's progressive involvement and independence in specific patient care activities.
MS.04.01.01, EP 4	Organized medical staff rules and regulations and policies delineate participants in professional education programs who may write patient care orders, the circumstances under which they may do so, and what entries, if any, must be countersigned by a supervising physician.	Moved and Revised	MS.16.02.01, EP 4	Organized medical staff rules and regulations and policies delineate the participants in professional education programs who may write patient care orders, the circumstances under which they may do so, and what entries, if any, must be countersigned by a supervising physician.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
MS.04.01.01, EP 5	There is a mechanism for effective communication between the committee(s) responsible for professional graduate education and the organized medical staff and the governing body.	Moved	MS.16.02.01, EP 5	There is a mechanism for effective communication between the committee(s) responsible for professional graduate education and the organized medical staff and the governing body.
MS.04.01.01, EP 6	There is responsibility for effective communication (whether training occurs at the organization that is responsible for the professional graduate education program or in a participating local or community organization or hospital). - The professional graduate medical education committee(s) (GMEC) must communicate with the medical staff and governing body about the safety and quality of patient care, treatment, and services provided by, and the related educational and supervisory needs of, the participants in professional graduate education programs. - If the graduate medical education program uses a community or local participating hospital or organization, the person(s) responsible for overseeing the participants from the program communicates to the organized medical staff and its governing body about the patient care, treatment, and services provided by, and the related educational and supervisory needs of, its participants in the professional graduate education programs. Note: The GMEC can represent one or multiple graduate education programs depending on the number of specialty graduate programs within the organization.	Moved and Revised	MS.16.02.01, EP 6	There is responsibility for effective communication with the medical staff and governing body, whether training occurs at the organization that is responsible for the professional graduate education program or in a participating local or community organization or hospital, as follows: - The professional graduate medical education committee(s) (GMEC) communicates with the medical staff and governing body about the safety and quality of patient care, treatment, and services provided by, and the related educational and supervisory needs of, the participants in professional graduate education programs. - If the graduate medical education program uses a community or local participating hospital or organization, the person(s) responsible for overseeing the participants from the program communicates to the organized medical staff and its governing body about the patient care, treatment, and services provided by, and the related educational and supervisory needs of, its participants in the professional graduate education programs. Note: The GMEC can represent one or multiple graduate education programs depending on the number of specialty graduate programs within the organization.
MS.04.01.01, EP 7	There is a mechanism for an appropriate person from the community or local hospital or organization to communicate information to the GMEC about the quality of care, treatment, and services and educational needs of the participants.	Moved and Revised	MS.16.02.01, EP 7	There is a mechanism for an appropriate person from the community or local hospital or organization to communicate information to the graduate medical education committee about the quality of care, treatment, and services and educational needs of the participants.
MS.04.01.01, EP 8	Information about the quality of care, treatment, and services and educational needs is included in the communication that the GMEC has with the governing board of the sponsoring hospital.	Moved and Revised	MS.16.02.01, EP 8	Information about the quality of care, treatment, and services and educational needs is included in the communication that the graduate medical education committee has with the governing board of the sponsoring hospital.
MS.04.01.01, EP 9	The medical staff demonstrates compliance with residency review committee citations. Note: Graduate medical education programs accredited by the Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), or the American Dental Association's Commission on Dental Accreditation are expected to be in compliance with the above requirements; the hospital should be able to demonstrate compliance with any postgraduate education review committee citations related to this standard.	Moved and Revised	MS.16.02.01, EP 9	The medical staff demonstrates compliance with residency review committee citations. Note: Graduate medical education programs accredited by the Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), or the American Dental Association's Commission on Dental Accreditation are expected to be in compliance with the requirements in this standard; the hospital should be able to demonstrate compliance with any postgraduate education review committee citations related to this standard.
MS.05.01.01, EP 1	The organized medical staff provides leadership for measuring, assessing, and improving processes that primarily depend on the activities of one or more physicians or other licensed practitioners credentialed and privileged through the medical staff process.	Consolidation of MS.05.01.01, EP 1; MS.05.01.01, EP 2	MS.16.03.01, EP 1	The organized medical staff provides leadership for measuring, assessing, and improving processes that primarily depend on the activities of one or more physicians or other licensed practitioners credentialed and privileged through the medical staff process.
MS.05.01.01, EP 2	The medical staff is actively involved in the measurement, assessment, and improvement of the following: Medical assessment and treatment of patients. CoPs: §482.62(b)(2)	Consolidation of MS.05.01.01, EP 1; MS.05.01.01, EP 2	MS.16.03.01, EP 1	The organized medical staff provides leadership for measuring, assessing, and improving processes that primarily depend on the activities of one or more physicians or other licensed practitioners credentialed and privileged through the medical staff process.
MS.05.01.01, EP 3	The medical staff is actively involved in the measurement, assessment, and improvement of the following: Use of information about adverse privileging decisions for any physician or other licensed practitioner privileged through the medical staff process.	Consolidation of MS.05.01.01, EP 3; MS.05.01.01, EP 4; MS.05.01.01, EP 5; MS.05.01.01, EP 6; MS.05.01.01, EP 7; MS.05.01.01, EP 8;	MS.16.03.01, EP 5	The organized medical staff participates in the following performance improvement activities: - Review of findings of the assessment process that are relevant to an individual's performance. The organized medical staff is responsible for determining the use of this information in the ongoing evaluation of a physician's or other licensed practitioner's competence.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
		MS.05.01.01, EP 9; MS.05.01.03, EP 1; MS.05.01.03, EP 4; MS.05.01.01, EP 5;		- Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body.
MS.05.01.01, EP 4	The medical staff is actively involved in the measurement, assessment, and improvement of the following: Use of medications.	Consolidation of MS.05.01.01, EP 3; MS.05.01.01, EP 4; MS.05.01.01, EP 5; MS.05.01.01, EP 6; MS.05.01.01, EP 7; MS.05.01.01, EP 8; MS.05.01.01, EP 9; MS.05.01.03, EP 1; MS.05.01.03, EP 4; MS.05.01.01, EP 5;	MS.16.03.01, EP 5	The organized medical staff participates in the following performance improvement activities: - Review of findings of the assessment process that are relevant to an individual's performance. The organized medical staff is responsible for determining the use of this information in the ongoing evaluation of a physician's or other licensed practitioner's competence. - Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body.
MS.05.01.01, EP 5	The medical staff is actively involved in the measurement, assessment, and improvement of the following: Use of blood and blood components.	Consolidation of MS.05.01.01, EP 3; MS.05.01.01, EP 4; MS.05.01.01, EP 5; MS.05.01.01, EP 6; MS.05.01.01, EP 7; MS.05.01.01, EP 8; MS.05.01.01, EP 9; MS.05.01.03, EP 1; MS.05.01.03, EP 4; MS.05.01.01, EP 5;	MS.16.03.01, EP 5	The organized medical staff participates in the following performance improvement activities: - Review of findings of the assessment process that are relevant to an individual's performance. The organized medical staff is responsible for determining the use of this information in the ongoing evaluation of a physician's or other licensed practitioner's competence. - Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body.
MS.05.01.01, EP 6	The medical staff is actively involved in the measurement, assessment, and improvement of the following: Operative and other procedures.	Consolidation of MS.05.01.01, EP 3; MS.05.01.01, EP 4; MS.05.01.01, EP 5; MS.05.01.01, EP 6; MS.05.01.01, EP 7; MS.05.01.01, EP 8; MS.05.01.01, EP 9; MS.05.01.03, EP 1; MS.05.01.03, EP 4; MS.05.01.01, EP 5;	MS.16.03.01, EP 5	The organized medical staff participates in the following performance improvement activities: - Review of findings of the assessment process that are relevant to an individual's performance. The organized medical staff is responsible for determining the use of this information in the ongoing evaluation of a physician's or other licensed practitioner's competence. - Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body.
MS.05.01.01, EP 7	The medical staff is actively involved in the measurement, assessment, and improvement of the following: Appropriateness of clinical practice patterns. CoPs: §482.62(b)(2)	Split to MS.16.03.01, EP 5; MS.16.01.01, EP 8	MS.16.03.01, EP 5	The organized medical staff participates in the following performance improvement activities: - Review of findings of the assessment process that are relevant to an individual's performance. The organized medical staff is responsible for determining the use of this information in the ongoing evaluation of a physician's or other licensed practitioner's competence. - Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body.
MS.05.01.01, EP 7	The medical staff is actively involved in the measurement, assessment, and improvement of the following: Appropriateness of clinical practice patterns. CoPs: §482.62(b)(2)	Split to MS.16.03.01, EP 5; MS.16.01.01, EP 8	MS.16.01.01, EP 8	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The clinical director, service chief, or equivalent for inpatient psychiatric services monitors and evaluates the medical staff's treatment and services for quality and appropriateness.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
				CoPs: §482.62(b)(2)
MS.05.01.01, EP 8	The medical staff is actively involved in the measurement, assessment, and improvement of the following: Significant departures from established patterns of clinical practice. CoPs: §482.62(b)(2)	Split to MS.16.03.01, EP 5; MS.16.01.01, EP 8	MS.16.03.01, EP 5	The organized medical staff participates in the following performance improvement activities: - Review of findings of the assessment process that are relevant to an individual's performance. The organized medical staff is responsible for determining the use of this information in the ongoing evaluation of a physician's or other licensed practitioner's competence. - Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body.
MS.05.01.01, EP 8	The medical staff is actively involved in the measurement, assessment, and improvement of the following: Significant departures from established patterns of clinical practice. CoPs: §482.62(b)(2)	Split to MS.16.03.01, EP 5; MS.16.01.01, EP 8	MS.16.01.01, EP 8	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The clinical director, service chief, or equivalent for inpatient psychiatric services monitors and evaluates the medical staff's treatment and services for quality and appropriateness. CoPs: §482.62(b)(2)
MS.05.01.01, EP 9	The medical staff is actively involved in the measurement, assessment, and improvement of the following: The use of developed criteria for autopsies.	Consolidation of MS.05.01.01, EP 3; MS.05.01.01, EP 4; MS.05.01.01, EP 5; MS.05.01.01, EP 6; MS.05.01.01, EP 7; MS.05.01.01, EP 8; MS.05.01.01, EP 9; MS.05.01.03, EP 1; MS.05.01.03, EP 4; MS.05.01.01, EP 5;	MS.16.03.01, EP 5	The organized medical staff participates in the following performance improvement activities: - Review of findings of the assessment process that are relevant to an individual's performance. The organized medical staff is responsible for determining the use of this information in the ongoing evaluation of a physician's or other licensed practitioner's competence. - Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body.
MS.05.01.01, EP 10	Information used as part of the performance improvement mechanisms, measurement, or assessment includes the following: Sentinel event data.	Consolidation of MS.05.01.01, EP 10; MS.05.01.01, EP 11	MS.16.03.01, EP 2	Information used as part of the performance improvement mechanisms, measurement, or assessment includes sentinel event data and patient safety data.
MS.05.01.01, EP 11	Information used as part of the performance improvement mechanisms, measurement, or assessment includes the following: Patient safety data.	Consolidation of MS.05.01.01, EP 10; MS.05.01.01, EP 11	MS.16.03.01, EP 2	Information used as part of the performance improvement mechanisms, measurement, or assessment includes sentinel event data and patient safety data.
MS.05.01.01, EP 18	The medical staff is actively involved in pain assessment, pain management, and safe opioid prescribing through the following: - Participating in the establishment of protocols and quality metrics - Reviewing performance improvement data	Moved	MS.16.03.01, EP 3	The medical staff is actively involved in pain assessment, pain management, and safe opioid prescribing through the following: - Participating in the establishment of protocols and quality metrics - Reviewing performance improvement data
MS.05.01.03, EP 1	The organized medical staff participates in the following activities: Education of patients and families.	Consolidation of MS.05.01.01, EP 3; MS.05.01.01, EP 4; MS.05.01.01, EP 5; MS.05.01.01, EP 6; MS.05.01.01, EP 7; MS.05.01.01, EP 8; MS.05.01.01, EP 9; MS.05.01.03, EP 1; MS.05.01.03, EP 4; MS.05.01.01, EP 5;	MS.16.03.01, EP 5	The organized medical staff participates in the following performance improvement activities: - Review of findings of the assessment process that are relevant to an individual's performance. The organized medical staff is responsible for determining the use of this information in the ongoing evaluation of a physician's or other licensed practitioner's competence. - Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
MS.05.01.03, EP 2	The organized medical staff participates in the following activities: Coordination of care, treatment, and services with other hospital staff, as relevant to the care, treatment, and services of an individual patient.	Deleted EP – Covered at the standard level and moved to guidance within SPG	Standard MS.16.03.01	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.
MS.05.01.03, EP 3	The organized medical staff participates in the following activities: Accurate, timely, and legible completion of patient's medical records. CoPs: §482.24(b)	Moved and Revised	MS.16.03.01, EP 4	The organized medical staff completes patient medical records accurately, timely, and legibly.
MS.05.01.03, EP 4	The organized medical staff participates in the following activities: Review of findings of the assessment process that are relevant to an individual's performance. The organized medical staff is responsible for determining the use of this information in the ongoing evaluations of a physician's or other licensed practitioner's competence.	Consolidation of MS.05.01.01, EP 3; MS.05.01.01, EP 4; MS.05.01.01, EP 5; MS.05.01.01, EP 6; MS.05.01.01, EP 7; MS.05.01.01, EP 8; MS.05.01.01, EP 9; MS.05.01.03, EP 1; MS.05.01.03, EP 4; MS.05.01.01, EP 5;	MS.16.03.01, EP 5	The organized medical staff participates in the following performance improvement activities: - Review of findings of the assessment process that are relevant to an individual's performance. The organized medical staff is responsible for determining the use of this information in the ongoing evaluation of a physician's or other licensed practitioner's competence. - Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body.
MS.05.01.03, EP 5	The organized medical staff participates in the following activities: Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body.	Consolidation of MS.05.01.01, EP 3; MS.05.01.01, EP 4; MS.05.01.01, EP 5; MS.05.01.01, EP 6; MS.05.01.01, EP 7; MS.05.01.01, EP 8; MS.05.01.01, EP 9; MS.05.01.03, EP 1; MS.05.01.03, EP 4; MS.05.01.01, EP 5;	MS.16.03.01, EP 5	The organized medical staff participates in the following performance improvement activities: - Review of findings of the assessment process that are relevant to an individual's performance. The organized medical staff is responsible for determining the use of this information in the ongoing evaluation of a physician's or other licensed practitioner's competence. - Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body.
MS.06.01.01, EP 1	There is a process to determine whether sufficient space, equipment, staffing, and financial resources are in place or available within a specified time frame to support each requested privilege.	Moved and Revised	MS.17.01.01, EP 1	The hospital has a process to determine whether sufficient space, equipment, staffing, and financial resources are in place or available within a specified time frame to support each requested privilege.
MS.06.01.01, EP 2	The hospital consistently determines the resources needed for each requested privilege.	Moved	MS.17.01.01, EP 2	The hospital consistently determines the resources needed for each requested privilege.
MS.06.01.03, EP 1	The hospital credentials applicants using a clearly defined process. CoPs: §482.22(a)(2)	Consolidation of MS.01.01.01, EP 5; MS.02.01.01, EP 11; MS.06.01.03, EP 1; MS.06.01.03, EP 2; MS.06.01.03, EP 4; MS.06.01.07, EP 8; MS.06.01.09, EP 1; MS.06.01.09, EP 2; MS.06.01.09, EP 3; MS.06.01.09, EP 4	MS.17.01.03, EP 4	The medical staff examines the credentials of all candidates eligible for medical staff membership and makes recommendations to the governing body on the appointment of these candidates, in accordance with state law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations. A candidate who has been recommended by the medical staff and who has been appointed by the governing body is subject to all medical staff bylaws, rules, and regulations. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: A candidate who has been recommended by the medical staff and who has been appointed by the governing body is also subject to 42 CFR 482.22(a). CoPs: §482.22(a)(2)
MS.06.01.03, EP 2	The credentialing process is based on recommendations by the organized medical staff.	Consolidation of MS.01.01.01, EP 5;	MS.17.01.03, EP 4	The medical staff examines the credentials of all candidates eligible for medical staff membership and makes recommendations to the governing body on the

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.22(a)(2)	MS.02.01.01, EP 11; MS.06.01.03, EP 1; MS.06.01.03, EP 2; MS.06.01.03, EP 4; MS.06.01.07, EP 8; MS.06.01.09, EP 1; MS.06.01.09, EP 2; MS.06.01.09, EP 3; MS.06.01.09, EP 4		appointment of these candidates, in accordance with state law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations. A candidate who has been recommended by the medical staff and who has been appointed by the governing body is subject to all medical staff bylaws, rules, and regulations. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: A candidate who has been recommended by the medical staff and who has been appointed by the governing body is also subject to 42 CFR 482.22(a). CoPs: §482.22(a)(2)
MS.06.01.03, EP 3	The credentialing process is approved by the governing body.	Moved and Revised	MS.17.01.03, EP 1	The governing body approves the credentialing process.
MS.06.01.03, EP 4	The credentialing process is outlined in the medical staff bylaws. CoPs: §482.22(a)(2), §482.51(a)(4)	Consolidation of MS.01.01.01, EP 5; MS.02.01.01, EP 11; MS.06.01.03, EP 1; MS.06.01.03, EP 2; MS.06.01.03, EP 4; MS.06.01.07, EP 8; MS.06.01.09, EP 1; MS.06.01.09, EP 2; MS.06.01.09, EP 3; MS.06.01.09, EP 4	MS.17.01.03, EP 4	The medical staff examines the credentials of all candidates eligible for medical staff membership and makes recommendations to the governing body on the appointment of these candidates, in accordance with state law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations. A candidate who has been recommended by the medical staff and who has been appointed by the governing body is subject to all medical staff bylaws, rules, and regulations. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: A candidate who has been recommended by the medical staff and who has been appointed by the governing body is also subject to 42 CFR 482.22(a). CoPs: §482.22(a)(2)
MS.06.01.03, EP 5	The hospital verifies that the physician or other licensed practitioner requesting approval is the same person identified in the credentialing documents by viewing one of the following: - A current picture hospital ID card - A valid picture ID issued by a state or federal agency (for example, a driver's license or passport)	Moved and Revised	MS.17.01.03, EP 2	The hospital verifies that the physician or other licensed practitioner requesting approval is the same person identified in the credentialing documents by viewing one of the following: - Current picture hospital ID card - Valid picture ID issued by a state or federal agency (for example, a driver's license or passport)
MS.06.01.03, EP 6	The credentialing process requires that the hospital verifies in writing and from the primary source whenever feasible, or from a credentials verification organization (CVO), the following information: - The applicant's current licensure at the time of initial granting, renewal, and revision of privileges, and at the time of license expiration - The applicant's relevant training - The applicant's current competence CoPs: §482.11(c), §482.12(a)(6), §482.22(a)(2), §482.58(b)(1), §483.10(d)(1)	Moved and Revised	MS.17.01.03, EP 3	The credentialing process requires that the hospital verifies in writing and from the primary source whenever feasible, or from a credentials verification organization (CVO), the following information for the applicant: - Current licensure at the time of initial granting, renewal, and revision of privileges and at the time of license expiration - Relevant training - Current competence CoPs: §482.11(c)
MS.06.01.03, EP 7	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Inpatient psychiatric services are under the direction of a clinical director, service chief, or equivalent who meets the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry. CoPs: §482.62(b), §482.62(b)(1)	Moved and Revised	MS.17.01.03, EP 6	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Inpatient psychiatric services are under the direction and supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program and who meets the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry. The number and qualifications of doctors of medicine and osteopathy are adequate to provide essential psychiatric services. CoPs: §482.62(b), §482.62(b)(1)
MS.06.01.03, EP 9	For hospitals that use Joint Commission accreditation for deemed status purposes: A full-time, part-time, or consulting radiologist who is a doctor of medicine or osteopathy qualified by education and experience in radiology supervises ionizing	Moved and Revised	MS.17.01.03, EP 5	For hospitals that use Joint Commission accreditation for deemed status purposes: A full-time, part-time, or consulting radiologist, who is a doctor of medicine or osteopathy qualified by education and experience in radiology, supervises ionizing

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	radiology services. CoPs: §482.26(c)(1)			radiology services and interprets radiologic tests that the medical staff determine to require a radiologist's specialized knowledge. CoPs: §482.26(c)(1)
MS.06.01.05, EP 1	All physicians and other licensed practitioners that provide care, treatment, and services possess a current license, certification, or registration, as required by law and regulation. CoPs: §482.11(c), §482.22(a)(2)	Moved	MS.17.02.01, EP 9	All physicians and other licensed practitioners that provide care, treatment, and services possess a current license, certification, or registration, as required by law and regulation. CoPs: §482.11(c)
MS.06.01.05, EP 2	The hospital, based on recommendations by the organized medical staff and approval by the governing body, establishes criteria that determine a physician's or other licensed practitioner's ability to provide patient care, treatment, and services within the scope of the privilege(s) requested. Evaluation of all of the following are included in the criteria: - Current licensure and/or certification, as appropriate, verified with the primary source - The applicant's specific relevant training, verified with the primary source - Evidence of physical ability to perform the requested privilege - Data from professional practice review by an organization(s) that currently privileges the applicant (if available) - Peer and/or faculty recommendation - When renewing privileges, review of the physician's or other licensed practitioner's performance within the hospital CoPs: §482.11(c), §482.12(a)(6), §482.22(a)(2), §482.26(c)(1), §482.54(c)(4)(i)	Moved and Revised	MS.17.02.01, EP 1	The hospital, based on recommendations by the organized medical staff and approval by the governing body, develops and implements criteria that determine if a physician or other licensed practitioner is allowed to provide patient care, treatment, and services within the scope of the privilege(s) requested. Evaluation of all of the following are included in the criteria: - Current licensure and/or certification, as appropriate, verified with the primary source - Specific relevant training, verified with the primary source - Evidence of physical ability to perform the requested privilege - Data from professional practice review by an organization(s) that currently privileges the applicant (if available) - Peer and/or faculty recommendation - When renewing privileges, review of the physician's or other licensed practitioner's performance within the hospital
MS.06.01.05, EP 3	All of the criteria used are consistently evaluated for all physicians and other licensed practitioners holding that privilege. CoPs: §482.22(a)(1), §482.54(c)(4)(i)	Consolidation of MS.01.01.01, EP 13; MS.06.01.05, EP 3; MS.07.01.01, EP 4	MS.14.01.01, EP 2	The medical staff bylaws include the qualifications for appointment and reappointment to the medical staff. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff is composed of doctors of medicine or osteopathy. In accordance with state law, including scope of practice laws, the medical staff may also include other categories of physicians, as listed at 42 CFR 482.12(c)(1), and other licensed practitioners who the governing body determines are eligible for appointment. Note 2: Gender, race, creed, and national origin are not used in making decisions regarding the granting or denying of medical staff membership. CoPs: §482.22(a)
MS.06.01.05, EP 4	The hospital has a clearly defined procedure for processing applications for the granting, renewal, or revision of clinical privileges.	Consolidation of MS.06.01.05, EP 4; MS.06.01.05, EP 5; MS.06.01.05, EP 10; MS.06.01.05, EP 12; MS.06.01.07, EP 2	MS.17.02.01, EP 2	The hospital has a clearly defined procedure approved by the organized medical staff for processing applications for the granting, renewal, or revision of clinical privileges.
MS.06.01.05, EP 5	The procedure for processing applications for the granting, renewal, or revision of clinical privileges is approved by the organized medical staff.	Consolidation of MS.06.01.05, EP 4; MS.06.01.05, EP 5; MS.06.01.05, EP 10; MS.06.01.05, EP 12; MS.06.01.07, EP 2	MS.17.02.01, EP 2	The hospital has a clearly defined procedure approved by the organized medical staff for processing applications for the granting, renewal, or revision of clinical privileges.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
MS.06.01.05, EP 6	An applicant submits a statement that no health problems exist that could affect their ability to perform the privileges requested.	Moved and Revised	MS.17.02.01, EP 3	An applicant submits a statement that no health problems exist that could affect their ability to perform the privileges requested.
MS.06.01.05, EP 7	The hospital queries the National Practitioner Data Bank (NPDB) in accordance with applicable law and regulation. CoPs: §482.12(a)(6), §482.22(a)(1)	Moved	MS.17.02.01, EP 4	The hospital queries the National Practitioner Data Bank (NPDB) in accordance with applicable law and regulation.
MS.06.01.05, EP 8	Peer recommendation includes written information regarding the physician's or other licensed practitioner's current: - Medical/clinical knowledge - Technical and clinical skills - Clinical judgment - Interpersonal skills - Communication skills - Professionalism Note: Peer recommendation may be in the form of written documentation reflecting informed opinions on each applicant's scope and level of performance, or a written peer evaluation of physician- or other licensed practitioner-specific data collected from various sources for the purpose of validating current competence. CoPs: §482.11(c), §482.12(a)(6), §482.22(a)(1), §482.22(a)(2)	Consolidation of MS.06.01.05, EP 8; MS.07.01.03, EP 3	MS.18.01.01, EP 3	Peer recommendations include the following information: - Medical/clinical knowledge - Technical and clinical skills - Clinical judgment - Interpersonal skills - Communication skills - Professionalism
MS.06.01.05, EP 9	Before recommending privileges, the organized medical staff also evaluates the following: - Challenges to any licensure or registration - Voluntary and involuntary relinquishment of any license or registration - Voluntary and involuntary termination of medical staff membership - Voluntary and involuntary limitation, reduction, or loss of clinical privileges - Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant - Documentation as to the applicant's health status - Relevant physician- or other licensed practitioner-specific data as compared to aggregate data, when available - Morbidity and mortality data, when available CoPs: §482.12(a)(6), §482.22(a)(1), §482.22(a)(2)	Consolidation of MS.06.01.05, EP 9; MS.06.01.11, EP 3; MS.06.01.11, EP 4; MS.06.01.11, EP 5; MS.06.01.11, EP 6; MS.06.01.11, EP 7	MS.17.03.01, EP 3	The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process: - There is a current challenge or a previously successful challenge to licensure or registration. - The applicant has received an involuntary termination of medical staff membership at another hospital. - The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges. - The hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.
MS.06.01.05, EP 10	The hospital has a process to determine whether there is sufficient clinical performance information to make a decision to grant, limit, or deny the requested privilege. CoPs: §482.22(a)(1)	Consolidation of MS.06.01.05, EP 4; MS.06.01.05, EP 5; MS.06.01.05, EP 10; MS.06.01.05, EP 12; MS.06.01.07, EP 2	MS.17.02.01, EP 2	The hospital has a clearly defined procedure approved by the organized medical staff for processing applications for the granting, renewal, or revision of clinical privileges.
MS.06.01.05, EP 11	Completed applications for privileges are acted on within the time period specified in the medical staff bylaws, rules and regulations, or policies and procedures.	Moved and Revised	MS.17.02.01, EP 5	Completed applications for privileges are acted on within the time period specified in the medical staff bylaws, rules, and regulations, or in policies and procedures.
MS.06.01.05, EP 12	Information regarding each physician's or other licensed practitioner's scope of privileges is updated as changes in clinical privileges are made. CoPs: §482.22(a)(1), §482.22(a)(2)	Consolidation of MS.06.01.05, EP 4; MS.06.01.05, EP 5; MS.06.01.05, EP 10; MS.06.01.05, EP 12; MS.06.01.07, EP 2	MS.17.02.01, EP 2	The hospital has a clearly defined procedure approved by the organized medical staff for processing applications for the granting, renewal, or revision of clinical privileges.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
MS.06.01.05, EP 15	For hospitals that use Joint Commission accreditation for deemed status purposes: The surgical service maintains a current roster listing each practitioner's surgical privileges. Note: The roster may be in paper or electronic format. CoPs: §482.51(a)(4)	Split to MS.17.02.01, EP 6; MS.17.02.01, EP 7	MS.17.02.01, EP 6	The hospital designates the practitioners who are allowed to perform surgery, in accordance with appropriate policies and procedures and with scope of practice laws and regulations. Surgery is performed only by the following: - A doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Social Security Act - A doctor of dental surgery or dental medicine - A doctor of podiatric medicine CoPs: §482.51(a)(4)
MS.06.01.05, EP 15	For hospitals that use Joint Commission accreditation for deemed status purposes: The surgical service maintains a current roster listing each practitioner's surgical privileges. Note: The roster may be in paper or electronic format. CoPs: §482.51(a)(4)	Split to MS.17.02.01, EP 6; MS.17.02.01, EP 7	MS.17.02.01, EP 7	The surgical service maintains a current roster listing each practitioner's surgical privileges. Note: The roster may be in paper or electronic format. CoPs: §482.51(a)(4)
MS.06.01.07, EP 1	The information review and analysis process is clearly defined. CoPs: §482.51(a)(4)	Consolidation of MS.06.01.07, EP 1; MS.06.01.07, EP 6; MS.06.01.07, EP 7	MS.17.02.03, EP 1	Decisions on membership and granting of privileges include criteria that are directly related to the quality of health care, treatment, and services. CoPs: §482.51(a)(4)
MS.06.01.07, EP 2	The hospital, based on recommendations by the organized medical staff and approval by the governing body, develops criteria that will be considered in the decision to grant, limit, or deny a requested privilege. Note: Medical staff membership and professional privileges are not dependent solely upon certification, fellowship, or membership in a specialty body or society. CoPs: §482.12(a)(7), §482.51(a)(4)	Consolidation of MS.06.01.05, EP 4; MS.06.01.05, EP 5; MS.06.01.05, EP 10; MS.06.01.05, EP 12; MS.06.01.07, EP 2	MS.17.02.01, EP 2	The hospital has a clearly defined procedure approved by the organized medical staff for processing applications for the granting, renewal, or revision of clinical privileges.
MS.06.01.07, EP 3	Gender, race, creed, and national origin are not used in making decisions regarding the granting or denying of clinical privileges.	Moved	MS.17.02.03, EP 2	Gender, race, creed, and national origin are not used in making decisions regarding the granting or denying of clinical privileges.
MS.06.01.07, EP 4	The hospital completes the credentialing and privileging decision process in a timely manner.	Moved	MS.17.02.03, EP 3	The hospital completes the credentialing and privileging decision process in a timely manner.
MS.06.01.07, EP 5	The hospital's privilege granting/denial criteria are consistently applied for each requesting physician or other licensed practitioner. CoPs: §482.51(a)(4)	Consolidation of MS.06.01.07, EP 5; MS.08.01.01, EP 2	MS.18.02.01, EP 1	The organized medical staff develops and consistently implements criteria to be used for evaluating the performance of physicians or other licensed practitioners when issues affecting the provision of safe, high quality patient care are identified.
MS.06.01.07, EP 6	Decisions on membership and granting of privileges include criteria that are directly related to the quality of health care, treatment, and services.	Consolidation of MS.06.01.07, EP 1; MS.06.01.07, EP 6; MS.06.01.07, EP 7	MS.17.02.03, EP 1	Decisions on membership and granting of privileges include criteria that are directly related to the quality of health care, treatment, and services. CoPs: §482.51(a)(4)
MS.06.01.07, EP 7	If privileging criteria are used that are unrelated to quality of care, treatment, and services or professional competence, evidence exists that the impact of resulting decisions on the quality of care, treatment, and services is evaluated.	Consolidation of MS.06.01.07, EP 1; MS.06.01.07, EP 6; MS.06.01.07, EP 7	MS.17.02.03, EP 1	Decisions on membership and granting of privileges include criteria that are directly related to the quality of health care, treatment, and services. CoPs: §482.51(a)(4)
MS.06.01.07, EP 8	The governing body or delegated governing body committee has final authority for granting, renewing, or denying privileges. CoPs: §482.12(a)(2), §482.12(a)(8), §482.12(a)(9), §482.22(a)(1), §482.22(a)(2)	Consolidation of MS.01.01.01, EP 5; MS.02.01.01, EP 11; MS.06.01.03, EP 1; MS.06.01.03, EP 2; MS.06.01.03, EP 4; MS.06.01.07, EP 8;	MS.17.01.03, EP 4	The medical staff examines the credentials of all candidates eligible for medical staff membership and makes recommendations to the governing body on the appointment of these candidates, in accordance with state law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations. A candidate who has been recommended by the medical staff and who has been appointed by the governing body is subject to all medical staff bylaws, rules, and regulations. Note: For hospitals that use Joint Commission accreditation for deemed status

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
		MS.06.01.09, EP 1; MS.06.01.09, EP 2; MS.06.01.09, EP 3; MS.06.01.09, EP 4		purposes: A candidate who has been recommended by the medical staff and who has been appointed by the governing body is also subject to 42 CFR 482.22(a). CoPs: §482.22(a)(2)
MS.06.01.07, EP 9	Privileges are granted for a period not to exceed three years or for the period required by law and regulation if shorter. CoPs: §482.22(a)(1)	Consolidation of MS.06.01.07, EP 9; MS.06.01.09, EP 1; MS.06.01.09, EP 2; MS.06.01.09, EP 3; MS.06.01.09, EP 4; MS.07.01.01, EP 3; MS.08.01.03, EP 1	MS.18.02.03, EP 1	The medical staff's ongoing professional practice evaluation includes a clearly defined process that facilitates the periodic evaluation of each physician's or other licensed practitioner's professional practice. Note: Privileges are granted for a period not to exceed three years or for the period required by law and regulation if shorter. CoPs: §482.22(a)(1)
MS.06.01.09, EP 1	Requesting physicians and other licensed practitioners are notified regarding the granting decision. CoPs: §482.22(a)(1), §482.22(a)(2)	Split to MS.17.01.03, EP 4; MS.18.02.03, EP 1	MS.17.01.03, EP 4	The medical staff examines the credentials of all candidates eligible for medical staff membership and makes recommendations to the governing body on the appointment of these candidates, in accordance with state law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations. A candidate who has been recommended by the medical staff and who has been appointed by the governing body is subject to all medical staff bylaws, rules, and regulations. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: A candidate who has been recommended by the medical staff and who has been appointed by the governing body is also subject to 42 CFR 482.22(a). CoPs: §482.22(a)(2)
MS.06.01.09, EP 1	Requesting physicians and other licensed practitioners are notified regarding the granting decision. CoPs: §482.22(a)(1), §482.22(a)(2)	Split to MS.17.01.03, EP 4; MS.18.02.03, EP 1	MS.18.02.03, EP 1	The medical staff's ongoing professional practice evaluation includes a clearly defined process that facilitates the periodic evaluation of each physician's or other licensed practitioner's professional practice. Note: Privileges are granted for a period not to exceed three years or for the period required by law and regulation if shorter. CoPs: §482.22(a)(1)
MS.06.01.09, EP 2	In the case of privilege denial, the applicant is informed of the reason for denial. CoPs: §482.22(a)(1), §482.22(a)(2)	Split to MS.17.01.03, EP 4; MS.18.02.03, EP 1	MS.17.01.03, EP 4	The medical staff examines the credentials of all candidates eligible for medical staff membership and makes recommendations to the governing body on the appointment of these candidates, in accordance with state law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations. A candidate who has been recommended by the medical staff and who has been appointed by the governing body is subject to all medical staff bylaws, rules, and regulations. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: A candidate who has been recommended by the medical staff and who has been appointed by the governing body is also subject to 42 CFR 482.22(a). CoPs: §482.22(a)(2)
MS.06.01.09, EP 2	In the case of privilege denial, the applicant is informed of the reason for denial. CoPs: §482.22(a)(1), §482.22(a)(2)	Split to MS.17.01.03, EP 4; MS.18.02.03, EP 1	MS.18.02.03, EP 1	The medical staff's ongoing professional practice evaluation includes a clearly defined process that facilitates the periodic evaluation of each physician's or other licensed practitioner's professional practice. Note: Privileges are granted for a period not to exceed three years or for the period required by law and regulation if shorter. CoPs: §482.22(a)(1)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
MS.06.01.09, EP 3	The decision to grant, deny, revise, or revoke privilege(s) is disseminated and made available to all appropriate internal and external persons or entities, as defined by the hospital and applicable law. CoPs: §482.22(a)(1), §482.22(a)(2), §482.51(a)(4)	Split to MS.17.01.03, EP 4; MS.18.02.03, EP 1	MS.17.01.03, EP 4	The medical staff examines the credentials of all candidates eligible for medical staff membership and makes recommendations to the governing body on the appointment of these candidates, in accordance with state law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations. A candidate who has been recommended by the medical staff and who has been appointed by the governing body is subject to all medical staff bylaws, rules, and regulations. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: A candidate who has been recommended by the medical staff and who has been appointed by the governing body is also subject to 42 CFR 482.22(a). CoPs: §482.22(a)(2)
MS.06.01.09, EP 3	The decision to grant, deny, revise, or revoke privilege(s) is disseminated and made available to all appropriate internal and external persons or entities, as defined by the hospital and applicable law. CoPs: §482.22(a)(1), §482.22(a)(2), §482.51(a)(4)	Split to MS.17.01.03, EP 4; MS.18.02.03, EP 1	MS.18.02.03, EP 1	The medical staff's ongoing professional practice evaluation includes a clearly defined process that facilitates the periodic evaluation of each physician's or other licensed practitioner's professional practice. Note: Privileges are granted for a period not to exceed three years or for the period required by law and regulation if shorter. CoPs: §482.22(a)(1)
MS.06.01.09, EP 4	The process to disseminate all granting, modification, or restriction decisions is approved by the organized medical staff. CoPs: §482.22(a)(1), §482.22(a)(2)	Split to MS.17.01.03, EP 4; MS.18.02.03, EP 1	MS.17.01.03, EP 4	The medical staff examines the credentials of all candidates eligible for medical staff membership and makes recommendations to the governing body on the appointment of these candidates, in accordance with state law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations. A candidate who has been recommended by the medical staff and who has been appointed by the governing body is subject to all medical staff bylaws, rules, and regulations. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: A candidate who has been recommended by the medical staff and who has been appointed by the governing body is also subject to 42 CFR 482.22(a). CoPs: §482.22(a)(2)
MS.06.01.09, EP 4	The process to disseminate all granting, modification, or restriction decisions is approved by the organized medical staff. CoPs: §482.22(a)(1), §482.22(a)(2)	Split to MS.17.01.03, EP 4; MS.18.02.03, EP 1	MS.18.02.03, EP 1	The medical staff's ongoing professional practice evaluation includes a clearly defined process that facilitates the periodic evaluation of each physician's or other licensed practitioner's professional practice. Note: Privileges are granted for a period not to exceed three years or for the period required by law and regulation if shorter. CoPs: §482.22(a)(1)
MS.06.01.09, EP 5	The hospital makes the physician or other licensed practitioner aware of available due process or, when applicable, the option to implement the Fair Hearing and Appeal Process for Adverse Privileging Decisions.	Deleted EP - Covered at the standard level and moved to guidance within SPG	Standard MS.18.04.01	There are mechanisms for a fair hearing and appeal process to address adverse decisions regarding reappointment, denial, reduction, suspension, or revocation of privileges that may relate to quality of care, treatment, and services issues.
MS.06.01.11, EP 1	The organized medical staff develops criteria for an expedited process for granting privileges. Note: To expedite initial appointments to membership and granting of privileges, reappointment to membership, or renewal or modification of privileges, the governing body may delegate the authority to render those decisions to a committee of at least two voting members of the governing body.	Moved and Revised	MS.17.03.01, EP 1	The organized medical staff develops and implements criteria for an expedited process for granting privileges. Note: To expedite initial appointments to membership and granting of privileges, reappointment to membership, or renewal or modification of privileges, the governing body may delegate the authority to render those decisions to a committee of at least two voting members of the governing body.
MS.06.01.11, EP 2	The criteria provide that an applicant for privileges is ineligible for the expedited process if any of the following has occurred:	Moved and Revised	MS.17.03.01, EP 2	The criteria provide that an applicant for privileges is ineligible for the expedited process if any of the following has occurred:

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	- The applicant submits an incomplete application. - The medical staff executive committee makes a final recommendation that is adverse or has limitations			- The applicant submits an incomplete application. - The medical staff executive committee makes a final recommendation that is adverse or has limitations.
MS.06.01.11, EP 3	The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process: There is a current challenge or a previously successful challenge to licensure or registration.	Consolidation of MS.06.01.05, EP 9; MS.06.01.11, EP 3; MS.06.01.11, EP 4; MS.06.01.11, EP 5; MS.06.01.11, EP 6; MS.06.01.11, EP 7	MS.17.03.01, EP 3	The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process: - There is a current challenge or a previously successful challenge to licensure or registration. - The applicant has received an involuntary termination of medical staff membership at another hospital. - The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges. - The hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.
MS.06.01.11, EP 4	The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process: The applicant has received an involuntary termination of medical staff membership at another hospital.	Consolidation of MS.06.01.05, EP 9; MS.06.01.11, EP 3; MS.06.01.11, EP 4; MS.06.01.11, EP 5; MS.06.01.11, EP 6; MS.06.01.11, EP 7	MS.17.03.01, EP 3	The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process: - There is a current challenge or a previously successful challenge to licensure or registration. - The applicant has received an involuntary termination of medical staff membership at another hospital. - The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges. - The hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.
MS.06.01.11, EP 5	The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process: The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges.	Consolidation of MS.06.01.05, EP 9; MS.06.01.11, EP 3; MS.06.01.11, EP 4; MS.06.01.11, EP 5; MS.06.01.11, EP 6; MS.06.01.11, EP 7	MS.17.03.01, EP 3	The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process: - There is a current challenge or a previously successful challenge to licensure or registration. - The applicant has received an involuntary termination of medical staff membership at another hospital. - The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges. - The hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.
MS.06.01.11, EP 6	The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process: The hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.	Consolidation of MS.06.01.05, EP 9; MS.06.01.11, EP 3; MS.06.01.11, EP 4; MS.06.01.11, EP 5; MS.06.01.11, EP 6; MS.06.01.11, EP 7	MS.17.03.01, EP 3	The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process: - There is a current challenge or a previously successful challenge to licensure or registration. - The applicant has received an involuntary termination of medical staff membership at another hospital. - The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges. - The hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.
MS.06.01.11, EP 7	The organized medical staff uses the criteria developed for the expedited process when recommending privileges.	Consolidation of MS.06.01.05, EP 9;	MS.17.03.01, EP 3	The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process:

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
		MS.06.01.11, EP 3; MS.06.01.11, EP 4; MS.06.01.11, EP 5; MS.06.01.11, EP 6; MS.06.01.11, EP 7		- There is a current challenge or a previously successful challenge to licensure or registration. - The applicant has received an involuntary termination of medical staff membership at another hospital. - The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges. - The hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.
MS.06.01.13, EP 1	Temporary privileges are granted to meet an important patient care need for the time period defined in the medical staff bylaws.	Moved and Revised	MS.17.04.01, EP 1	Temporary privileges are granted to meet an important patient care need for a time period defined in the medical staff bylaws.
MS.06.01.13, EP 2	When temporary privileges are granted to meet an important care need, the organized medical staff verifies current licensure and current competence.	Moved	MS.17.04.01, EP 2	When temporary privileges are granted to meet an important care need, the organized medical staff verifies current licensure and current competence.
MS.06.01.13, EP 3	Temporary privileges for applicants for new privileges may be granted while awaiting review and approval by the organized medical staff upon verification of the following: - Current licensure - Relevant training or experience - Current competence - Ability to perform the privileges requested - Other criteria required by the medical staff bylaws - A query and evaluation of the National Practitioner Data Bank (NPDB) information - A complete application - No current or previously successful challenge to licensure or registration - No subjection to involuntary termination of medical staff membership at another organization - No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges	Moved and Revised	MS.17.04.01, EP 3	Temporary privileges may be granted to applicants for new privileges while awaiting review and approval by the organized medical staff upon verification of the following: - Current licensure - Relevant training or experience - Current competence - Ability to perform the privileges requested - Other criteria required by the medical staff bylaws - A query and evaluation of the National Practitioner Data Bank (NPDB) information - A complete application - No current or previously successful challenge to licensure or registration - No subjection to involuntary termination of medical staff membership at another organization - No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges
MS.06.01.13, EP 4	All temporary privileges are granted by the chief executive officer or authorized designee.	Moved	MS.17.04.01, EP 4	All temporary privileges are granted by the chief executive officer or authorized designee.
MS.06.01.13, EP 5	All temporary privileges are granted on the recommendation of the medical staff president or authorized designee.	Moved	MS.17.04.01, EP 5	All temporary privileges are granted on the recommendation of the medical staff president or authorized designee.
MS.06.01.13, EP 6	Temporary privileges for applicants for new privileges are granted for no more than 120 days.	Moved	MS.17.04.01, EP 6	Temporary privileges for applicants for new privileges are granted for no more than 120 days.
MS.07.01.01, EP 1	The organized medical staff develops criteria for medical staff membership. Note: Medical staff membership and professional privileges are not dependent solely upon certification, fellowship, or membership in a specialty body or society. CoPs: §482.12(a)(7), §482.22(a), §482.22(a)(2), §482.22(c)(4)	Consolidation of MS.03.01.01, EP 13; MS.03.01.01, EP 14; MS.07.01.01, EP 1; MS.07.01.01, EP 5	LD.11.01.01, EP 2	The governing body does the following: - Approves and is responsible for the effective operation of the grievance process - Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee - Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff - Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff - Makes certain that the medical staff has bylaws - Approves medical staff bylaws and other medical staff rules and regulations - Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients - Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment - Makes certain that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification,

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
				fellowship, or membership in a specialty body or society - Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the locations without emergency services when emergency services are not provided at the hospital, or are provided at the hospital but not at one or more off-campus locations CoPs: §482.12(a)(1), §482.12(a)(2), §482.12(a)(3), §482.12(a)(4), §482.12(a)(5), §482.12(a)(6), §482.12(a)(7), §482.12(f)(2), §482.12(f)(3), §482.13(a)(2)
MS.07.01.01, EP 2	The professional criteria are designed to assure the medical staff and governing body that patients will receive quality care, treatment, and services. CoPs: §482.22(a)(2)	Consolidation of MS.01.01.01, EP 5; MS.01.01.01, EP 7; MS.07.01.01, EP 2	MS.16.01.01, EP 1	The hospital has an organized medical staff that operates under bylaws approved by the governing body and that is responsible for the quality of medical care provided by the hospital. CoPs: §482.22
MS.07.01.01, EP 3	The organized medical staff uses the criteria in appointing members to the medical staff and appointment does not exceed three years or the period required by law and regulation if shorter. CoPs: §482.22(a)(2)	Consolidation of MS.06.01.07, EP 9; MS.06.01.09, EP 1; MS.06.01.09, EP 2; MS.06.01.09, EP 3; MS.06.01.09, EP 4; MS.07.01.01, EP 3; MS.08.01.03, EP 1	MS.18.02.03, EP 1	The medical staff's ongoing professional practice evaluation includes a clearly defined process that facilitates the periodic evaluation of each physician's or other licensed practitioner's professional practice. Note: Privileges are granted for a period not to exceed three years or for the period required by law and regulation if shorter. CoPs: §482.22(a)(1)
MS.07.01.01, EP 4	Gender, race, creed, and national origin are not used in making decisions regarding the granting or denying of medical staff membership.	Consolidation of MS.01.01.01, EP 13; MS.06.01.05, EP 3; MS.07.01.01, EP 4	MS.14.01.01, EP 2	The medical staff bylaws include the qualifications for appointment and reappointment to the medical staff. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff is composed of doctors of medicine or osteopathy. In accordance with state law, including scope of practice laws, the medical staff may also include other categories of physicians, as listed at 42 CFR 482.12(c)(1), and other licensed practitioners who the governing body determines are eligible for appointment. Note 2: Gender, race, creed, and national origin are not used in making decisions regarding the granting or denying of medical staff membership. CoPs: §482.22(a)
MS.07.01.01, EP 5	Membership is recommended by the medical staff and granted by the governing body. CoPs: §482.12(a)(2), §482.22(a), §482.22(a)(2)	Consolidation of MS.03.01.01, EP 13; MS.03.01.01, EP 14; MS.07.01.01, EP 1; MS.07.01.01, EP 5	LD.11.01.01, EP 2	The governing body does the following: - Approves and is responsible for the effective operation of the grievance process - Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee - Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff - Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff - Makes certain that the medical staff has bylaws - Approves medical staff bylaws and other medical staff rules and regulations - Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients - Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment - Makes certain that under no circumstances is the accordance of staff membership

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
				or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society - Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the locations without emergency services when emergency services are not provided at the hospital, or are provided at the hospital but not at one or more off-campus locations CoPs: §482.12(a)(1), §482.12(a)(2), §482.12(a)(3), §482.12(a)(4), §482.12(a)(5), §482.12(a)(6), §482.12(a)(7), §482.12(f)(2), §482.12(f)(3), §482.13(a)(2)
MS.07.01.03, EP 1	Recommendations from peers are obtained and evaluated for all new applicants for privileges.	Moved	MS.18.01.01, EP 1	Recommendations from peers are obtained and evaluated for all new applicants for privileges.
MS.07.01.03, EP 2	Upon renewal of privileges, when insufficient physician- or other licensed practitioner-specific data are available, the medical staff obtains and evaluates peer recommendations.	Moved	MS.18.01.01, EP 2	Upon renewal of privileges, when insufficient physician- or other licensed practitioner-specific data are available, the medical staff obtains and evaluates peer recommendations.
MS.07.01.03, EP 3	Peer recommendations include the following information: - Medical/clinical knowledge - Technical and clinical skills - Clinical judgment - Interpersonal skills - Communication skills - Professionalism	Consolidation of MS.06.01.05, EP 8; MS.07.01.03, EP 3	MS.18.01.01, EP 3	Peer recommendations include the following information: - Medical/clinical knowledge - Technical and clinical skills - Clinical judgment - Interpersonal skills - Communication skills - Professionalism
MS.07.01.03, EP 4	Peer recommendations are obtained from a physician or other licensed practitioner in the same professional discipline as the applicant with personal knowledge of the applicant’s ability to practice.	Moved	MS.18.01.01, EP 4	Peer recommendations are obtained from a physician or other licensed practitioner in the same professional discipline as the applicant with personal knowledge of the applicant’s ability to practice.
MS.08.01.01, EP 1	A period of focused professional practice evaluation is implemented for all initially requested privileges. CoPs: §482.22(a)(1)	Moved and Revised	MS.18.02.01, EP 2	A period of focused professional practice evaluation is implemented for all initially requested privileges.
MS.08.01.01, EP 2	The organized medical staff develops criteria to be used for evaluating the performance of physicians or other licensed practitioners when issues affecting the provision of safe, high quality patient care are identified.	Consolidation of MS.06.01.07, EP 5; MS.08.01.01, EP 2	MS.18.02.01, EP 1	The organized medical staff develops and consistently implements criteria to be used for evaluating the performance of physicians or other licensed practitioners when issues affecting the provision of safe, high quality patient care are identified.
MS.08.01.01, EP 3	The performance monitoring process is clearly defined and includes each of the following elements: - Criteria for conducting performance monitoring - Method for establishing a monitoring plan specific to the requested privilege - Method for determining the duration of performance monitoring - Circumstances under which monitoring by an external source is required	Consolidation of MS.08.01.01, EP 3; MS.08.01.01, EP 6; MS.09.01.01, EP 2	MS.18.02.01, EP 3	The performance monitoring process is clearly defined and includes each of the following elements: - Criteria for conducting performance monitoring - Method for establishing a monitoring plan specific to the requested privilege - Method for determining the duration of performance monitoring - Circumstances under which monitoring by an external source is required
MS.08.01.01, EP 4	Focused professional practice evaluation is consistently implemented in accordance with the criteria and requirements defined by the organized medical staff. CoPs: §482.22(a)(1)	Deleted EP - Covered under the standard and moved to guidance within SPG	Standard MS.18.02.01	The organized medical staff defines the circumstances requiring monitoring and evaluation of a physician's or other licensed practitioner’s professional performance.
MS.08.01.01, EP 5	The triggers that indicate the need for performance monitoring are clearly defined. Note: Triggers can be single incidents or evidence of a clinical practice trend.	Moved	MS.18.02.01, EP 4	The triggers that indicate the need for performance monitoring are clearly defined. Note: Triggers can be single incidents or evidence of a clinical practice trend.
MS.08.01.01, EP 6	The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of a physician's or other licensed practitioner’s current clinical competence, practice behavior, and ability to perform the requested privilege.	Consolidation of MS.08.01.01, EP 3; MS.08.01.01, EP 6; MS.09.01.01, EP 2	MS.18.02.01, EP 3	The performance monitoring process is clearly defined and includes each of the following elements: - Criteria for conducting performance monitoring - Method for establishing a monitoring plan specific to the requested privilege

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	Note: Other existing privileges in good standing should not be affected by this decision. CoPs: §482.22(a)(1)			- Method for determining the duration of performance monitoring - Circumstances under which monitoring by an external source is required
MS.08.01.01, EP 7	Criteria are developed that determine the type of monitoring to be conducted.	Moved	MS.18.02.01, EP 5	Criteria are developed that determine the type of monitoring to be conducted.
MS.08.01.01, EP 8	The measures employed to resolve performance issues are clearly defined.	Moved	MS.18.02.01, EP 6	The measures employed to resolve performance issues are clearly defined.
MS.08.01.01, EP 9	The measures employed to resolve performance issues are consistently implemented.	Moved	MS.18.02.01, EP 7	The measures employed to resolve performance issues are consistently implemented.
MS.08.01.03, EP 1	The process for the ongoing professional practice evaluation includes the following: There is a clearly defined process in place that facilitates the evaluation of each physician's or other licensed practitioner’s professional practice. CoPs: §482.22(a)(1)	Consolidation of MS.06.01.07, EP 9; MS.06.01.09, EP 1; MS.06.01.09, EP 2; MS.06.01.09, EP 3; MS.06.01.09, EP 4; MS.07.01.01, EP 3; MS.08.01.03, EP 1	MS.18.02.03, EP 1	The medical staff's ongoing professional practice evaluation includes a clearly defined process that facilitates the periodic evaluation of each physician's or other licensed practitioner’s professional practice. Note: Privileges are granted for a period not to exceed three years or for the period required by law and regulation if shorter. CoPs: §482.22(a)(1)
MS.08.01.03, EP 2	The process for the ongoing professional practice evaluation includes the following: The type of data to be collected is determined by individual departments and approved by the organized medical staff. CoPs: §482.22(a)(1)	Moved and Revised	MS.18.02.03, EP 2	The process for the ongoing professional practice evaluation includes the type of data to be collected, which is determined by individual departments and approved by the organized medical staff.
MS.08.01.03, EP 3	The process for the ongoing professional practice evaluation includes the following: Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s). CoPs: §482.22(a)(1)	Moved and Revised	MS.18.02.03, EP 3	The process for the ongoing professional practice evaluation includes the use of information resulting from the ongoing professional practice evaluation to determine whether to continue, limit, or revoke any existing privilege(s).
MS.09.01.01, EP 1	The hospital, based on recommendations by the organized medical staff and approval by the governing body, has a clearly defined process for collecting, investigating, and addressing clinical practice concerns. CoPs: §482.22(a)(1)	Moved and Revised	MS.18.03.01, EP 1	The hospital, based on recommendations by the organized medical staff and approval by the governing body, has a clearly defined process for collecting, investigating, and addressing clinical practice concerns. Note: Reported concerns regarding a privileged physician's or other licensed practitioner’s professional practice are uniformly investigated and addressed, as defined by the hospital and applicable law.
MS.09.01.01, EP 2	Reported concerns regarding a privileged physician's or other licensed practitioner’s professional practice are uniformly investigated and addressed, as defined by the hospital and applicable law. CoPs: §482.22(a)(1)	Consolidation of MS.08.01.01, EP 3; MS.08.01.01, EP 6; MS.09.01.01, EP 2	MS.18.02.01, EP 3	The performance monitoring process is clearly defined and includes each of the following elements: - Criteria for conducting performance monitoring - Method for establishing a monitoring plan specific to the requested privilege - Method for determining the duration of performance monitoring - Circumstances under which monitoring by an external source is required
MS.10.01.01, EP 1	The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has the following characteristics: Is designed to provide a fair process that may differ for members and nonmembers of the medical staff.	Moved and Revised	MS.18.04.01, EP 1	The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that may differ for members and nonmembers of the medical staff.
MS.10.01.01, EP 2	The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has the following characteristics: Has a mechanism to schedule a hearing of such requests.	Consolidation of MS.01.01.01, EP 34; MS.10.01.01, EP 2	MS.18.04.01, EP 2	The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has a mechanism to schedule a hearing of such requests.
MS.10.01.01, EP 3	The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has the following characteristics: Has identified the procedures for the hearing to follow.	Consolidation of MS.01.01.01, EP 34; MS.10.01.01, EP 3	MS.18.04.01, EP 3	The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has identified the procedures for the hearing to follow.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
MS.10.01.01, EP 4	The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has the following characteristics: Identifies the composition of the hearing committee as a committee that includes impartial peers.	Moved and Revised	MS.18.04.01, EP 4	The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that identifies the composition of the hearing committee as a committee that includes impartial peers.
MS.10.01.01, EP 5	The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has the following characteristics: With the governing body, provides a mechanism to appeal adverse decisions as provided in the medical staff bylaws.	Moved and Revised	MS.18.04.01, EP 5	The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that, with the governing body, provides a mechanism to appeal adverse decisions as provided in the medical staff bylaws.
MS.11.01.01, EP 1	Process design addresses the following issues: Education of physicians or other licensed practitioners and other organization staff about illness and impairment recognition issues specific to practitioners (at-risk criteria).	Moved and Revised	MS.18.05.01, EP 1	The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses the education of physicians or other licensed practitioners and other organization staff about illness and impairment recognition issues specific to practitioners (at-risk criteria).
MS.11.01.01, EP 2	Process design addresses the following issues: Self referral by a physician or other licensed practitioner.	Moved and Revised	MS.18.05.01, EP 2	The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses self-referral by a physician or other licensed practitioner.
MS.11.01.01, EP 3	Process design addresses the following issues: Referral by others and maintaining informant confidentiality.	Moved and Revised	MS.18.05.01, EP 3	The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses referral by others and maintaining informant confidentiality.
MS.11.01.01, EP 4	Process design addresses the following issues: Referral of the physician or other licensed practitioner to appropriate professional internal or external resources for evaluation, diagnosis, and treatment of the condition or concern.	Moved and Revised	MS.18.05.01, EP 4	The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses referral of the physician or other licensed practitioner to appropriate professional internal or external resources for evaluation, diagnosis, and treatment of the condition or concern.
MS.11.01.01, EP 5	Process design addresses the following issues: Maintenance of confidentiality of the physician or other licensed practitioner seeking referral or referred for assistance, except as limited by applicable law, ethical obligation, or when the health and safety of a patient is threatened.	Moved and Revised	MS.18.05.01, EP 5	The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses maintenance of confidentiality of the physician or other licensed practitioner seeking referral or referred for assistance, except as limited by applicable law, ethical obligation, or when the health and safety of a patient is threatened.
MS.11.01.01, EP 6	Process design addresses the following issues: Evaluation of the credibility of a complaint, allegation, or concern.	Moved and Revised	MS.18.05.01, EP 6	The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses evaluation of the credibility of a complaint, allegation, or concern.
MS.11.01.01, EP 7	Process design addresses the following issues: Monitoring the physician or other licensed practitioner and the safety of patients until the rehabilitation is complete and periodically thereafter, if required.	Moved and Revised	MS.18.05.01, EP 7	The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses monitoring the physician or other licensed practitioner and the safety of patients until the rehabilitation is complete and periodically thereafter, if required.
MS.11.01.01, EP 8	Process design addresses the following issues: Reporting to the organized medical staff leadership instances in which a physician or other licensed practitioner is providing unsafe treatment.	Moved and Revised	MS.18.05.01, EP 8	The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses reporting to the organized medical staff leadership instances in which a physician or other licensed practitioner is providing unsafe treatment.
MS.11.01.01, EP 9	Process design addresses the following issues: Initiating appropriate actions when a physician or other licensed practitioner fails to complete the required rehabilitation program.	Moved and Revised	MS.18.05.01, EP 9	The process to identify and manage matters of individual health for physicians and other licensed practitioners addresses initiating appropriate actions when a physician or other licensed practitioner fails to complete the required rehabilitation program.
MS.11.01.01, EP 10	The medical staff implements its process to identify and manage matters of individual health for physicians and other licensed practitioners.	Moved	MS.18.05.01, EP 10	The medical staff implements its process to identify and manage matters of individual health for physicians and other licensed practitioners.
MS.12.01.01, EP 1	Hospital-sponsored educational activities are prioritized by the organized medical staff.	Consolidation of MS.12.01.01, EP 1; MS.12.01.01, EP 2	MS.19.01.01, EP 1	The organized medical staff prioritizes hospital-sponsored educational activities that relate, at least in part, to the type and nature of care, treatment, and services offered by the hospital.
MS.12.01.01, EP 2	These activities relate, at least in part, to the type and nature of care, treatment, and services offered by the hospital.	Consolidation of MS.12.01.01, EP 1; MS.12.01.01, EP 2	MS.19.01.01, EP 1	The organized medical staff prioritizes hospital-sponsored educational activities that relate, at least in part, to the type and nature of care, treatment, and services offered by the hospital.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
MS.12.01.01, EP 3	Education is based on the findings of performance improvement activities.	Moved	MS.19.01.01, EP 2	Education is based on the findings of performance improvement activities.
MS.12.01.01, EP 4	Each individual's participation in continuing education is documented.	Moved	MS.19.01.01, EP 3	Each individual's participation in continuing education is documented.
MS.12.01.01, EP 5	Participation in continuing education is considered in decisions about reappointment to membership on the medical staff or renewal or revision of individual clinical privileges.	Moved	MS.19.01.01, EP 4	Participation in continuing education is considered in decisions about reappointment to membership on the medical staff or renewal or revision of individual clinical privileges.
MS.13.01.01, EP 1	All physicians or other licensed practitioners who are responsible for the patient's care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms: - The originating site fully credentials and privileges the physician or other licensed practitioner according to Standards MS.06.01.03 through MS.06.01.13. Or - The originating site privileges physicians or other licensed practitioners using credentialing information from the distant site if the distant site is a Joint Commission–accredited or a Medicare-participating organization. The distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services. Or - The originating site may choose to use the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met: - The distant site is a Joint Commission–accredited or a Medicare-participating organization. - The physician or other licensed practitioner is privileged at the distant site for those services to be provided at the originating site. - For hospitals that use Joint Commission accreditation for deemed status purposes: The distant site provides the originating site with a current list of the physician's or other licensed practitioner's privileges. - The originating site has evidence of an internal review of the physician's or other licensed practitioner's performance of these privileges and sends to the distant site information that is useful to assess the physician's or other licensed practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided and complaints about the distant site physician or other licensed practitioner from patients, physicians or other licensed practitioners, or staff at the originating site. This occurs in a way consistent with any hospital policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law. - The distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services. Note 1: In the case of an accredited ambulatory care organization, the hospital must verify that the distant site made its decision using the process described in Standards MS.06.01.03 through MS.06.01.07 (excluding EP 2 from MS.06.01.03). This is equivalent to meeting Standard HR.02.01.03 in the Comprehensive Accreditation Manual for Ambulatory Care. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: As indicated at LD.04.03.09, EP 23, the originating site makes certain that all distant-site telemedicine providers' credentialing and privileging processes meet,	Moved and Revised	MS.20.01.01, EP 1	When telemedicine services are furnished to the hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing such services if the hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity: - The distant site telemedicine entity provides services in accordance with contract service requirements - The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the hospital's process and standards, at a minimum. - The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. - The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity. - The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the hospital whose patients are receiving the telemedicine services is located. - For distant-site physicians or other licensed practitioners privileged by the originating hospital, the originating hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the hospital's patients and complaints the hospital has received about the distant-site physician or other licensed practitioner. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2). CoPs: §482.12(a)(8), §482.22(a)(3), §482.22(a)(3)(i), §482.22(a)(3)(ii), §482.22(a)(3)(iii), §482.22(a)(3)(iv), §482.22(a)(4), §482.22(a)(4)(i), §482.22(a)(4)(ii), §482.22(a)(4)(iii), §482.22(a)(4)(iv)

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	at a minimum, the Medicare Conditions of Participation at 42 CFR 482.12(a)(1) through (a)(9) and 482.22(a)(1) through (a)(4). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A. CoPs: §482.22(a)(3), §482.22(a)(3)(i), §482.22(a)(3)(ii), §482.22(a)(3)(iii), §482.22(a)(3)(iv), §482.22(a)(4), §482.22(a)(4)(i), §482.22(a)(4)(ii), §482.22(a)(4)(iii), §482.22(a)(4)(iv), §482.22(c)(6)			
MS.13.01.03, EP 1	The medical staff recommends which clinical services are appropriately delivered by physicians or other licensed practitioners through this medium.	Moved	MS.20.01.03, EP 1	The medical staff recommends which clinical services are appropriately delivered by physicians or other licensed practitioners through this medium.
MS.13.01.03, EP 2	The clinical services offered are consistent with commonly accepted quality standards.	Moved	MS.20.01.03, EP 2	The clinical services offered are consistent with commonly accepted quality standards.
N/A	N/A	New, more-direct EP for CoP requirement	MS.16.01.01, EP 9	If the hospital provides emergency services, the medical staff establishes and is continually responsible for the policies and procedures governing emergency medical care. CoPs: §482.55(a)(3)
N/A	N/A	New, more-direct EP for CoP requirement	MS.16.01.03, EP 4	For hospitals that use Joint Commission accreditation for deemed status purposes: Every Medicare patient is under the care of at least one of the following: - A doctor of medicine or osteopathy (This requirement does not limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified health care staff to the extent recognized under state law or a state's regulatory mechanism.) - A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the state and who is acting within the scope of their license - A doctor of podiatric medicine, but only with respect to functions which they are legally authorized by the state to perform - A doctor of optometry who is legally authorized to practice optometry by the state in which they practice - A chiropractor who is licensed by the state or legally authorized to perform the services of a chiropractor, but only with respect to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by x-ray to exist - A clinical psychologist as defined in 42 CFR 410.71, but only with respect to clinical psychologist services as defined in 42 CFR 410.71 and only to the extent permitted by state CoPs: §482.12(c)(1)(i), §482.12(c)(1)(ii), §482.12(c)(1)(iii), §482.12(c)(1)(iv), §482.12(c)(1)(v), §482.12(c)(1)(vi)
N/A	N/A	New, more-direct EP for CoP requirement	NPG.12.03.01, EP 2	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The hospital makes certain a registered professional nurse is available 24 hours a day. CoPs: §482.62(d)(2)
N/A	N/A	New, more-direct EP for CoP requirement	NPG.12.03.01, EP 3	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The number of qualified therapists, support personnel, and consultants is adequate to provide therapeutic activities consistent with each patient's active treatment program. CoPs: §482.62(g)(2)
N/A	N/A	New, more-direct EP for CoP requirement	NPG.12.03.01, EP 4	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: There is an adequate number of qualified professional, technical, and

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
				consultative staff (including but not limited to doctors of medicine and/or osteopathy, registered nurses, licensed practical nurses, and mental health workers) to do the following: - Evaluate patients - Formulate written individualized, comprehensive treatment plans - Provide active treatment measures - Engage in discharge planning - Provide the nursing care necessary under each patient's active treatment program - Maintain progress notes on each patient - Provide essential psychiatric services CoPs: §482.62, §482.62(a)(1), §482.62(a)(2), §482.62(a)(3), §482.62(a)(4), §482.62(d), §482.62(d)(2)
NPSG.01.01.01, EP 1	Use at least two patient identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. The patient's room number or physical location is not used as an identifier.	Consolidation of NPSG.01.01.01, EP 1; PC.02.01.01, EP 10	NPG.01.01.01, EP 1	The hospital has a process in place to correctly identify patients when providing care, treatment, and services. This includes using at least two patient identifiers. The hospital does not use the patient's room number or physical location as an identifier. Note: Examples of patient identifiers may include but are not limited to the following: - Assigned identification number (for example, medical record number) - Telephone number or another person-specific identifier - Electronic identification technology coding, such as bar coding or RFID, that includes two or more person-specific identifiers
NPSG.01.01.01, EP 2	Label containers used for blood and other specimens in the presence of the patient.	Moved and Revised	NPG.01.01.01, EP 2	The hospital labels containers used for blood and other specimens in the presence of the patient.
NPSG.01.01.01, EP 3	Use distinct methods of identification for newborn patients. Note: Examples of methods to prevent misidentification may include the following: - Distinct naming systems could include using the mother's first and last names and the newborn's gender (for example, "Smith, Judy Girl" or "Smith, Judy Girl A" and "Smith, Judy Girl B" for multiples). - Standardized practices for identification banding (for example, using two body sites and/or bar coding for identification). - Establish communication tools among staff (for example, visually alerting staff with signage noting newborns with similar names).	Moved and Revised	NPG.01.01.01, EP 3	The hospital uses distinct methods of identification for newborn patients. Note: Examples of methods to prevent misidentification may include the following: - Distinct naming systems could include using the mother's first and last names and the newborn's gender (for example: "Smith, Judy Girl" or "Smith, Judy Girl A" and "Smith, Judy Girl B" for multiples). - Standardized practices for identification banding (for example, using two body sites and/or bar coding for identification). - Establish communication tools among staff (for example, visually alerting staff with signage noting newborns with similar names).
NPSG.02.03.01, EP 1	Develop and implement written procedures for managing the critical results of tests and diagnostic procedures that address the following: - The definition of critical results of tests and diagnostic procedures - By whom and to whom critical results of tests and diagnostic procedures are reported - The acceptable length of time between the availability and reporting of critical results of tests and diagnostic procedures	Moved and Revised	NPG.01.02.01, EP 1	The hospital develops and implements written procedures for managing the critical results of tests and diagnostic procedures that address the following: - The definition of critical results of tests and diagnostic procedures - By whom and to whom critical results of tests and diagnostic procedures are reported - The acceptable length of time between the availability and reporting of critical results of tests and diagnostic procedures
NPSG.02.03.01, EP 3	Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures.	Moved and Revised	NPG.01.02.01, EP 2	The hospital evaluates the timeliness of reporting the critical results of tests and diagnostic procedures.
NPSG.03.04.01, EP 1	In perioperative and other procedural settings both on and off the sterile field, label medications and solutions that are not immediately administered. This applies even if there is only one medication being used. Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.	Moved and Revised	NPG.14.03.01, EP 1	In perioperative and other procedural settings both on and off the sterile field, the hospital labels medications and solutions that are not immediately administered. This applies even if there is only one medication being used. Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
NPSG.03.04.01, EP 2	In perioperative and other procedural settings both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to another container.	Moved	NPG.14.03.01, EP 2	In perioperative and other procedural settings both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to another container.
NPSG.03.04.01, EP 3	In perioperative and other procedural settings both on and off the sterile field, medication or solution labels include the following: - Medication or solution name - Strength - Amount of medication or solution containing medication (if not apparent from the container) - Diluent name and volume (if not apparent from the container) - Expiration date and time Note: The date and time are not necessary for short procedures, as defined by the hospital.	Moved	NPG.14.03.01, EP 3	In perioperative and other procedural settings both on and off the sterile field, medication or solution labels include the following: - Medication or solution name - Strength - Amount of medication or solution containing medication (if not apparent from the container) - Diluent name and volume (if not apparent from the container) - Expiration date and time Note: The date and time are not necessary for short procedures, as defined by the hospital.
NPSG.03.04.01, EP 4	Verify all medication or solution labels both verbally and visually. Verification is done by two individuals qualified to participate in the procedure whenever the person preparing the medication or solution is not the person who will be administering it.	Moved and Revised	NPG.14.03.01, EP 4	The hospital verifies all medication or solution labels both verbally and visually. Verification is done by two individuals qualified to participate in the procedure whenever the person preparing the medication or solution is not the person who will be administering it.
NPSG.03.04.01, EP 5	Label each medication or solution as soon as it is prepared, unless it is immediately administered. Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.	Moved and Revised	NPG.14.03.01, EP 5	The hospital labels each medication or solution as soon as it is prepared, unless it is immediately administered. Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.
NPSG.03.05.01, EP 2	The hospital uses approved protocols and evidence-based practice guidelines for reversal of anticoagulation and management of bleeding events related to each anticoagulant medication.	Moved	NPG.14.04.01, EP 1	The hospital uses approved protocols and evidence-based practice guidelines for reversal of anticoagulation and management of bleeding events related to each anticoagulant medication.
NPSG.03.05.01, EP 3	The hospital uses approved protocols and evidence-based practice guidelines for perioperative management of all patients on oral anticoagulants. Note: Perioperative management may address the use of bridging medications, timing for stopping an anticoagulant, and timing and dosing for restarting an anticoagulant.	Moved	NPG.14.04.01, EP 2	The hospital uses approved protocols and evidence-based practice guidelines for perioperative management of all patients on oral anticoagulants. Note: Perioperative management may address the use of bridging medications, timing for stopping an anticoagulant, and timing and dosing for restarting an anticoagulant.
NPSG.03.05.01, EP 7	The hospital uses only oral unit-dose products, prefilled syringes, or premixed infusion bags when these types of products are available. Note: For pediatric patients, prefilled syringe products should be used only if specifically designed for children.	Moved	NPG.14.04.01, EP 3	The hospital uses only oral unit-dose products, prefilled syringes, or premixed infusion bags when these types of products are available. Note: For pediatric patients, prefilled syringe products should be used only if specifically designed for children.
NPSG.03.06.01, EP 1	Obtain information on the medications the patient is currently taking when they are admitted to the hospital or is seen in an outpatient setting. This information is documented in a list or other format that is useful to those who manage medications. Note 1: Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications. Note 2: It is often difficult to obtain complete information on current medications from a patient. A good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the EP.	Moved and Revised	NPG.14.05.01, EP 1	The hospital obtains information on the medications the patient is currently taking when they are admitted to the hospital or are seen in an outpatient setting. This information is documented in a list or other format that is useful to those who manage medications. Note 1: Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications. Note 2: It is often difficult to obtain complete information on current medications from a patient. A good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the EP.
NPSG.03.06.01, EP 2	Define the types of medication information (for example, name, dose, route, frequency, purpose) to be collected in non-24-hour settings. Note: Examples of non-24-hour settings include the emergency department, primary care, outpatient radiology, ambulatory surgery, and diagnostic settings.	Moved	NPG.14.05.01, EP 2	Define the types of medication information (for example, name, dose, route, frequency, purpose) to be collected in non-24-hour settings. Note: Examples of non-24-hour settings include the emergency department, primary care, outpatient radiology, ambulatory surgery, and diagnostic settings.
NPSG.03.06.01, EP 3	Compare the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve	Moved and Revised	NPG.14.05.01, EP 3	Compare the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	discrepancies. Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the hospital, does the comparison.			discrepancies. Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the hospital, does the comparison.
NPSG.03.06.01, EP 4	Provide the patient (or family, caregiver, or support person as needed) with written information on the medications the patient should be taking when they are discharged from the hospital or at the end of an outpatient encounter (for example, name, dose, route, frequency, purpose).	Moved	NPG.14.05.01, EP 4	Provide the patient (or family, caregiver, or support person as needed) with written information on the medications the patient should be taking when they are discharged from the hospital or at the end of an outpatient encounter (for example, name, dose, route, frequency, purpose).
NPSG.03.06.01, EP 5	Explain the importance of managing medication information to the patient when they are discharged from the hospital or at the end of an outpatient encounter. Note: Examples include instructing the patient to give a list to their primary care provider; to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added; and to carry medication information at all times in the event of emergency situations. (For information on patient education on medications, refer to Standards MM.06.01.03, PC.02.03.01, and PC.04.01.05.)	Moved and Revised	NPG.14.05.01, EP 5	Explain the importance of managing medication information to the patient when they are discharged from the hospital or at the end of an outpatient encounter. Note: Examples include instructing the patient to give a list to their primary care provider; to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added; and to carry medication information at all times in the event of emergency situations. (For information on patient education on medications, refer to Standards MM.16.01.01, PC.12.02.01, and PC.14.01.01.)
NPSG.06.01.01, EP 1	Leaders establish alarm system safety as a hospital priority.	Deleted	N/A	N/A
NPSG.06.01.01, EP 2	Identify the most important alarm signals to manage based on the following: - Input from the medical staff and clinical departments - Risk to patients if the alarm signal is not attended to or if it malfunctions - Whether specific alarm signals are needed or unnecessarily contribute to alarm noise and alarm fatigue - Potential for patient harm based on internal incident history - Published best practices and guidelines (For more information on managing medical equipment risks, refer to Standard EC.02.04.01)	Moved and Revised	NPG.01.05.01, EP 1	Identify the most important alarm signals to manage based on the following: - Input from the medical staff and clinical departments - Risk to patients if the alarm signal is not attended to or if it malfunctions - Whether specific alarm signals are needed or unnecessarily contribute to alarm noise and alarm fatigue - Potential for patient harm based on internal incident history - Published best practices and guidelines
NPSG.06.01.01, EP 3	Establish policies and procedures for managing the alarms identified in EP 2 above that, at a minimum, address the following: - Clinically appropriate settings for alarm signals - When alarm signals can be disabled - When alarm parameters can be changed - Who in the organization has the authority to set alarm parameters - Who in the organization has the authority to change alarm parameters - Who in the organization has the authority to set alarm parameters to “off” - Monitoring and responding to alarm signals - Checking individual alarm signals for accurate settings, proper operation, and detectability (For more information, refer to Standard EC.02.04.03)	Moved and Revised	NPG.01.05.01, EP 2	Establish policies and procedures for managing the alarms identified in NPG.01.05.01, EP 1 that, at a minimum, address the following: - Clinically appropriate settings for alarm signals - When alarm signals can be disabled - When alarm parameters can be changed - Who in the organization has the authority to set alarm parameters - Who in the organization has the authority to change alarm parameters - Who in the organization has the authority to set alarm parameters to “off” - Monitoring and responding to alarm signals - Checking individual alarm signals for accurate settings, proper operation, and detectability.
NPSG.07.01.01, EP 1	Implement a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) and/or the current World Health Organization (WHO) hand hygiene guidelines.	Consolidation of NPSG.07.01.01, EP 1; NPSG.07.01.01, EP 2; NPSG.07.01.01, EP 3	NPG.05.03.01, EP 1	The hospital implements a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) and/or the current World Health Organization (WHO) hand hygiene guidelines. The program sets goals for improving compliance with hand hygiene based on established goals.
NPSG.07.01.01, EP 2	Set goals for improving compliance with hand hygiene guidelines.	Consolidation of NPSG.07.01.01, EP 1; NPSG.07.01.01, EP 2;	NPG.05.03.01, EP 1	The hospital implements a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) and/or the current World Health Organization (WHO) hand hygiene guidelines. The program sets goals for improving compliance with hand hygiene based on established goals.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
		NPSG.07.01.01, EP 3		
NPSG.07.01.01, EP 3	Improve compliance with hand hygiene guidelines based on established goals.	Consolidation of NPSG.07.01.01, EP 1; NPSG.07.01.01, EP 2; NPSG.07.01.01, EP 3	NPG.05.03.01, EP 1	The hospital implements a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) and/or the current World Health Organization (WHO) hand hygiene guidelines. The program sets goals for improving compliance with hand hygiene based on established goals.
NPSG.15.01.01, EP 1	For psychiatric hospitals and psychiatric units in general hospitals: The hospital conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the hospital takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging). For nonpsychiatric units in general hospitals: The organization implements procedures to mitigate the risk of suicide for patients at high risk for suicide, such as one-to-one monitoring, removing objects that pose a risk for self-harm if they can be removed without adversely affecting the patient's medical care, assessing objects brought into a room by visitors, and using safe transportation procedures when moving patients to other parts of the hospital. Note: Nonpsychiatric units in general hospitals do not need to be ligature resistant. Nevertheless, these facilities should routinely assess clinical areas to identify objects that could be used for self-harm and remove those objects, when possible, from the area around a patient who has been identified as high risk for suicide. This information can be used for training staff who monitor high-risk patients (for example, developing checklists to help staff remember which equipment should be removed when possible). CoPs: §482.13(c)(2)	Moved and Revised	NPG.08.01.01, EP 1	For psychiatric hospitals and psychiatric units in general hospitals: The hospital conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the hospital takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging). For nonpsychiatric units in hospitals: The organization implements procedures to mitigate the risk of suicide for patients at high risk for suicide, such as one-to-one monitoring, removing objects that pose a risk for self-harm if they can be removed without adversely affecting the patient's medical care, assessing objects brought into a room by visitors, and using safe transportation procedures when moving patients to other parts of the hospital. Note: Nonpsychiatric units in hospitals do not need to be ligature resistant. Nevertheless, these facilities should routinely assess clinical areas to identify objects that could be used for self-harm and remove those objects, when possible, from the area around a patient who has been identified as high risk for suicide. This information can be used for training staff who monitor high-risk patients (for example, developing checklists to help staff remember which equipment should be removed when possible). CoPs: §482.13(c)(2)
NPSG.15.01.01, EP 2	Screen all patients for suicidal ideation who are being evaluated or treated for behavioral health conditions as their primary reason for care using a validated screening tool. Note: The Joint Commission requires screening for suicidal ideation using a validated tool starting at age 12 and above. CoPs: §482.13(c)(2)	Moved and Revised	NPG.08.01.01, EP 2	The hospital screens all patients for suicidal ideation who are being evaluated or treated for behavioral health conditions as their primary reason for care using a validated screening tool. Note: The Joint Commission requires screening for suicidal ideation using a validated tool starting at age 12 and above. CoPs: §482.13(c)(2)
NPSG.15.01.01, EP 3	Use an evidence-based process to conduct a suicide assessment of patients who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens patients for suicidal ideation and assesses the severity of suicidal ideation. CoPs: §482.13(c)(2)	Moved and Revised	NPG.08.01.01, EP 3	The hospital uses an evidence-based process to conduct a suicide assessment of patients who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens patients for suicidal ideation and assesses the severity of suicidal ideation. CoPs: §482.13(c)(2)
NPSG.15.01.01, EP 4	Document patients' overall level of risk for suicide and the plan to mitigate the risk for suicide.	Moved and Revised	NPG.08.01.01, EP 4	The hospital documents patients' overall level of risk for suicide and the plan to mitigate the risk for suicide.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.13(c)(2)			CoPs: §482.13(c)(2)
NPSG.15.01.01, EP 5	Follow written policies and procedures addressing the care of patients identified as at risk for suicide. At a minimum, these should include the following: - Training and competence assessment of staff who care for patients at risk for suicide - Guidelines for reassessment - Monitoring patients who are at high risk for suicide CoPs: §482.13(c)(2)	Moved and Revised	NPG.08.01.01, EP 5	The hospital follows written policies and procedures addressing the care of patients identified as at risk for suicide. At a minimum, these should include the following: - Training and competence assessment of staff who care for patients at risk for suicide - Guidelines for reassessment - Monitoring patients who are at high risk for suicide CoPs: §482.13(c)(2)
NPSG.15.01.01, EP 6	Follow written policies and procedures for counseling and follow-up care at discharge for patients identified as at risk for suicide.	Moved and Revised	NPG.08.01.01, EP 6	The hospital follows written policies and procedures for counseling and follow-up care at discharge for patients identified as at risk for suicide.
NPSG.15.01.01, EP 7	Monitor implementation and effectiveness of policies and procedures for screening, assessment, and management of patients at risk for suicide and take action as needed to improve compliance. CoPs: §482.13(c)(2)	Moved and Revised	NPG.08.01.01, EP 7	The hospital monitors implementation and effectiveness of policies and procedures for screening, assessment, and management of patients at risk for suicide and takes action as needed to improve compliance. CoPs: §482.13(c)(2)
NPSG.16.01.01, EP 1	The hospital designates an individual(s) to lead activities to improve health care equity for the hospital's patients. Note: Leading the hospital's activities to improve health care equity may be an individual's primary role or part of a broader set of responsibilities.	Moved and Revised	NPG.04.01.01, EP 1	The hospital designates an individual(s) to lead activities to improve health care equity for the hospital's patients. Note: Leading the hospital's activities to improve health care equity may be an individual's primary role or part of a broader set of responsibilities.
NPSG.16.01.01, EP 2	The hospital assesses the patient's health-related social needs (HRSNs) and provides information about community resources and support services. Note 1: Hospitals determine which HRSNs to include in the patient assessment. Examples of a patient's HRSNs may include the following: - Access to transportation - Difficulty paying for prescriptions or medical bills - Education and literacy - Food insecurity - Housing insecurity Note 2: HRSNs may be identified for a representative sample of the hospital's patients or for all the hospital's patients.	Moved and Revised	NPG.04.01.01, EP 2	The hospital assesses the patient's health-related social needs (HRSNs) and provides information about community resources and support services. Note 1: Hospitals determine which HRSNs to include in the patient assessment. Examples of a patient's HRSNs may include the following: - Access to transportation - Difficulty paying for prescriptions or medical bills - Education and literacy - Food insecurity - Housing insecurity Note 2: HRSNs may be identified for a representative sample of the hospital's patients or for all the hospital's patients.
NPSG.16.01.01, EP 3	The hospital identifies health care disparities in its patient population by stratifying quality and safety data using the sociodemographic characteristics of the hospital's patients. Note 1: Hospitals may focus on areas with known health care disparities identified in the scientific literature (for example, organ transplantation, maternal care, diabetes management) or select measures that affect all patients (for example, experience of care and communication). Note 2: Hospitals determine which sociodemographic characteristics to use for stratification analyses. Examples of sociodemographic characteristics may include the following: - Age - Gender - Preferred language - Race and ethnicity	Moved and Revised	NPG.04.01.01, EP 3	The hospital identifies health care disparities in its patient population by stratifying quality and safety data using the sociodemographic characteristics of the hospital's patients. Note 1: Hospitals may focus on areas with known health care disparities identified in the scientific literature (for example, organ transplantation, maternal care, diabetes management) or select measures that affect all patients (for example, experience of care and communication). Note 2: Hospitals determine which sociodemographic characteristics to use for stratification analyses. Examples of sociodemographic characteristics may include the following: - Age - Gender - Preferred language - Race and ethnicity - Veterans - Patients in rural communities - Physical, mental, and cognitive disabilities

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
NPSG.16.01.01, EP 4	The hospital develops a written action plan that describes how it will improve health care equity by addressing at least one of the health care disparities identified in its patient population.	Moved	NPG.04.01.01, EP 4	The hospital develops a written action plan that describes how it will improve health care equity by addressing at least one of the health care disparities identified in its patient population.
NPSG.16.01.01, EP 5	The hospital acts when it does not achieve or sustain the goal(s) in its action plan to improve health care equity.	Moved	NPG.04.01.01, EP 5	The hospital acts when it does not achieve or sustain the goal(s) in its action plan to improve health care equity.
NPSG.16.01.01, EP 6	At least annually, the hospital informs key stakeholders, including leaders, licensed practitioners, and staff, about its progress to improve health care equity.	Moved	NPG.04.01.01, EP 6	At least annually, the hospital informs key stakeholders, including leaders, licensed practitioners, and staff, about its progress to improve health care equity.
NR.01.01.01, EP 1	The nurse executive functions at the senior leadership level to provide effective leadership and to coordinate leaders to deliver nursing care, treatment, and services. CoPs: §482.23(a)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
NR.01.01.01, EP 3	An identified nurse leader, at the executive level, assumes an active leadership role with the hospital's governing body, senior leadership, medical staff, management, and other clinical leaders in the hospital's decision-making structure and process.	Consolidation of NR.01.01.01, EP 3; NR.01.02.01, EP 3	NPG.12.02.01, EP 2	The nurse executive assumes an active leadership role with the hospital's governing body, senior leadership, medical staff, management, and other clinical leaders in the hospital's decision-making structure and process. Note 1: The nurse executive possesses a postgraduate degree in nursing or a related field, the knowledge and skills associated with an advanced degree, or a written plan to obtain these qualifications. Note 2: A related field may include health care administration or business administration.
NR.01.01.01, EP 5	The hospital defines the nurse executive's authority and responsibility in a written contract, written agreement, letter, memorandum, job or position description, or other document. CoPs: §482.23(a)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
NR.01.02.01, EP 2	The nurse executive is currently licensed as a registered professional nurse in the state in which they practice, in accordance with law and regulation. CoPs: §482.23(a)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
NR.01.02.01, EP 3	The nurse executive possesses a postgraduate degree in nursing or a related field; or the knowledge and skills associated with an advanced degree; or a written plan to obtain these qualifications. Note: A related field may include health care administration or business administration.	Consolidation of NR.01.01.01, EP 3; NR.01.02.01, EP 3	NPG.12.02.01, EP 2	The nurse executive assumes an active leadership role with the hospital's governing body, senior leadership, medical staff, management, and other clinical leaders in the hospital's decision-making structure and process. Note 1: The nurse executive possesses a postgraduate degree in nursing or a related field, the knowledge and skills associated with an advanced degree, or a written plan to obtain these qualifications. Note 2: A related field may include health care administration or business administration.
NR.02.01.01, EP 2	The nurse executive coordinates the following: - The development of hospitalwide programs, policies, and procedures that address how nursing care needs of the patient population are assessed, met, and evaluated. Note: Examples of patient populations include pediatric, diabetic, and geriatric patients. - The development of an effective, ongoing program to measure, analyze, and improve the quality of nursing care, treatment, and services. CoPs: §482.23(a), §482.23(b)(3), §482.23(b)(5)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
NR.02.01.01, EP 4	The nurse executive directs the following: - The implementation of hospitalwide plans to provide nursing care, treatment, and services. - The implementation of hospitalwide programs, policies, and procedures that address how nursing care needs of the patient population are assessed, met, and evaluated. Note: Examples of patient populations include pediatric, diabetic, and geriatric patients. - The implementation of an effective, ongoing program to measure, analyze, and improve the quality of nursing care, treatment, and services. CoPs: §482.23(a), §482.23(b)(3), §482.23(b)(5), §482.23(b)(6)	Consolidation of NR.02.01.01, EP 4; NR.02.03.01, EP 3	NR.11.01.01, EP 2	All licensed nurses who provide services in the hospital adhere to its policies and procedures. Note: This applies to all nursing staff providing services (that is, hospital employee, contract, lease, other agreement, or volunteer). CoPs: §482.23(b)(6)
NR.02.02.01, EP 1	The nurse executive, registered nurses, and other designated nursing staff write and approve the following before implementation: - Standards of nursing practice for the hospital - Nursing standards of patient care, treatment, and services - Nursing policies and procedures - Nurse staffing plan(s) CoPs: §482.23(b)	Moved and Revised	NPG.12.02.01, EP 1	The nurse executive, who is a licensed registered nurse, is responsible for the operation of nursing services, including determining the following: - Nursing policies and procedures - Types and numbers of nursing and other staff necessary to provide nursing care for all areas of the hospital CoPs: §482.23(a)
NR.02.03.01, EP 2	The nurse executive implements nursing policies, procedures, and standards that describe and guide how the staff provide nursing care, treatment, and services. CoPs: §482.23(a), §482.23(b)(4), §482.23(b)(5), §482.23(b)(6)	Moved and Revised	NR.11.01.01, EP 3	The nurse executive provides for the supervision and evaluation of the clinical activities of all nursing staff in accordance with nursing policies and procedures. Note: This applies to all nursing staff who are providing services (that is, hospital employee, contract, lease, other agreement, or volunteer). CoPs: §482.23(b)(6)
NR.02.03.01, EP 3	The nurse executive provides access to all nursing policies, procedures, and standards to the nursing staff. CoPs: §482.23(a), §482.23(b)(6)	Consolidation of NR.02.01.01, EP 4; NR.02.03.01, EP 3	NR.11.01.01, EP 2	All licensed nurses who provide services in the hospital adhere to its policies and procedures. Note: This applies to all nursing staff providing services (that is, hospital employee, contract, lease, other agreement, or volunteer). CoPs: §482.23(b)(6)
NR.02.03.01, EP 4	The nurse executive is responsible for the provision of nursing services 24 hours a day, 7 days a week. CoPs: §482.23, §482.23(a), §482.23(b), §482.23(b)(1), §482.23(b)(3), §482.62(d)(2)	Split to LD.13.03.01, EP 2; NPG.12.02.01, EP 5	LD.13.03.01, EP 2	The hospital has an organized nursing service, with a plan of administrative authority and delineation of responsibility for patient care, that provides 24-hour nursing services. Note: For hospitals that use The Joint Commission for deemed-status purposes: Rural hospitals with a 24-hour nursing waiver granted under 42 CFR 488.54(c) are not required to have 24-hour nursing services. CoPs: §482.23, §482.23(a), §482.23(b)(1)
NR.02.03.01, EP 4	The nurse executive is responsible for the provision of nursing services 24 hours a day, 7 days a week. CoPs: §482.23, §482.23(a), §482.23(b), §482.23(b)(1), §482.23(b)(3), §482.62(d)(2)	Split to LD.13.03.01, EP 2; NPG.12.02.01, EP 5	NPG.12.02.01, EP 5	There must be an adequate number of licensed registered nurses, licensed practical (vocational) nurses, and other staff to provide nursing care to all patients, as needed. Note: There are supervisors and staff for each department or nursing unit to make certain a registered nurse is immediate availability for the care of any patient. CoPs: §482.23(b)
NR.02.03.01, EP 6	The nurse executive or designee exercises final authority over staff who provide nursing care, treatment, and services.	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.23(a)	moved to guidance within SPG		
NR.02.03.01, EP 7	A registered nurse provides or supervises the nursing services 24 hours a day, 7 days a week. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: A registered nurse is immediately available for the provision of care of any patient. CoPs: §482.23, §482.23(b), §482.23(b)(1), §482.23(b)(3), §482.62(d)(2)	Moved and Revised	NPG.12.02.01, EP 4	A registered nurse directly provides or supervises the nursing services provided by other staff to patients 24 hours a day, 7 days a week. The hospital has a licensed practical nurse or registered nurse on duty at all times. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: A registered nurse is immediately available for the provision of care of any patient. Note 2: For hospitals that use The Joint Commission for deemed-status purposes: Rural hospitals with a 24-hour nursing waiver granted under 42 CFR 488.54(c) are not required to have 24-hour nursing services. CoPs: §482.23, §482.23(b)(1)
NR.02.03.01, EP 8	For hospitals that use Joint Commission accreditation for deemed status purposes: A registered nurse assigns the nursing care for each patient to other nursing personnel in accordance with the patient's needs and the qualifications and competence of the nursing staff available. CoPs: §482.23(b)(5)	Moved and Revised	NR.11.01.01, EP 1	A registered nurse assigns the nursing care for each patient to other nursing staff in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. CoPs: §482.23(b)(5)
NR.02.03.01, EP 9	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has policies and procedures that establish which outpatient departments, if any, are not required to have a registered nurse present. The policies and procedures are as follows: - Establish criteria that such outpatient departments need to meet, taking into account the types of services delivered, the general level of acuity of patients served by the department, and established standards of practice for the services delivered - Describe alternative staffing plans - Approved by the director of nursing - Reviewed at least once every three years CoPs: §482.23(b)(7), §482.23(b)(7)(i), §482.23(b)(7)(ii), §482.23(b)(7)(iii), §482.23(b)(7)(iv)	Moved and Revised	NPG.12.02.01, EP 7	The hospital has policies and procedures that establish which outpatient departments, if any, are not required to have a registered nurse present. The policies and procedures meet the following requirements: - Establish criteria that such outpatient departments need to meet, taking into account the types of services delivered, the general level of acuity of patients served by the department, and established standards of practice for the services delivered - Describe alternative staffing plans - Are approved by the director of nursing - Are reviewed at least once every three years CoPs: §482.23(b)(7), §482.23(b)(7)(i), §482.23(b)(7)(ii), §482.23(b)(7)(iii), §482.23(b)(7)(iv)
PC.01.01.01, EP 2	The hospital follows a written process for accepting a patient that addresses the following: - Criteria to determine the patient's eligibility for care, treatment, and services - Procedures for accepting referrals	Moved and Revised	PC.11.01.01, EP 1	The hospital develops and implements a written process for accepting a patient that addresses admission criteria and procedures for accepting referrals.
PC.01.01.01, EP 6	Administrative and clinical decisions are coordinated for patients under legal or correctional restrictions on the following: - The use of seclusion and restraint for nonclinical purposes - The imposition of disciplinary restrictions - The restriction of rights - The plan for discharge and continuing care, treatment, and services - The length of stay	Moved and Revised	NPG.11.01.01, EP 4	The hospital coordinates administrative and clinical decisions for patients under legal or correctional restrictions on the following: - Use of seclusion and restraint for nonclinical purposes - Imposition of disciplinary restrictions - Restriction of rights - Plan for discharge and continuing care, treatment, and services - Length of stay
PC.01.02.01, EP 1	The hospital defines, in writing, the scope and content of screening, assessment, and reassessment. Patient information is collected according to these requirements. Note 1: In defining the scope and content of the information it collects, the organization may want to consider information that it can obtain, with the patient's consent, from the patient's family and the patient's other care providers, as well as information conveyed on any medical jewelry.	Moved and Revised	PC.11.02.01, EP 9	The hospital defines, in writing, the scope and content of screening, assessment, and reassessment. Patient information is collected according to these requirements. Note 1: In defining the scope and content of the information it collects, the hospital may want to consider information that it can obtain, with the patient's consent, from the patient's family and the patient's other care providers, as well as information conveyed on any medical jewelry.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	Note 2: Assessment and reassessment information includes the patient's perception of the effectiveness of, and any side effects related to, their medication(s).			Note 2: Assessment and reassessment information includes the patient's perception of the effectiveness of, and any side effects related to, their medication(s).
PC.01.02.01, EP 2	The hospital defines, in writing, criteria that identify when additional, specialized, or more in-depth assessments are performed. Note: Examples of criteria could include those that identify when a nutritional, functional, or pain assessment should be performed for patients who are at risk.	Moved and Revised	PC.11.02.01, EP 10	The hospital defines, in writing, criteria that identify when additional, specialized, or more in-depth assessments are performed. Note: Examples may include criteria that identify when a nutritional, functional, or pain assessment should be performed.
PC.01.02.01, EP 3	The hospital has defined criteria that identify when nutritional plans are developed. CoPs: §482.28(b)(1)	Consolidation of PC.01.02.01, EP 3; RC.02.04.01, EP 3	RC.12.03.01, EP 5	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: When the hospital anticipates the discharge of a resident, the discharge summary includes but is not limited to the following: - A summary of the resident's stay that includes at a minimum the resident's diagnosis, course of illness/treatment or therapy, and pertinent laboratory, radiology, and consultation results - A final summary of the resident's status to include items in 42 CFR 483.20 (b)(1) at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. - Reconciliation of all predischarge medications with the resident's postdischarge medications (both prescribed and over-the-counter). - A postdischarge plan of care, which will assist the resident to adjust to his or her new living environment, that is developed with the participation of the resident and, with the resident's consent, the resident representative(s). The postdischarge plan of care indicates where the individual plans to reside, any arrangements that have been made for the resident's follow up care, and any postdischarge medical and nonmedical services CoPs: §482.58(b)(5), §483.21(c)(2)(i), §483.21(c)(2)(ii), §483.21(c)(2)(iii), §483.21(c)(2)(iv)
PC.01.02.01, EP 14	For hospitals that provide obstetric services: Upon admission to labor and delivery, the mother's status of the following diseases (during the current pregnancy) is documented in the mother's medical record: - Human immunodeficiency virus (HIV) - Hepatitis B - Group B Streptococcus (GBS) - Syphilis	Deleted	N/A	N/A
PC.01.02.01, EP 15	For hospitals that provide obstetric services: If the mother had no prenatal care or the disease status is unknown, testing for the following diseases is performed and the results documented in the mother's medical record: - Human immunodeficiency virus (HIV) - Hepatitis B - Group B Streptococcus (GBS) - Syphilis Note: Because GBS test results may not be available for 24–48 hours, hospitals may consider the administration of prophylactic antibiotics to the mother based on CDC guidelines: Prevention of Perinatal Group B Streptococcal Disease https://www.cdc.gov/mmwr/pdf/rr/rr5910.pdf	Deleted	N/A	N/A
PC.01.02.01, EP 16	For hospitals that provide obstetric services: If the mother tests positive for human immunodeficiency virus (HIV), hepatitis B, group B Streptococcus (GBS), or syphilis when tested in labor and delivery or during the current pregnancy, that information is also documented in the newborn's medical record after delivery.	Deleted	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
PC.01.02.01, EP 53	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes the following: - Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into the resident's assessment, care planning, and transitions of care - Referring all level II residents and all residents with newly evident or possibly serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment CoPs: §482.58(b)(5)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.01.02.03, EP 1	The hospital conducts the patient's initial assessment in accordance with written time frames it defines and law and regulation.	Moved and Revised	PC.11.02.01, EP 1	The hospital conducts the patient's initial assessment within the written time frames it defines and in accordance with law and regulation.
PC.01.02.03, EP 3	Each patient is reassessed as necessary based on their plan for care or changes in their condition. Note: Reassessments may also be based on the patient's diagnosis; desire for care, treatment, and services; response to previous care, treatment, and services; discharge planning needs; and/or their setting requirements. CoPs: §482.23(b)(4), §482.43(a)(6)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.01.02.03, EP 4	The patient receives a medical history and physical examination no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: Medical histories and physical examinations are performed as required in this element of performance, except any specific outpatient surgical or procedural services for which an assessment is performed instead. Note 2: For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text. CoPs: §482.22(c)(5)(i), §482.22(c)(5)(ii), §482.24(c)(4)(i)(A), §482.51(b)(1)(i), §482.61(a)(5), §482.61(b)(2)	Moved and Revised	PC.11.02.01, EP 2	A medical history and physical examination is completed and documented no more than 30 days prior to, or within 24 hours after, registration or inpatient admission but prior to surgery or a procedure requiring anesthesia services. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: Medical histories and physical examinations are performed as required in this element of performance, except prior to any specific outpatient surgical or procedural services for which an assessment is performed instead as provided under 42 CFR 482.24(c)(4)(i)(C). Note 2: For law and regulation guidance pertaining to the medical history and physical examination at 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii), refer to https://www.ecfr.gov/. CoPs: §482.24(c)(4)(i)(A), §482.51(b)(1)(i)
PC.01.02.03, EP 5	For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: Medical histories and physical examinations are performed as required in this element of performance, except any specific outpatient surgical or procedural services for which an assessment is performed instead. Note 2: For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text. CoPs: §482.22(c)(5)(i), §482.22(c)(5)(ii), §482.24(c)(4)(i)(B), §482.51(b)(1)(ii), §482.61(a)(5), §482.61(b)(2)	Moved and Revised	PC.11.02.01, EP 3	For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: Medical histories and physical examinations are performed as required in this element of performance, except prior to any specific outpatient surgical or procedural services for which an assessment is performed instead as provided under 42 CFR 482.24(c)(4)(i)(C). Note 2: For law and regulation guidance pertaining to the medical history and physical examination at 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii), refer to https://www.ecfr.gov/. CoPs: §482.24(c)(4)(i)(B), §482.51(b)(1)(ii)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
PC.01.02.03, EP 6	A registered nurse completes a nursing assessment within 24 hours after the patient's inpatient admission. CoPs: §482.23(b)(3), §482.23(b)(4)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.01.02.03, EP 7	For hospitals that use Joint Commission accreditation for deemed status purposes: When the medical staff has chosen to allow an assessment (in lieu of a comprehensive medical history and physical examination) for patients receiving specific outpatient surgical or procedural services, the assessment of the patient is completed and documented after registration but prior to surgery or a procedure requiring anesthesia services when the patient is receiving specific outpatient surgical or procedural services. (For more information, refer to Standard MS.03.01.01) Note: For further regulatory guidance, refer to 42 CFR 482.24(c)(4)(i)(A) and (B), 482.51(b)(1)(i) and (ii), and 482.22(c)(5)(v). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text. CoPs: §482.24(c)(4)(i)(A), §482.24(c)(4)(i)(B), §482.24(c)(4)(i)(C), §482.51(b)(1)(iii)	Moved and Revised	PC.11.02.01, EP 4	When the medical staff allows an assessment (in lieu of a comprehensive medical history and physical examination) for patients receiving specific outpatient surgical or procedural services, the patient assessment is completed and documented after registration but prior to the surgery or procedure requiring anesthesia services. Note: For further regulatory guidance at 42 CFR 482.24(c)(4)(i)(A) and (B), 482.51(b)(1)(i) and (ii), and 482.22(c)(5)(v), refer to https://www.ecfr.gov/. CoPs: §482.51(b)(1)(iii)
PC.01.02.05, EP 1	Based on the initial assessment, a registered nurse determines the patient's need for nursing care, as required by hospital policy and law and regulation. CoPs: §482.23(b)(3), §482.23(b)(4)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.01.02.07, EP 1	The hospital has defined criteria to screen, assess, and reassess pain that are consistent with the patient's age, condition, and ability to understand.	Moved and Revised	NPG.06.02.01, EP 7	The hospital reassesses and responds to the patient's pain through the following: - Evaluation and documentation of response(s) to pain intervention(s) - Progress toward pain management goals, including functional ability (for example, ability to take a deep breath, turn in bed, walk with improved pain control) - Side effects of treatment - Risk factors for adverse events caused by the treatment
PC.01.02.07, EP 2	The hospital screens patients for pain during emergency department visits and at the time of admission.	Moved and Revised	NPG.06.02.01, EP 1	The hospital has defined criteria to screen, assess, and reassess pain that are consistent with the patient's age, condition, and ability to understand.
PC.01.02.07, EP 3	The hospital treats the patient's pain or refers the patient for treatment. Note: Treatment strategies for pain may include nonpharmacologic, pharmacologic, or a combination of approaches.	Moved and Revised	NPG.06.02.01, EP 8	The hospital educates the patient and family on discharge plans related to pain management, including the following: - Pain management plan of care - Side effects of pain management treatment - Daily living activities, including the home environment, that might exacerbate pain or reduce effectiveness of the pain management plan of care and strategies to address these issues - Safe use, storage, and disposal of opioids when prescribed
PC.01.02.07, EP 4	The hospital develops a pain treatment plan based on evidence-based practices and the patient's clinical condition, past medical history, and pain management goals.	Moved and Revised	NPG.06.02.01, EP 3	The hospital treats the patient's pain or refers the patient for treatment. Note: Treatment strategies for pain may include nonpharmacologic, pharmacologic, or a combination of approaches.
PC.01.02.07, EP 5	The hospital involves patients in the pain management treatment planning process through the following: - Developing realistic expectations and measurable goals that are understood by the patient for the degree, duration, and reduction of pain - Discussing the objectives used to evaluate treatment progress (for example, relief of pain and improved physical and psychosocial function)	Moved and Revised	NPG.06.02.01, EP 2	The hospital screens patients for pain during emergency department visits and at the time of admission.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	- Providing education on pain management, treatment options, and safe use of opioid and non-opioid medications when prescribed			
PC.01.02.07, EP 6	The hospital monitors patients identified as being high risk for adverse outcomes related to opioid treatment.	Moved and Revised	NPG.06.02.01, EP 4	The hospital develops a pain treatment plan based on evidence-based practices and the patient's clinical condition, past medical history, and pain management goals.
PC.01.02.07, EP 7	The hospital reassesses and responds to the patient's pain through the following: - Evaluation and documentation of response(s) to pain intervention(s) - Progress toward pain management goals including functional ability (for example, ability to take a deep breath, turn in bed, walk with improved pain control) - Side effects of treatment - Risk factors for adverse events caused by the treatment	Moved and Revised	NPG.06.02.01, EP 5	The hospital involves the patient in the pain management treatment planning process through the following: - Developing realistic expectations and measurable goals that the patient understands for the degree, duration, and reduction of pain - Discussing the objectives used to evaluate treatment progress (for example, relief of pain and improved physical and psychosocial function) - Providing education on pain management, treatment options, and safe use of opioid and nonopioid medications when prescribed
PC.01.02.07, EP 8	The hospital educates the patient and family on discharge plans related to pain management including the following: - Pain management plan of care - Side effects of pain management treatment - Activities of daily living, including the home environment, that might exacerbate pain or reduce effectiveness of the pain management plan of care, as well as strategies to address these issues - Safe use, storage, and disposal of opioids when prescribed	Moved and Revised	NPG.06.02.01, EP 6	The hospital monitors patients identified as being high risk for adverse outcomes related to opioid treatment.
PC.01.02.08, EP 1	The hospital implements fall risk reduction interventions based on the patient population, setting, and individual patient's assessed risks.	Moved	NPG.11.02.01, EP 1	The hospital implements fall risk reduction interventions based on the patient population, setting, and individual patient's assessed risks.
PC.01.02.09, EP 1	The hospital uses written criteria to identify those patients who may be victims of physical assault, sexual assault, sexual molestation, domestic abuse, or elder or child abuse and neglect. Patients are evaluated upon entry into the hospital and on an ongoing basis. Note: Criteria can be based on age, sex, and circumstance.	Moved and Revised	NPG.07.03.01, EP 1	The hospital uses written criteria to identify those patients who may be victims of physical assault, sexual assault, sexual molestation, domestic abuse, elder or child abuse, neglect, and exploitation. Patients are evaluated upon entry into the hospital and on an ongoing basis. Note: Criteria can be based on age, sex, and circumstance.
PC.01.02.09, EP 2	To assist with referrals of possible victims of abuse and neglect, the hospital maintains a list of private and public community agencies that can provide or arrange for assessment and care.	Moved and Revised	NPG.07.03.01, EP 2	To assist with referrals of possible victims of abuse, neglect, and exploitation, the hospital maintains a list of private and public community agencies that can provide or arrange for assessment and care.
PC.01.02.09, EP 3	The hospital educates staff about how to recognize signs of possible abuse and neglect and about their roles in follow-up.	Moved and Revised	NPG.07.03.01, EP 3	The hospital educates staff about how to recognize signs of possible abuse, neglect, and exploitation and about their roles in follow-up.
PC.01.02.09, EP 6	The hospital internally reports cases of possible abuse and neglect.	Moved and Revised	NPG.07.03.01, EP 4	The hospital internally reports cases of possible abuse, neglect, and exploitation.
PC.01.02.09, EP 7	The hospital reports cases of possible abuse and neglect to external agencies, in accordance with law and regulation. CoPs: §482.58(b)(3), §483.12(c)(1)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.01.02.09, EP 8	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital reports to the state nurse aide registry or licensing authorities any knowledge it has of any actions taken by a court of law against an employee that would indicate unfitness for service as a nurse aide or other facility staff. CoPs: §482.58(b)(3), §483.12(a)(4), §483.12(c)(1)	Moved	RI.13.01.01, EP 2	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital reports to the state nurse aide registry or licensing authorities any knowledge it has of any actions taken by a court of law against an employee that would indicate unfitness for service as a nurse aide or other facility staff. CoPs: §482.58(b)(3), §483.12(a)(4)
PC.01.02.11, EP 1	Patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders receive an assessment that includes the following: - The patient's history of each substance use, including age of onset, duration, intensity, patterns of use, consequences of use, types of previous treatments, and	Moved and Revised	PC.11.02.05, EP 1	Patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders receive an assessment that includes the following: - History of each substance use, including age of onset, duration, intensity, patterns of use, consequences of use, types of previous treatments, and responses to such

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	responses to such treatment - A history of the patient's mental, emotional, and behavioral problems; their co-occurrence with substance use disorders; and their treatment - A history of the patient's biomedical complications associated with substance use disorders and the patient's level of awareness of the relationships between their behavioral conditions and pattern of substance use			treatment - History of mental, emotional, and behavioral problems; their co-occurrence with substance use disorders; and their treatment - History of biomedical complications associated with substance use disorders and the patient's level of awareness of the relationships between their behavioral conditions and pattern of substance use
PC.01.02.11, EP 4	Based on the patient's age and needs, the assessment for patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders includes the following: - The patient's acceptance of treatment or motivation for change, as well as recovery environment features that serve as resources or obstacles to recovery, including family members' use of alcohol or other substances - The patient's family circumstances, including the composition of the family group and the need for their participation in the patient's care	Moved and Revised	PC.11.02.05, EP 2	Based on the patient's age and needs, the assessment for patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders includes the following: - Acceptance of treatment or motivation for change, as well as recovery environment features that serve as resources or obstacles to recovery, including family members' use of alcohol or other substances - Family circumstances, including the composition of the family group and the need for their participation in the patient's care
PC.01.02.11, EP 5	Based on the patient's age and needs, the assessment for patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders includes the following: - The patient's religion and spiritual beliefs, values, and preferences - Living situation - Leisure and recreational activities - Military service history - Peer-group - Social factors - Ethnic and cultural factors - Financial status - Vocational or educational background - Legal history - Communication skills	Moved and Revised	PC.11.02.05, EP 3	Based on the patient's age and needs, the assessment for patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders includes the following: - Religion and spiritual beliefs, values, and preferences - Living situation - Leisure and recreational activities - Military service history - Peer-group - Social factors - Ethnic and cultural factors - Financial status - Vocational or educational background - Legal history - Communication skills
PC.01.02.11, EP 6	Based on the patient's age and needs, the assessment for patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders includes the following: - The patient's history of any physical or sexual abuse, as either the abuser or the abused - The patient's sexual history and identification - Childhood history - Emotional and health issues - Visual-motor functioning - Self care	Moved and Revised	PC.11.02.05, EP 4	Based on the patient's age and needs, the assessment for patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders includes the following: - History of any physical or sexual abuse, as either the abuser or the abused - Sexual history and identification - Childhood history - Emotional and health issues - Visual-motor functioning - Self care
PC.01.02.13, EP 1	Patients who receive treatment for emotional and behavioral disorders receive an assessment that includes a history of mental, emotional, behavioral, and substance use problems, their co-occurrence, and their treatment. CoPs: §482.61(a), §482.61(b)(4), §482.61(b)(5)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.01.02.13, EP 2	Patients who receive treatment for emotional and behavioral disorders receive an assessment that includes the following: - Current mental, emotional, and behavioral functioning - Maladaptive or other behaviors that create a risk to the patient or others - Mental status examination - For psychiatric hospitals that use Joint Commission accreditation for deemed	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	status purposes: Reason for admission as stated by the patient and/or others significantly involved in the patient's care - For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Onset of the patient's illness and circumstances leading to admission - For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Inventory of the patient's strengths and disabilities (such as psychiatric, biopsychosocial problems requiring treatment/intervention) written in a descriptive manner on which to base a treatment plan CoPs: §482.61(a), §482.61(a)(3), §482.61(b)(3), §482.61(b)(4), §482.61(b)(5), §482.61(b)(6), §482.61(b)(7)			
PC.01.02.13, EP 3	Based on the patient's age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following: - The patient's religion and spiritual beliefs, values, and preferences - Living situation - Leisure and recreational activities - Military service history - Peer group - Social factors - Ethnic and cultural factors - Financial status - Vocational or educational background - Legal history - Communication skills CoPs: §482.61(a)(4), §482.61(b)(7)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.01.02.13, EP 4	Based on the patient's age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following: - Any history of physical or sexual abuse as either the abuser or abused - The patient's sexual history - Childhood history - Emotional and health care issues - Visual-motor functioning - Self care CoPs: §482.61(a)(4), §482.61(b)(7)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.01.02.13, EP 5	Based on the patient's age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following: - The patient's family circumstances, including the composition of the family group - The community resources currently used by the patient - The need for the family members' participation in the patient's care - For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: A social history and reports of interviews with patients, family members, and others CoPs: §482.61(a)(4), §482.61(b)(7)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.01.02.13, EP 6	Based on the patient's age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following:	Moved and Revised	PC.11.02.03, EP 1	The assessment for patients who receive treatment for emotional and behavioral disorders includes the following, based on their age and needs:

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	- A psychiatric evaluation - Psychological assessments, including intellectual, projective, neuropsychological, and personality testing - For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Complete neurological examination at the time of the admission physical examination, when indicated (For more information on physical examination, see PC.01.02.03, EP 4) CoPs: §482.61(a)(5), §482.61(b)(6), §482.61(b)(7)			- Psychiatric evaluation - Psychological assessments, including intellectual, projective, neuropsychological, and personality testing - For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Complete neurological examination at the time of the admission physical examination, when indicated (For more information on physical examination, see PC.11.02.01, EP 2) CoPs: §482.61(a)(5)
PC.01.02.13, EP 7	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Each patient receives a psychiatric evaluation completed within 60 hours of admission. CoPs: §482.61(b)(1)	Moved and Revised	PC.11.02.03, EP 2	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Each patient receives a psychiatric evaluation completed within 60 hours of admission. The psychiatric evaluation includes the following: - Medical history - Record of mental status - Description of the onset of illness and the circumstances leading to admission - Description of attitudes and behavior - Estimation of intellectual functioning, memory functioning, and orientation - Inventory of the patient's assets in descriptive, not interpretative, fashion CoPs: §482.61(b), §482.61(b)(1), §482.61(b)(2), §482.61(b)(3), §482.61(b)(4), §482.61(b)(5), §482.61(b)(6), §482.61(b)(7)
PC.01.02.15, EP 2	Diagnostic testing and procedures are performed as ordered within time frames defined by the hospital. CoPs: §482.62(a)(1)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.01.02.15, EP 5	The hospital documents the radiation dose index (computed tomography dose index [CTDIvol], dose length product [DLP], or size-specific dose estimate [SSDE]) on every study produced during a diagnostic computed tomography (CT) examination. The radiation dose index must be exam specific, summarized by series or anatomic area, and documented in a retrievable format. Note 1: This element of performance is only applicable for systems capable of calculating and displaying radiation dose indices. Note 2: This element of performance does not apply to systems used for therapeutic radiation treatment planning or delivery, or for calculating attenuation coefficients for nuclear medicine studies. Note 3: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. Note 4: While the CTDIvol, DLP, and SSDE are useful indicators for monitoring radiation dose indices from the CT machine, they do not represent the patient's radiation dose.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.01.02.15, EP 10	For hospitals that provide diagnostic computed tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), or nuclear medicine (NM) services: Prior to conducting a diagnostic imaging study, the hospital verifies the following: - Correct patient - Correct imaging site - Correct patient positioning	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	- For CT only: Correct imaging protocol - For CT only: Correct scanner parameters Note: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.			
PC.01.02.15, EP 12	For hospitals that provide diagnostic computed tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), or nuclear medicine (NM) services: The hospital considers the patient's age and recent imaging exams when deciding on the most appropriate type of imaging exam. Note 1: Knowledge of a patient's recent imaging exams can help to prevent unnecessary duplication of these examinations. Note 2: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.01.02.15, EP 13	For hospitals that provide fluoroscopic services: The cumulative-air kerma or kerma-area product is documented in a retrievable format. For fluoroscopy equipment that cannot display or provide cumulative-air kerma or kerma-area product, fluoroscopy time and number of images acquired are documented in a retrievable format, such as a picture archiving and communication system. Note: This element of performance does not apply to fluoroscopy equipment used for therapeutic radiation treatment planning or delivery or fluoroscopy equipment classified as a mini C-arm.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.01.03.01, EP 1	The hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. CoPs: §482.23(b)(4), §482.28(b)(1), §482.58(b)(6), §482.61(c)(1), §482.61(c)(1)(ii), §482.62, §482.62(a)(1), §482.62(a)(2), §482.62(a)(3), §482.62(a)(4), §483.65(b)	Consolidation of PC.01.03.01, EP 1; PC.01.03.01, EP 5; PC.01.03.01, EP 22; PC.01.03.01, EP 23	PC.11.03.01, EP 1	The hospital develops, implements, and revises a written individualized plan of care based on the following: - Needs identified by the patient's assessment, reassessment, and results of diagnostic testing - The patient's goals and the time frames, settings, and services required to meet those goals Note 1: Nursing staff develops and keeps current a nursing plan of care plan, which may be a part of an interdisciplinary plan of care, for each patient. Note 2: The hospital evaluates the patient's progress and revises the plan of care based on the patient's progress. Note 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The patient's goals include both short- and long-term goals. CoPs: §482.23(b)(4)
PC.01.03.01, EP 5	The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals. Note: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The patient's goals include both short- and long-term goals. CoPs: §482.23(b)(4), §482.61(c)(1), §482.61(c)(1)(ii), §482.62, §482.62(a)(1), §482.62(a)(2), §482.62(a)(3), §482.62(a)(4)	Consolidation of PC.01.03.01, EP 1; PC.01.03.01, EP 5; PC.01.03.01, EP 22; PC.01.03.01, EP 23	PC.11.03.01, EP 1	The hospital develops, implements, and revises a written individualized plan of care based on the following: - Needs identified by the patient's assessment, reassessment, and results of diagnostic testing - The patient's goals and the time frames, settings, and services required to meet those goals Note 1: Nursing staff develops and keeps current a nursing plan of care plan, which may be a part of an interdisciplinary plan of care, for each patient. Note 2: The hospital evaluates the patient's progress and revises the plan of care based on the patient's progress. Note 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The patient's goals include both short- and long-term

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
				goals. CoPs: §482.23(b)(4)
PC.01.03.01, EP 6	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The written plan of care includes the following: - A substantiated diagnosis (The substantiated diagnosis is the diagnosis identified by the treatment team to be the primary focus upon which treatment planning will be based. It evolves from the synthesis of data from various disciplines. The substantiated diagnosis may be the same as the initial diagnosis or it may differ, based on new information and assessment.) - Documentation to justify the diagnosis and the treatment and rehabilitation activities carried out - Documentation that demonstrates all active therapeutic efforts are included - The specific treatment modalities used to treat the patient CoPs: §482.61(c)(1)(i), §482.61(c)(1)(iii), §482.61(c)(1)(v), §482.61(c)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.01.03.01, EP 22	Based on the goals established in the patient's plan of care, staff evaluate the patient's progress. CoPs: §482.43(a)(6), §482.61(d), §482.62, §482.62(a)(1), §482.62(a)(2), §482.62(a)(3), §482.62(a)(4)	Consolidation of PC.01.03.01, EP 1; PC.01.03.01, EP 5; PC.01.03.01, EP 22; PC.01.03.01, EP 23	PC.11.03.01, EP 1	The hospital develops, implements, and revises a written individualized plan of care based on the following: - Needs identified by the patient's assessment, reassessment, and results of diagnostic testing - The patient's goals and the time frames, settings, and services required to meet those goals Note 1: Nursing staff develops and keeps current a nursing plan of care plan, which may be a part of an interdisciplinary plan of care, for each patient. Note 2: The hospital evaluates the patient's progress and revises the plan of care based on the patient's progress. Note 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The patient's goals include both short- and long-term goals. CoPs: §482.23(b)(4)
PC.01.03.01, EP 23	The hospital revises plans and goals for care, treatment, and services based on the patient's needs. CoPs: §482.23(b)(4), §482.43(a)(6), §482.61(d), §482.61(c)(1), §482.62, §482.62(a)(1), §482.62(a)(2), §482.62(a)(3), §482.62(a)(4)	Consolidation of PC.01.03.01, EP 1; PC.01.03.01, EP 5; PC.01.03.01, EP 22; PC.01.03.01, EP 23	PC.11.03.01, EP 1	The hospital develops, implements, and revises a written individualized plan of care based on the following: - Needs identified by the patient's assessment, reassessment, and results of diagnostic testing - The patient's goals and the time frames, settings, and services required to meet those goals Note 1: Nursing staff develops and keeps current a nursing plan of care plan, which may be a part of an interdisciplinary plan of care, for each patient. Note 2: The hospital evaluates the patient's progress and revises the plan of care based on the patient's progress. Note 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The patient's goals include both short- and long-term goals. CoPs: §482.23(b)(4)
PC.01.03.01, EP 25	The hospital establishes or adopts diagnostic computed tomography (CT) imaging protocols based on current standards of practice, which address key criteria including the following:	Moved and Revised	NPG.13.02.01, EP 3	The hospital establishes or adopts diagnostic computed tomography (CT) imaging protocols based on current standards of practice, which address key criteria including the following:

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	- Clinical indication - Contrast administration - Age (to indicate whether the patient is pediatric or an adult) - Patient size and body habitus - Expected radiation dose index range Note: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.			- Clinical indication - Contrast administration - Age (to indicate whether the patient is pediatric or an adult) - Patient size and body habitus - Expected radiation dose index range Note: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.
PC.01.03.01, EP 26	Diagnostic computed tomography (CT) imaging protocols are reviewed and kept current with input from an interpreting physician, medical physicist, and lead imaging technologist to make certain that they adhere to current standards of practice and account for changes in CT imaging equipment. These reviews are conducted at time frames identified by the hospital. (For hospitals that use Joint Commission accreditation for deemed status purposes, refer to MS.06.01.03, EP 9 for supervision of radiologic services) Note: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.	Moved and Revised	NPG.13.02.01, EP 4	Diagnostic computed tomography (CT) imaging protocols are reviewed and kept current with input from an interpreting physician, medical physicist, and lead imaging technologist to make certain that they adhere to current standards of practice and account for changes in CT imaging equipment. These reviews are conducted at time frames identified by the hospital. (For rehabilitation and psychiatric distinct part units in hospitals, refer to MS.17.01.03, EP 5 for supervision of radiologic services) Note: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.
PC.01.03.01, EP 43	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The plan of care includes the responsibilities of each member of the treatment team. CoPs: §482.61(c)(1)(iv)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.01.03.01, EP 44	For hospitals that elect The Joint Commission Primary Care Medical Home option: Patient self-management goals are developed in partnership with patients, based on criteria established by the organization, and incorporated into the patient's treatment plan. Note: Examples of criteria include the patient's disease process or condition and specific patient populations, such as those with multiple comorbidities or a chronic disease. It is not expected that self-management goals be developed for every patient. (Refer to RI.01.02.01, EP 1)	Moved and Revised	PC.11.03.01, EP 4	For hospitals that elect The Joint Commission Primary Care Medical Home option: Patient self-management goals are developed in partnership with patients, based on criteria established by the organization, and incorporated into the patient's treatment plan. Note: Examples of criteria include the patient's disease process or condition and specific patient populations, such as those with multiple comorbidities or a chronic disease. It is not expected that self-management goals be developed for every patient.
PC.01.03.01, EP 45	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home uses clinical decision support tools to guide decision making. (Refer to LD.03.10.01, EP 3)	Moved and Revised	PC.11.03.01, EP 5	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home uses clinical decision support tools to guide decision making.
PC.01.03.05, EP 2	Behavior management procedures, when used, are part of the patient's plan of care. The patient plan of care for behavior management includes the following: - Target behavior(s) - Adaptive or replacement behavior(s) - Interventions - Criteria for discontinuation of behavior management procedures - Behavior management techniques used	Deleted	N/A	N/A
PC.01.03.05, EP 3	The patient and, based on their plan of care, the family participate in selecting behavior management and treatment interventions.	Deleted	N/A	N/A
PC.02.01.01, EP 1	The hospital provides the patient with care, treatment, and services according to the patient's individualized plan of care. CoPs: §482.58(b)(6), §482.61(c)(1)(iv), §482.62, §482.62(a)(1), §482.62(a)(2), §482.62(a)(3), §482.62(a)(4), §483.65(a)(1), §483.65(a)(2), §483.65(b)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
PC.02.01.01, EP 5	For hospitals that use Joint Commission accreditation for deemed status purposes: A registered nurse supervises and evaluates the nursing care for each patient. CoPs: §482.23(b)(3)	Moved and Revised	NR.11.01.01, EP 4	A registered nurse supervises and evaluates the nursing care for each patient. CoPs: §482.23(b)(3)
PC.02.01.01, EP 10	Before initiating a blood or blood component transfusion, the hospital follows a process to correctly identify patients that includes the following: - Matching the blood or blood component to the order - Matching the patient to the blood or blood component - Using a two-person verification process or a one-person verification process accompanied by automated identification technology, such as bar coding Note: When using a two-person verification process, one individual conducting the identification verification is the qualified transfusionist who will administer the blood or blood component to the patient. The second individual conducting the identification verification is qualified to participate in the process, as determined by the hospital.	Consolidation of NPSG.01.01.01, EP 1; PC.02.01.01, EP 10	NPG.01.01.01, EP 1	The hospital has a process in place to correctly identify patients when providing care, treatment, and services. This includes using at least two patient identifiers. The hospital does not use the patient's room number or physical location as an identifier. Note: Examples of patient identifiers may include but are not limited to the following: - Assigned identification number (for example, medical record number) - Telephone number or another person-specific identifier - Electronic identification technology coding, such as bar coding or RFID, that includes two or more person-specific identifiers
PC.02.01.01, EP 15	For hospitals that use Joint Commission accreditation for deemed status purposes: Blood transfusions and intravenous medications are administered in accordance with state law and approved medical staff policies and procedures. CoPs: §482.23(c)(4)	Moved and Revised	PC.12.01.01, EP 3	The hospital administers blood transfusions and intravenous medications in accordance with state law and approved medical staff policies and procedures. CoPs: §482.23(c)(4)
PC.02.01.01, EP 16	For hospitals that elect The Joint Commission Primary Care Medical Home option: Each patient has a designated primary care clinician.	Moved	PC.12.01.01, EP 5	For hospitals that elect The Joint Commission Primary Care Medical Home option: Each patient has a designated primary care clinician.
PC.02.01.01, EP 30	For hospitals that provide fluoroscopic services: The hospital identifies radiation exposure and skin dose threshold levels that, if exceeded, trigger further review and/or patient evaluation to assess for adverse radiation effects. Note 1: Information on radiation exposure thresholds can be found in the National Council on Radiation Protection's (NCRP) report number 168 and on the US Food and Drug Administration's (FDA) Center for Devices for Radiological Health (CDRH) website. Note 2: Radiation exposure thresholds may be established based on metrics such as reference-air kerma, cumulative-air kerma, kerma-area product, or fluoroscopy time.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.02.01.03, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes: Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a physician or other licensed practitioner in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations. Note 1: Outpatient services may be ordered by a physician or other licensed practitioner not appointed to the medical staff as long as the practitioner meets the following: - Responsible for the care of the patient - Licensed to practice in the state where the practitioner provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements - Acting within the practitioner's scope of practice under state law - Authorized in accordance with state law and policies adopted by the medical staff and approved by the governing body to order the applicable outpatient services Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: Patient diets, including therapeutic diets, are ordered by the physician or other licensed practitioner responsible for the patient's care, or by a qualified	Moved and Revised	PC.12.01.01, EP 1	Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a physician or other licensed practitioner in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations. Note 1: This includes but is not limited to respiratory services, radiology services, rehabilitation services, nuclear medicine services, and dietetic services, if provided. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: Patient diets, including therapeutic diets, are ordered by the physician or other licensed practitioner responsible for the patient's care or by a qualified dietitian or qualified nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals. CoPs: §482.26(b)(4), §482.28(b)(2), §482.53(d)(4), §482.56(b), §482.57(b)(3), §482.58(b)(6), §483.65(b)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	dietitian or qualified nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals. CoPs: §482.23(c)(1), §482.23(c)(3), §482.23(c)(6)(i)(A), §482.23(c)(6)(ii)(A), §482.24(c)(2), §482.26(b)(4), §482.28(b)(2), §482.54(c)(1), §482.54(c)(2), §482.54(c)(3), §482.54(c)(4), §482.54(c)(4)(i), §482.54(c)(4)(ii), §482.56(b), §482.57(b)(3)			
PC.02.01.03, EP 7	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital provides care, treatment, and services using the most recent patient order(s). CoPs: §482.28(b)(2), §482.56(b), §482.57(b)(3)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.02.01.03, EP 20	Before taking action on a verbal order or verbal report of a critical test result, staff uses a record and "read back" process to verify the information.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.02.01.05, EP 1	Care, treatment, and services are provided to the patient in an interdisciplinary, collaborative manner. CoPs: §482.43(a)(5), §482.55(a)(2), §482.58(b)(6), §482.61(c)(1)(iv), §483.65(b)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.02.01.11, EP 1	Resuscitative services are provided to the patient according to the hospital's policies, procedures, or protocols.	Moved and Revised	NPG.01.05.03, EP 1	The hospital provides resuscitative services based on national standards of care, guidelines, and the hospital's policies, procedures, or protocols.
PC.02.01.11, EP 2	Resuscitation equipment is available for use based on the needs of the population served. Note: For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available.	Moved and Revised	NPG.01.05.03, EP 2	Resuscitation equipment is available for use based on the needs of the population served. Note: For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available.
PC.02.01.11, EP 4	The hospital provides education and training to staff involved in the provision of resuscitative services. The hospital determines which staff complete this education and training based upon their job responsibilities and hospital policies and procedures. The education and training are provided at the following intervals: - At orientation - A periodic basis thereafter, as determined by the hospital - When staff responsibilities change Note 1: Topics may cover resuscitation procedures or protocols; use of cardiopulmonary resuscitation techniques, devices, or equipment; and the roles and responsibilities during resuscitation events. Note 2: The format and content of education and training are determined by the hospital (for example, a skills day, a mock code).	Moved and Revised	NPG.01.05.03, EP 3	The hospital provides education and training to staff involved in the provision of resuscitative services. The hospital determines which staff complete this education and training based on their job responsibilities and hospital policies and procedures. The education and training are provided at the following intervals: - At orientation - A periodic basis thereafter, as determined by the hospital - When staff responsibilities change Note 1: Topics may cover resuscitation procedures or protocols; use of cardiopulmonary resuscitation techniques, devices, or equipment; and roles and responsibilities during resuscitation events. Note 2: The hospital determines the format and content of education and training (for example, a skills day, a mock code).
PC.02.01.11, EP 5	For hospitals that use Joint Commission accreditation for deemed status purposes: At a minimum, operating room suites have the following equipment available: - Call-in system (process to communicate with or summon staff outside of the operating room when needed) - Cardiac monitor - Resuscitator (hand-held or mechanical device that provides positive airway pressure) - Defibrillator - Aspirator (hand-held or mechanical device used to suction out fluids or secretions)	Moved	PC.12.01.05, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes: At a minimum, operating room suites have the following equipment available: - Call-in system (process to communicate with or summon staff outside of the operating room when needed) - Cardiac monitor - Resuscitator (hand-held or mechanical device that provides positive airway pressure) - Defibrillator - Aspirator (hand-held or mechanical device used to suction out fluids or secretions)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	- Tracheotomy set CoPs: §482.51(b)(3)			- Tracheotomy set CoPs: §482.51(b)(3)
PC.02.01.19, EP 2	The hospital develops and follows written criteria describing early warning signs of a change or deterioration in a patient's condition and the appropriate action to take.	Moved and Revised	NPG.01.05.02, EP 1	The hospital develops and implements written criteria describing early warning signs of a change or deterioration in a patient's condition and the appropriate action to take.
PC.02.01.20, EP 1	The hospital develops and follows policies, procedures, or protocols based on current scientific literature for interdisciplinary post–cardiac arrest care. Note 1: Post–cardiac arrest care is aimed at identifying, treating, and mitigating acute pathophysiological processes after cardiac arrest and includes evaluation for targeted temperature management and other aspects of critical care management. Note 2: This requirement does not apply to hospitals that do not provide post–cardiac arrest care.	Moved and Revised	NPG.01.05.04, EP 1	The hospital develops and implements policies, procedures, or protocols based on current scientific literature for interdisciplinary post–cardiac arrest care. Note 1: Post–cardiac arrest care is aimed at identifying, treating, and mitigating acute pathophysiological processes after cardiac arrest and includes evaluation for targeted temperature management and other aspects of critical care management. Note 2: This requirement does not apply to hospitals that do not provide post–cardiac arrest care.
PC.02.01.20, EP 2	The hospital develops and follows policies, procedures, or protocols based on current scientific literature to determine the neurological prognosis for patients who remain comatose after cardiac arrest. Note 1: Because any single method of neuroprognostication has an intrinsic error rate, current guidelines recommend that multiple testing modalities be incorporated into organizations' routine procedures and protocols to improve decision-making accuracy. Note 2: This requirement does not apply to hospitals that do not provide post–cardiac arrest care.	Moved and Revised	NPG.01.05.04, EP 2	The hospital develops and implements policies, procedures, or protocols based on current scientific literature to determine the neurological prognosis for patients who remain comatose after cardiac arrest. Note 1: Because any single method of neuroprognostication has an intrinsic error rate, current guidelines recommend that multiple testing modalities be incorporated into the hospital's routine procedures and protocols to improve decision-making accuracy. Note 2: This requirement does not apply to hospitals that do not provide post–cardiac arrest care.
PC.02.01.20, EP 3	The hospital follows written criteria or a protocol for inter-facility transfers of patients for post–cardiac arrest care, when indicated.	Deleted	N/A	N/A
PC.02.01.21, EP 1	The hospital identifies the patient's oral and written communication needs, including the patient's preferred language for discussing health care. Note: Examples of communication needs include the need for personal devices such as hearing aids or glasses, language interpreters, communication boards, and translated or plain language materials.	Moved	PC.11.02.07, EP 1	The hospital identifies the patient's oral and written communication needs, including the patient's preferred language for discussing health care. Note: Examples of communication needs include the need for personal devices such as hearing aids or glasses, language interpreters, communication boards, and translated or plain language materials.
PC.02.01.21, EP 2	The hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs.	Deleted	N/A	N/A
PC.02.02.01, EP 1	The hospital follows a process to receive or share patient information when the patient is referred to other internal or external providers of care, treatment, and services. CoPs: §482.43(b), §482.54(a)	Moved and Revised	NPG.01.04.01, EP 1	The hospital follows a process to receive or share patient information when the patient is referred to internal providers of care, treatment, and services.
PC.02.02.01, EP 2	The hospital's process for hand-off communication provides for the opportunity for discussion between the giver and receiver of patient information. Note: Such information may include the patient's condition, care, treatment, medications, services, and any recent or anticipated changes to any of these.	Moved and Revised	NPG.01.04.01, EP 2	The hospital's process for hand-off communication provides for the opportunity for discussion between the giver and receiver of patient information. Note: Such information may include the patient's condition, care, treatment, medications, services, and any recent or anticipated changes to any of these.
PC.02.02.01, EP 3	The hospital coordinates the patient's care, treatment, and services within a time frame that meets the patient's needs. Note: Coordination involves resolving scheduling conflicts and duplication of care, treatment, and services. CoPs: §482.43(a)(5), §482.54(a), §482.55(a)(2), §482.58(b)(6), §483.65(a)(1), §483.65(a)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
PC.02.02.01, EP 9	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides services (directly or through referral) to facilitate family support, social work, nursing care, dental care, rehabilitation, primary physician care, or discharge. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital promptly refers residents with lost or damaged dentures to a dentist. CoPs: §482.58(b)(4), §482.58(b)(6), §482.58(b)(7), §483.40(d), §483.55(a)(4)(i), §483.55(a)(4)(ii), §483.55(b)(1)(i), §483.55(b)(2)(i), §483.55(b)(2)(ii), §483.65(b)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.02.02.01, EP 10	When the hospital uses external resources to meet the patient's needs, it coordinates the patient's care, treatment, and services. CoPs: §482.58(b)(6), §482.58(b)(7), §483.55(a)(4)(i), §483.55(a)(4)(ii), §483.55(b)(2)(i), §483.55(b)(2)(ii), §483.65(a)(1), §483.65(a)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.02.02.01, EP 12	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital assists residents who are eligible and wish to apply for reimbursement of dental services as an incurred medical expense under the state plan. The hospital may charge a Medicare resident an additional amount for routine and emergency dental services. CoPs: §482.58(b)(7), §483.55, §483.55(a)(2), §483.55(b)(1)(i), §483.55(b)(5)	Moved	PC.14.02.01, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital assists residents who are eligible and wish to apply for reimbursement of dental services as an incurred medical expense under the state plan. The hospital may charge a Medicare resident an additional amount for routine and emergency dental services. CoPs: §482.58(b)(7), §483.55(a)(2), §483.55(b)(5)
PC.02.02.01, EP 29	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital follows its policy identifying circumstances when loss of or damage to a resident's dentures is the hospital's responsibility and it may not charge a resident for the loss or damage of dentures. CoPs: §482.58(b)(7), §483.55(a)(3), §483.55(b)(4)	Moved and Revised	PC.14.02.01, EP 4	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital develops and implements a policy identifying circumstances when loss of or damage to a resident's dentures is the hospital's responsibility, and it may not charge a resident for the loss or damage of dentures. CoPs: §482.58(b)(7), §483.55(a)(3), §483.55(b)(4)
PC.02.02.01, EP 30	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital refers residents with lost or damaged dentures for dental services within three days. If referral does not occur within three days, the hospital documents what was done to make sure that the resident could adequately eat and drink and any extenuating circumstances that led to the delay. CoPs: §482.58(b)(7), §483.55(a)(5), §483.55(b)(3)	Moved	PC.14.02.01, EP 6	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital refers residents with lost or damaged dentures for dental services within three days. If referral does not occur within three days, the hospital documents what was done to make sure that the resident could adequately eat and drink and any extenuating circumstances that led to the delay. CoPs: §482.58(b)(7), §483.55(a)(5), §483.55(b)(3)
PC.02.02.03, EP 6	The hospital prepares food and nutrition products using proper sanitation, temperature, light, moisture, ventilation, and security.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.02.02.03, EP 7	Food and nutrition products are consistent with each patient's care, treatment, and services. CoPs: §482.28(b), §482.28(b)(1)	Moved and Revised	PC.12.01.09, EP 1	The nutritional needs of the individual patient are met in accordance with clinical practice guidelines and recognized dietary practices. Note: Diet menus meet the needs of the patients. CoPs: §482.28(b), §482.28(b)(1)
PC.02.02.03, EP 11	The hospital stores food and nutrition products, including those brought in by patients or their families, using proper sanitation, temperature, light, moisture, ventilation, and security.	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
		moved to guidance within SPG		
PC.02.02.03, EP 22	For hospitals that use Joint Commission accreditation for deemed status purposes: A current therapeutic diet manual approved by the dietitian and medical staff is available to all medical, nursing, and food service staff. CoPs: §482.28(b)(1), §482.28(b)(3)	Moved and Revised	PC.12.01.09, EP 2	For hospitals that use Joint Commission accreditation for deemed status purposes: The dietitian and medical staff approve a therapeutic diet manual that is current and available to all medical, nursing, and food service staff. Note: For the purposes of this element of performance, current is defined as having a publication or revision date no more than five years old. CoPs: §482.28(b)(3)
PC.02.03.01, EP 1	The hospital performs a learning needs assessment for each patient, which includes the following: - The patient's cultural and religious beliefs - Emotional barriers - Desire and motivation to learn - Physical or cognitive limitations - Barriers to communication	Moved and Revised	PC.12.02.01, EP 1	The hospital performs a learning needs assessment for each patient, which includes the following: - Cultural and religious beliefs - Emotional barriers - Desire and motivation to learn - Physical or cognitive limitations - Barriers to communication
PC.02.03.01, EP 5	The hospital coordinates the patient education and training provided by all disciplines involved in the patient's care, treatment, and services.	Moved	PC.12.02.01, EP 2	The hospital coordinates the patient education and training provided by all disciplines involved in the patient's care, treatment, and services.
PC.02.03.01, EP 10	Based on the patient's condition and assessed needs, the education and training provided to the patient by the hospital include any of the following: - An explanation of the plan for care, treatment, and services - Basic health practices and safety - Information on the safe and effective use of medications - Nutrition interventions (for example, supplements) and modified diets - Discussion of pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management - Information on oral health - Information on the safe and effective use of medical equipment or supplies provided by the hospital - Habilitation or rehabilitation techniques to help the patient reach maximum independence - Fall reduction strategies	Moved	PC.12.02.01, EP 3	Based on the patient's condition and assessed needs, the education and training provided to the patient by the hospital include any of the following: - An explanation of the plan for care, treatment, and services - Basic health practices and safety - Information on the safe and effective use of medications - Nutrition interventions (for example, supplements) and modified diets - Discussion of pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management - Information on oral health - Information on the safe and effective use of medical equipment or supplies provided by the hospital - Habilitation or rehabilitation techniques to help the patient reach maximum independence - Fall reduction strategies
PC.02.03.01, EP 25	The hospital evaluates the patient's understanding of the education and training it provided.	Moved	PC.12.02.01, EP 4	The hospital evaluates the patient's understanding of the education and training it provided.
PC.02.03.01, EP 27	The hospital provides the patient education on how to communicate concerns about patient safety issues that occur before, during, and after care is received.	Moved	PC.12.02.01, EP 5	The hospital provides the patient education on how to communicate concerns about patient safety issues that occur before, during, and after care is received.
PC.02.03.01, EP 28	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care clinician and the interdisciplinary team educate the patient on self-management tools and techniques based on the patient's individual needs. (Refer to PC.01.03.01, EP 44)	Moved and Revised	PC.12.02.01, EP 6	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care clinician and the interdisciplinary team educate the patient on self-management tools and techniques based on the patient's individual needs. (Refer to PC.11.03.01, EP 7)
PC.02.03.01, EP 30	For hospitals that elect The Joint Commission Primary Care Medical Home option: The interdisciplinary team identifies the patient's health literacy needs. Note: Typically this is an interactive process. For example, patients may be asked to demonstrate their understanding of information provided by explaining it in their own words.	Moved	PC.12.02.01, EP 7	For hospitals that elect The Joint Commission Primary Care Medical Home option: The interdisciplinary team identifies the patient's health literacy needs. Note: Typically this is an interactive process. For example, patients may be asked to demonstrate their understanding of information provided by explaining it in their own words.
PC.02.03.01, EP 31	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care clinician and the interdisciplinary team incorporate the patient's health literacy needs into the patient's education.	Moved	PC.12.02.01, EP 8	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care clinician and the interdisciplinary team incorporate the patient's health literacy needs into the patient's education.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
PC.02.04.01, EP 1	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides patients with access to the following 24 hours a day, 7 days a week: - Appointment availability/scheduling - Requests for prescription renewal - Test results - Clinical advice for urgent health needs	Moved	PC.12.03.01, EP 1	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides patients with access to the following 24 hours a day, 7 days a week: - Appointment availability/scheduling - Requests for prescription renewal - Test results - Clinical advice for urgent health needs
PC.02.04.01, EP 2	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home offers flexible scheduling to accommodate patient care needs. Note: This may include open scheduling, same-day appointments, group visits, expanded hours, and arrangements with other organizations.	Moved	PC.12.03.01, EP 2	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home offers flexible scheduling to accommodate patient care needs. Note: This may include open scheduling, same-day appointments, group visits, expanded hours, and arrangements with other organizations.
PC.02.04.01, EP 3	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home has a process to address patient urgent care needs 24 hours a day, 7 days a week.	Moved	PC.12.03.01, EP 3	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home has a process to address patient urgent care needs 24 hours a day, 7 days a week.
PC.02.04.03, EP 1	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home manages transitions in care and provides or facilitates patient access to care, treatment, or services including the following: - Acute care - Management of chronic care - Preventive services that are age- and gender-specific - Behavioral health needs - Oral health care - Urgent and emergent care - Substance abuse treatment Note: Some of these services may be obtained through the use of community resources as available, or in collaboration with other organizations.	Moved and Revised	PC.12.03.03, EP 1	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home manages transitions in care and provides or facilitates patient access to care, treatment, or services, including the following: - Acute care - Management of chronic care - Preventive services that are age- and gender-specific - Behavioral health needs - Oral health care - Urgent and emergent care - Substance abuse treatment Note: Some of these services may be obtained through the use of community resources, as available, or in collaboration with other organizations.
PC.02.04.03, EP 2	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides care that addresses various phases of a patient's lifespan, including end-of-life care.	Moved	PC.12.03.03, EP 2	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides care that addresses various phases of a patient's lifespan, including end-of-life care.
PC.02.04.03, EP 3	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides disease and chronic care management services to its patients.	Moved	PC.12.03.03, EP 3	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides disease and chronic care management services to its patients.
PC.02.04.03, EP 4	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides population-based care.	Moved	PC.12.03.03, EP 4	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides population-based care.
PC.02.04.03, EP 5	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home uses health information technology to do the following: - Support the continuity of care, and the provision of comprehensive and coordinated care, treatment, or services - Document and track care, treatment, or services - Support disease management, including providing patient education - Support preventive care, treatment, or services - Create reports for internal use and external reporting - Facilitate electronic exchange of information among providers - Support performance improvement	Moved and Revised	PC.12.03.03, EP 5	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home uses health information technology to do the following: - Support the continuity of care and the provision of comprehensive and coordinated care, treatment, or services - Document and track care, treatment, or services - Support disease management, including providing patient education - Support preventive care, treatment, or services - Create reports for internal use and external reporting - Facilitate electronic exchange of information among providers - Support performance improvement
PC.02.04.05, EP 1	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home identifies the composition of the interdisciplinary team, based on individual patient needs.	Moved	PC.12.03.05, EP 1	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home identifies the composition of the interdisciplinary team, based on individual patient needs.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
PC.02.04.05, EP 2	For hospitals that elect The Joint Commission Primary Care Medical Home option: The members of the interdisciplinary team provide comprehensive and coordinated care, treatment, or services and maintain the continuity of care. Note: The provision of care may include making internal and external referrals.	Moved	PC.12.03.05, EP 2	For hospitals that elect The Joint Commission Primary Care Medical Home option: The members of the interdisciplinary team provide comprehensive and coordinated care, treatment, or services and maintain the continuity of care. Note: The provision of care may include making internal and external referrals.
PC.02.04.05, EP 4	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care clinician and the interdisciplinary team provide care for a designated group of patients.	Moved	PC.12.03.05, EP 3	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care clinician and the interdisciplinary team provide care for a designated group of patients.
PC.02.04.05, EP 5	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care clinician is responsible for making certain that the interdisciplinary team provides comprehensive and coordinated care, treatment, or services and maintains the continuity of care as described in EPs 6–12. Note: Coordination of care may include making internal and external referrals, developing and evaluating treatment plans, and resolving conflicts in the provision of care.	Moved and Revised	PC.12.03.05, EP 4	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care clinician is responsible for making certain that the interdisciplinary team provides comprehensive and coordinated care, treatment, or services and maintains the continuity of care as described in EPs 6–10. Note: Coordination of care may include making internal and external referrals, developing and evaluating treatment plans, and resolving conflicts in the provision of care.
PC.02.04.05, EP 6	For hospitals that elect The Joint Commission Primary Care Medical Home option: When a patient is referred internally or externally, the interdisciplinary team reviews and tracks the care provided to the patient and, as needed, acts on recommendations for additional care, treatment, and services. Note: Internal referrals include orders for laboratory tests and imaging.	Moved	PC.12.03.05, EP 5	For hospitals that elect The Joint Commission Primary Care Medical Home option: When a patient is referred internally or externally, the interdisciplinary team reviews and tracks the care provided to the patient and, as needed, acts on recommendations for additional care, treatment, and services. Note: Internal referrals include orders for laboratory tests and imaging.
PC.02.04.05, EP 8	For hospitals that elect The Joint Commission Primary Care Medical Home option: The interdisciplinary team participates in the development of the patient's treatment plan.	Moved	PC.12.03.05, EP 6	For hospitals that elect The Joint Commission Primary Care Medical Home option: The interdisciplinary team participates in the development of the patient's treatment plan.
PC.02.04.05, EP 9	For hospitals that elect The Joint Commission Primary Care Medical Home option: The interdisciplinary team works in partnership with the patient to achieve planned outcomes.	Moved	PC.12.03.05, EP 7	For hospitals that elect The Joint Commission Primary Care Medical Home option: The interdisciplinary team works in partnership with the patient to achieve planned outcomes.
PC.02.04.05, EP 10	For hospitals that elect The Joint Commission Primary Care Medical Home option: The interdisciplinary team monitors the patient's progress toward achieving treatment goals.	Moved	PC.12.03.05, EP 8	For hospitals that elect The Joint Commission Primary Care Medical Home option: The interdisciplinary team monitors the patient's progress toward achieving treatment goals.
PC.02.04.05, EP 11	For hospitals that elect The Joint Commission Primary Care Medical Home option: The interdisciplinary team involves the patient in the development of the patient's treatment plan.	Moved	PC.12.03.05, EP 9	For hospitals that elect The Joint Commission Primary Care Medical Home option: The interdisciplinary team involves the patient in the development of the patient's treatment plan.
PC.02.04.05, EP 12	For hospitals that elect The Joint Commission Primary Care Medical Home option: The interdisciplinary team assesses patients for health risk behaviors.	Moved	PC.12.03.05, EP 10	For hospitals that elect The Joint Commission Primary Care Medical Home option: The interdisciplinary team assesses patients for health risk behaviors.
PC.03.01.01, EP 5	A registered nurse supervises perioperative nursing care. Note: Qualified registered nurses may perform circulating duties in the operating room. In accordance with state law and regulation and hospital policy, licensed practical nurses and surgical technologists may assist the circulating registered nurse in performing circulatory duties as long as the registered nurse supervises these staff and is immediately available to respond to emergencies. CoPs: §482.23(b)(3), §482.51(a)(1), §482.51(a)(2), §482.51(a)(3)	Moved and Revised	NPG.12.01.01, EP 13	The surgical services include but are not limited to the following staff: - An experienced registered nurse or doctor of medicine or osteopathy who supervises the operating rooms - Licensed practical nurses (LPNs) and surgical technologists (operating room technicians) who serve as scrub nurses, if under the supervision of a registered nurse - Qualified registered nurses who perform circulating duties in the operating room Note: In accordance with applicable state laws and approved medical staff policies and procedures, LPNs and surgical technologists may assist in circulatory duties under the supervision of a qualified registered nurse who is immediately available to respond to emergencies. CoPs: §482.51(a)(1), §482.51(a)(2), §482.51(a)(3)
PC.03.01.01, EP 6	For operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia, the following is available:	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	- Equipment to monitor the patient's physiological status - Equipment to administer intravenous fluids and medications and, if needed, blood and blood components CoPs: §482.52(b)	moved to guidance within SPG		
PC.03.01.01, EP 10	For hospitals that use Joint Commission accreditation for deemed status purposes: In accordance with the hospital's policy and state scope-of-practice laws, anesthesia is administered only by the following individuals: - An anesthesiologist - A doctor of medicine or osteopathy other than an anesthesiologist - A doctor of dental surgery or dental medicine - A doctor of podiatric medicine - A certified registered nurse anesthetist (CRNA) supervised by the operating practitioner except as provided in 42 CFR 482.52(c) regarding the state exemption for this supervision * - An anesthesiologist's assistant supervised by an anesthesiologist who is immediately available if needed - A supervised trainee in an approved educational program Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law or, if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission. Note 2: "Anesthesiologist assistant" is defined in 42 CFR 410.69(b). Footnote *: The CoP at 42 CFR 482.52(c) for state exemption states: A hospital may be exempt from the requirement for doctors of medicine or osteopathy to supervise CRNAs if the state in which the hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's Boards of Medicine and Nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor attests that they have consulted with the state Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement, and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission. CoPs: §482.52(a)(1), §482.52(a)(2), §482.52(a)(3), §482.52(a)(4), §482.52(a)(5), §482.52(c)(1), §482.52(c)(2)	Moved and Revised	PC.13.01.01, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes: General anesthesia, regional anesthesia, and monitored anesthesia, including deep sedation/analgesia, is administered only by the following individuals: - A qualified anesthesiologist - A doctor of medicine or osteopathy other than an anesthesiologist - A doctor of dental surgery or dental medicine, who is qualified to administer anesthesia under state law - A doctor of podiatric medicine, who is qualified to administer anesthesia under state law - A certified registered nurse anesthetist (CRNA), as defined in 42 CFR 410.69(b), supervised by the operating practitioner, except as provided in 42 CFR 482.52(c) regarding the state exemption for this supervision - An anesthesiologist's assistant, as defined in 42 CFR 410.69(b), supervised by an anesthesiologist who is immediately available if needed Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law or, if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission. Note 2: See Glossary for the definition of certified registered nurse anesthetist (CRNA) and anesthesiologist assistant. Note 3: The CoP at 42 CFR 482.52(c) for state exemption states: A hospital may be exempt from the requirement for doctors of medicine or osteopathy to supervise CRNAs if the state in which the hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's boards of medicine and nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor attests that they have consulted with the state boards of medicine and nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission. CoPs: §482.52(a)(1), §482.52(a)(2), §482.52(a)(3), §482.52(a)(4), §482.52(a)(5), §482.52(c)(1), §482.52(c)(2)
PC.03.01.03, EP 1	Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered: The hospital conducts a presedation or preanesthesia patient assessment. CoPs: §482.52(b)	Moved and Revised	PC.13.01.03, EP 1	Before operative or other high-risk procedures are initiated or before anesthesia is administered, the hospital conducts a preanesthesia patient assessment.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
PC.03.01.03, EP 4	Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered: The hospital provides the patient with preprocedural education, according to the plan for care.	Moved and Revised	PC.13.01.03, EP 4	Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered, the hospital provides the patient with preprocedural education, according to the plan for care.
PC.03.01.03, EP 8	The hospital reevaluates the patient immediately before administering moderate or deep sedation or anesthesia. CoPs: §482.52(b)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.03.01.03, EP 18	For hospitals that use Joint Commission accreditation for deemed status purposes: A preanesthesia evaluation is completed and documented by an individual qualified to administer anesthesia within 48 hours prior to surgery or a procedure requiring anesthesia services. CoPs: §482.52(b)(1)	Consolidation of PC.03.01.03, EP 18	PC.13.01.03, EP 2	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital develops and implements policies and procedures for anesthesia that include the delineation of preanesthesia and postanesthesia responsibilities. The policies require the following for each patient: - A preanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in 42 CFR 482.52(a), within 48 hours prior to surgery or a procedure requiring anesthesia services. - An intraoperative anesthesia record. - A postanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in 42 CFR 482.52(a), no later than 48 hours after surgery or a procedure requiring anesthesia services. The postanesthesia evaluation for anesthesia recovery is completed in accordance with state law and hospital policies and procedures that have been approved by the medical staff and reflect current standards of anesthesia care. CoPs: §482.52(b), §482.52(b)(1), §482.52(b)(2), §482.52(b)(3)
PC.03.01.05, EP 1	During operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia, the patient's oxygenation, ventilation, and circulation are monitored continuously. CoPs: §482.52(b)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.03.01.07, EP 1	The hospital assesses the patient's physiological status immediately after the operative or other high-risk procedure and/or as the patient recovers from moderate or deep sedation or anesthesia. CoPs: §482.51(b)(4), §482.52(b)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.03.01.07, EP 2	The hospital monitors the patient's physiological status, mental status, and pain level at a frequency and intensity consistent with the potential effect of the operative or other high-risk procedure and/or the sedation or anesthesia administered. CoPs: §482.51(b)(4), §482.52(b)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.03.01.07, EP 4	A qualified physician or other licensed practitioner discharges the patient from the recovery area or from the hospital. In the absence of a qualified individual, patients are discharged according to criteria approved by clinical leaders. CoPs: §482.52(b)	Moved	PC.13.01.03, EP 6	A qualified physician or other licensed practitioner discharges the patient from the recovery area or from the hospital. In the absence of a qualified individual, patients are discharged according to criteria approved by clinical leaders.
PC.03.01.07, EP 7	For hospitals that use Joint Commission accreditation for deemed status purposes: A postanesthesia evaluation is completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.52(b)(3)			
PC.03.01.07, EP 8	For hospitals that use Joint Commission accreditation for deemed status purposes: The postanesthesia evaluation for anesthesia recovery is completed in accordance with law and regulation and policies and procedures that have been approved by the medical staff. CoPs: §482.52(b)(3)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.03.01.08, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes: The laboratory follows a written policy, approved by the medical staff and a pathologist, that establishes which tissue specimens require only a macroscopic examination, and which require both a macroscopic and microscopic examination. CoPs: §482.27(a)(4)	Moved and Revised	PC.13.01.05, EP 2	The laboratory develops and implements a written policy, approved by the medical staff and a pathologist, that establishes which tissue specimens require only a macroscopic examination and which require both a macroscopic and microscopic examination. CoPs: §482.27(a)(4)
PC.03.01.08, EP 2	For hospitals that use Joint Commission accreditation for deemed status purposes: The laboratory follows written policies and procedures for collecting, preserving, transporting, receiving, and reporting examination results for tissue specimens. CoPs: §482.27(a)(3)	Moved and Revised	PC.13.01.05, EP 1	The laboratory develops and implements written policies and procedures for collecting, preserving, transporting, receiving, and reporting examination results for tissue specimens. CoPs: §482.27(a)(3)
PC.03.05.01, EP 1	The hospital uses restraint or seclusion only to protect the immediate physical safety of the patient, staff, or others. CoPs: §482.13(e), §482.58(b)(3), §483.12(a)(2)	Consolidation of PC.03.05.01, EP 1; PC.03.05.01, EP 2; PC.03.05.01, EP 3	PC.13.02.01, EP 1	The hospital does not use restraint or seclusion of any form as a means of coercion, discipline, convenience, or staff retaliation. Restraint or seclusion is only used to protect the immediate physical safety of the patient, staff, or others when less restrictive interventions have been ineffective and is discontinued at the earliest possible time, regardless of the length of time specified in the order. CoPs: §482.13(e), §482.13(e)(2), §482.13(e)(9), §482.58(b)(3)
PC.03.05.01, EP 2	The hospital does not use restraint or seclusion as a means of corporal punishment, coercion, discipline, convenience, or staff retaliation. CoPs: §482.13(e), §482.58(b)(3), §483.12(a)(2)	Consolidation of PC.03.05.01, EP 1; PC.03.05.01, EP 2; PC.03.05.01, EP 3	PC.13.02.01, EP 1	The hospital does not use restraint or seclusion of any form as a means of coercion, discipline, convenience, or staff retaliation. Restraint or seclusion is only used to protect the immediate physical safety of the patient, staff, or others when less restrictive interventions have been ineffective and is discontinued at the earliest possible time, regardless of the length of time specified in the order. CoPs: §482.13(e), §482.13(e)(2), §482.13(e)(9), §482.58(b)(3)
PC.03.05.01, EP 3	The hospital uses restraint or seclusion only when less restrictive interventions are ineffective. CoPs: §482.13(e)(2), §482.58(b)(3), §483.12(a)(2)	Consolidation of PC.03.05.01, EP 1; PC.03.05.01, EP 2; PC.03.05.01, EP 3	PC.13.02.01, EP 1	The hospital does not use restraint or seclusion of any form as a means of coercion, discipline, convenience, or staff retaliation. Restraint or seclusion is only used to protect the immediate physical safety of the patient, staff, or others when less restrictive interventions have been ineffective and is discontinued at the earliest possible time, regardless of the length of time specified in the order. CoPs: §482.13(e), §482.13(e)(2), §482.13(e)(9), §482.58(b)(3)
PC.03.05.01, EP 4	The hospital uses the least restrictive form of restraint or seclusion that protects the physical safety of the patient, staff, or others. CoPs: §482.13(e)(2), §482.13(e)(3), §482.58(b)(3), §483.12(a)(2)	Moved and Revised	PC.13.02.01, EP 2	The hospital uses the least restrictive form of restraint or seclusion that will be effective to protect the patient, a staff member, or others from harm. CoPs: §482.13(e)(3), §482.58(b)(3)
PC.03.05.01, EP 5	The hospital discontinues restraint or seclusion at the earliest possible time, regardless of the scheduled expiration of the order. CoPs: §482.13(e), §482.13(e)(9), §482.58(b)(3), §483.12(a)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
PC.03.05.03, EP 1	The hospital implements restraint or seclusion using safe techniques identified by the hospital's policies and procedures in accordance with law and regulation. CoPs: §482.13(e)(4)(ii), §482.13(f)	Consolidation of PC.03.05.03, EP 1; PC.03.05.03, EP 2	PC.13.02.03, EP 1	The hospital's use of restraint or seclusion meets the following requirements: - In accordance with a written modification to the patient's plan of care. - Implemented by trained staff using safe techniques identified by the hospital's policies and procedures in accordance with law and regulation CoPs: §482.13(e)(4)(i), §482.13(e)(4)(ii), §482.13(f)
PC.03.05.03, EP 2	The use of restraint and seclusion is in accordance with a written modification to the patient's plan of care. CoPs: §482.13(e)(4)(i)	Consolidation of PC.03.05.03, EP 1; PC.03.05.03, EP 2	PC.13.02.03, EP 1	The hospital's use of restraint or seclusion meets the following requirements: - In accordance with a written modification to the patient's plan of care. - Implemented by trained staff using safe techniques identified by the hospital's policies and procedures in accordance with law and regulation CoPs: §482.13(e)(4)(i), §482.13(e)(4)(ii), §482.13(f)
PC.03.05.05, EP 1	A physician or other authorized licensed practitioner responsible for the patient's care orders the use of restraint or seclusion in accordance with hospital policy and law and regulation. CoPs: §482.13(e)(5)	Moved and Revised	PC.13.02.05, EP 1	The hospital uses restraint or seclusion as ordered by a physician or other authorized licensed practitioner responsible for the patient's care in accordance with hospital policy and state law and regulation. CoPs: §482.13(e)(5)
PC.03.05.05, EP 2	The hospital does not use standing orders or PRN (also known as "as needed") orders for restraint or seclusion. CoPs: §482.13(e)(6)	Moved	PC.13.02.05, EP 2	The hospital does not use standing orders or PRN (also known as "as needed") orders for restraint or seclusion. CoPs: §482.13(e)(6)
PC.03.05.05, EP 3	The attending physician or clinical psychologist is consulted as soon as possible, in accordance with hospital policy, if they did not order the restraint or seclusion. Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). CoPs: §482.13(e)(7)	Moved and Revised	PC.13.02.05, EP 3	The attending physician is consulted as soon as possible, in accordance with hospital policy, if they did not order the restraint or seclusion. Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). CoPs: §482.13(e)(7)
PC.03.05.05, EP 4	Unless state law is more restrictive, orders for the use of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others may be renewed within the following limits: - 4 hours for adults 18 years of age or older - 2 hours for children and adolescents 9 to 17 years of age - 1 hour for children under 9 years of age Orders may be renewed according to the time limits for a maximum of 24 consecutive hours. CoPs: §482.13(e)(8)(i), §482.13(e)(8)(i)(A), §482.13(e)(8)(i)(B), §482.13(e)(8)(i)(C)	Moved and Revised	PC.13.02.05, EP 4	Unless state law is more restrictive, orders for the use of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others may be renewed within the following time limits: - 4 hours for adults 18 years of age or older - 2 hours for children and adolescents 9 to 17 years of age - 1 hour for children under 9 years of age Orders may be renewed according to the time limits for a maximum of 24 consecutive hours. CoPs: §482.13(e)(8)(i), §482.13(e)(8)(i)(A), §482.13(e)(8)(i)(B), §482.13(e)(8)(i)(C)
PC.03.05.05, EP 5	Unless state law is more restrictive, every 24 hours, a physician or other authorized licensed practitioner responsible for the patient's care sees and evaluates the patient before writing a new order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others in accordance with hospital policy and law and regulation. CoPs: §482.13(e)(8)(ii)	Moved and Revised	PC.13.02.05, EP 5	Unless state law is more restrictive, every 24 hours, a physician or other authorized licensed practitioner responsible for the patient's care sees and evaluates the patient before writing a new order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others, in accordance with hospital policy and law and regulation. CoPs: §482.13(e)(8)(ii)
PC.03.05.05, EP 6	Orders for restraint used to protect the physical safety of the nonviolent or non-self-destructive patient are renewed in accordance with hospital policy.	Moved and Revised	PC.13.02.05, EP 6	Orders for restraint used to protect the physical safety of a nonviolent or non-self-destructive patient are renewed in accordance with hospital policy.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.13(e)(8)(iii)			CoPs: §482.13(e)(8)(iii)
PC.03.05.07, EP 1	Physicians, other licensed practitioners, or staff who have been trained in accordance with 42 CFR 482.13(f) monitor the condition of patients in restraint or seclusion. CoPs: §482.13(e)(10)	Moved	PC.13.02.07, EP 1	Physicians, other licensed practitioners, or staff who have been trained in accordance with 42 CFR 482.13(f) monitor the condition of patients in restraint or seclusion. CoPs: §482.13(e)(10)
PC.03.05.09, EP 1	The hospital's policies and procedures regarding restraint or seclusion include the following: - Physician and other licensed practitioner training requirements - Staff training requirements - The determination of who has authority to order restraint and seclusion - The determination of who has authority to discontinue the use of restraint or seclusion - The determination of who can initiate the use of restraint or seclusion - The circumstances under which restraint or seclusion is discontinued - The requirement that restraint or seclusion is discontinued as soon as is safely possible - A determination of who can assess and monitor patients in restraint or seclusion - Time frames for assessing and monitoring patients in restraint or seclusion - A definition of restraint - A definition of seclusion - A definition or description of what constitutes the use of medications as a restraint Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's definition of restraint or the use of medications as a restraint is in accordance with 42 CFR 482.13(e)(1)(i)(A–C): 42 CFR 482.13(e)(1) Definitions. (i) A restraint is— (A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or 42 CFR 482.13(e)(1)(i)(B) (A restraint is—) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. 42 CFR 482.13(e)(1)(i)(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort). Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's definition of seclusion is in accordance with 42 CFR 482.13(e)(1)(ii): Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior. CoPs: §482.13(e)(1)(i)(A), §482.13(e)(1)(i)(B), §482.13(e)(1)(i)(C), §482.13(e)(1)(ii), §482.13(e)(11)	Moved and Revised	PC.13.02.09, EP 1	The hospital's policies and procedures regarding the use of restraint or seclusion include the following: - Definitions for restraint and seclusion that are consistent with state and federal law and regulation - Physician and other licensed practitioner training requirements - Staff training requirements - Who has authority to order restraint or seclusion - Who has authority to discontinue the use of 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 CoPs: §482.13(e)(11)
PC.03.05.09, EP 2	Physicians and other licensed practitioners authorized to order restraint or seclusion (through hospital policy in accordance with law and regulation) have a working	Moved and Revised	PC.13.02.09, EP 2	Physicians and other licensed practitioners authorized to order restraint or seclusion (through hospital policy in accordance with law and regulation) have a working

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	knowledge of the hospital policy regarding the use of restraint and seclusion. CoPs: §482.13(e)(11)			knowledge of the hospital policy regarding the use of restraint or seclusion. CoPs: §482.13(e)(11)
PC.03.05.11, EP 1	A physician or other licensed practitioner responsible for the care of the patient evaluates the patient in-person within one hour of the initiation of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. A registered nurse may conduct the in-person evaluation within one hour of the initiation of restraint or seclusion; this individual is trained in accordance with the requirements in PC.03.05.17, EP 3. Note: States may have statute or regulation requirements that are more restrictive than the requirements in this element of performance. CoPs: §482.13(e)(12)(i)(A), §482.13(e)(12)(i)(B), §482.13(e)(13), §482.13(e)(14)	Moved and Revised	PC.13.02.11, EP 1	A physician or other licensed practitioner responsible for the patient's care evaluates the patient in person within one hour of the initiation of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. A registered nurse may conduct the in-person evaluation within one hour of the initiation of restraint or seclusion if they are trained in accordance with the requirements in PC.13.02.17, EP 3. Note: The hospital also follows any state statute or regulation that may be more stringent than the requirements in this element of performance. CoPs: §482.13(e)(12)(i)(A), §482.13(e)(12)(i)(B), §482.13(e)(13)
PC.03.05.11, EP 2	When the in-person evaluation (performed within one hour of the initiation of restraint or seclusion) is done by a trained registered nurse, they consult with the attending physician or other licensed practitioner responsible for the care of the patient as soon as possible after the evaluation, as determined by hospital policy. CoPs: §482.13(e)(12)(ii)(A), §482.13(e)(12)(ii)(B), §482.13(e)(12)(ii)(C), §482.13(e)(12)(ii)(D), §482.13(e)(14)	Moved	PC.13.02.11, EP 3	When the in-person evaluation (performed within one hour of the initiation of restraint or seclusion) is done by a trained registered nurse, they consult with the attending physician or other licensed practitioner responsible for the care of the patient as soon as possible after the evaluation, as determined by hospital policy. CoPs: §482.13(e)(14)
PC.03.05.11, EP 3	The in-person evaluation, conducted within one hour of the initiation of restraint or seclusion for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others, includes the following: - An evaluation of the patient's immediate situation - The patient's reaction to the intervention - The patient's medical and behavioral condition - The need to continue or terminate the restraint or seclusion CoPs: §482.13(e)(12)(ii)(A), §482.13(e)(12)(ii)(B), §482.13(e)(12)(ii)(C), §482.13(e)(12)(ii)(D)	Moved and Revised	PC.13.02.11, EP 2	The in-person evaluation is conducted within one hour of the initiation of restraint or seclusion for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. The evaluation includes the following: - An evaluation of the patient's immediate situation - The patient's reaction to the intervention - The patient's medical and behavioral condition - The need to continue or terminate the restraint or seclusion CoPs: §482.13(e)(12)(ii)(A), §482.13(e)(12)(ii)(B), §482.13(e)(12)(ii)(C), §482.13(e)(12)(ii)(D)
PC.03.05.13, EP 1	The patient who is simultaneously restrained and secluded is continually monitored by trained staff either in-person or through the use of both video and audio equipment that is in close proximity to the patient. Note: In this element of performance "continually" means ongoing without interruption. CoPs: §482.13(e)(15)(i), §482.13(e)(15)(ii)	Moved and Revised	PC.13.02.13, EP 1	The patient who is simultaneously restrained and secluded is continually monitored by trained staff, either in person or through the use of both video and audio equipment that is in close proximity to the patient. Note: In this element of performance, continually means ongoing without interruption. CoPs: §482.13(e)(15)(i), §482.13(e)(15)(ii)
PC.03.05.15, EP 1	Documentation of restraint and seclusion in the medical record includes the following: - Any in-person medical and behavioral evaluation for restraint or seclusion used to manage violent or self-destructive behavior - A description of the patient’s behavior and the intervention used - Any alternatives or other less restrictive interventions attempted - The patient’s condition or symptom(s) that warranted the use of the restraint or seclusion - The patient’s response to the intervention(s) used, including the rationale for continued use of the intervention	Moved and Revised	PC.13.02.15, EP 1	Documentation of restraint or seclusion in the medical record includes the following: - The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior - Description of the patient's behavior and the intervention used - Alternatives or other less restrictive interventions attempted (as applicable) - Patient's condition or symptom(s) that warranted the use of the restraint or seclusion - Patient's response to the intervention(s) used, including the rationale for continued use of the intervention

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	- Individual patient assessments and reassessments - The intervals for monitoring - Revisions to the plan of care - The patient's behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint or seclusion - Injuries to the patient - Death associated with the use of restraint or seclusion - The identity of the physician, clinical psychologist, or other licensed practitioner who ordered the restraint or seclusion - Orders for restraint or seclusion - Notification of the use of restraint or seclusion to the attending physician - Consultations Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). CoPs: §482.13(e)(16)(i), §482.13(e)(16)(ii), §482.13(e)(16)(iii), §482.13(e)(16)(iv), §482.13(e)(16)(v)			CoPs: §482.13(e)(16)(i), §482.13(e)(16)(ii), §482.13(e)(16)(iii), §482.13(e)(16)(iv), §482.13(e)(16)(v)
PC.03.05.17, EP 2	The hospital trains staff on the use of restraint and seclusion, and assesses their competence, at the following intervals: - At orientation - Before participating in the use of restraint and seclusion - On a periodic basis thereafter CoPs: §482.13(f)(1)(i), §482.13(f)(1)(ii), §482.13(f)(1)(iii)	Moved and Revised	PC.13.02.17, EP 1	The hospital trains staff on the use of restraint and seclusion and assesses their competence at the following intervals: - At orientation - Before participating in the use of restraint or seclusion - On a periodic basis thereafter, as determined by hospital policy CoPs: §482.13(f)(1)(i), §482.13(f)(1)(ii), §482.13(f)(1)(iii)
PC.03.05.17, EP 3	Based on the population served, staff education, training, and demonstrated knowledge focus on the following: - Strategies to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion - Use of nonphysical intervention skills - Methods for choosing the least restrictive intervention based on an assessment of the patient's medical or behavioral status or condition - Safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia) - Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary - Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including, but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the in-person evaluation conducted within one hour of initiation of restraint or seclusion - Use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification CoPs: §482.13(f), §482.13(f)(1), §482.13(f)(2)(i), §482.13(f)(2)(ii), §482.13(f)(2)(iii), §482.13(f)(2)(iv), §482.13(f)(2)(v), §482.13(f)(2)(vi), §482.13(f)(2)(vii)	Moved and Revised	PC.13.02.17, EP 3	Based on the population served, staff education, training, and demonstrated knowledge focus on the following: - Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion - Use of nonphysical intervention skills - Methods for choosing the least restrictive intervention based on an assessment of the patient's medical or behavioral status or condition - Safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia) - Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary - Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the in-person evaluation conducted within one hour of initiation of restraint or seclusion - Use of first aid techniques and certification in the use of cardiopulmonary resuscitation (CPR), including required periodic recertification CoPs: §482.13(f)(2)(i), §482.13(f)(2)(ii), §482.13(f)(2)(iii), §482.13(f)(2)(iv), §482.13(f)(2)(v), §482.13(f)(2)(vi), §482.13(f)(2)(vii)

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PC.03.05.17, EP 4	Individuals providing staff training in restraint or seclusion have education, training, and experience in the techniques used to address patient behaviors that necessitate the use of restraint or seclusion. CoPs: §482.13(f)(3)	Moved and Revised	PC.13.02.17, EP 4	Individuals providing staff training in restraint or seclusion are qualified as evidenced by education, training, and experience in the techniques used to address patient behaviors that necessitate the use of restraint or seclusion. CoPs: §482.13(f)(3)
PC.03.05.17, EP 5	The hospital documents in staff records that restraint and seclusion training and demonstration of competence were completed. CoPs: §482.13(f)(4)	Moved and Revised	PC.13.02.17, EP 5	The hospital documents in staff records that they have completed restraint and seclusion training and demonstrated competence. CoPs: §482.13(f)(4)
PC.03.05.19, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital reports the following information to the Centers for Medicare & Medicaid Services (CMS) regarding deaths related to restraint or seclusion (this requirement does not apply to deaths related to the use of soft wrist restraints; for more information, refer to EP 3 in this standard): - Each death that occurs while a patient is in restraint or seclusion - Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion - Each death known to the hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death. The types of restraints included in this reporting requirement are all restraints except soft wrist restraints. Note: In this element of performance "reasonable to assume" includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time or deaths related to chest compression, restriction of breathing, or asphyxiation. CoPs: §482.13(g), §482.13(g)(1)(i), §482.13(g)(1)(ii), §482.13(g)(1)(iii)	Moved and Revised	PC.13.02.19, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital reports the following information to the Centers for Medicare & Medicaid Services regarding deaths related to restraint or seclusion: - Each death that occurs while a patient is in restraint or seclusion - Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion - Each death known to the hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death Note 1: This reporting requirement includes all restraints except soft wrist restraints. For more information on deaths related to the use of soft wrist restraints, refer to EP 3 in this standard. Note 2: In this element of performance "reasonable to assume" includes but is not limited to deaths related to restrictions of movement for prolonged periods of time or deaths related to chest compression, restriction of breathing, or asphyxiation. CoPs: §482.13(g), §482.13(g)(1)(i), §482.13(g)(1)(ii), §482.13(g)(1)(iii)
PC.03.05.19, EP 2	For hospitals that use Joint Commission accreditation for deemed status purposes: The deaths addressed in PC.03.05.19, EP 1, are reported to the Centers for Medicare & Medicaid Services (CMS) by telephone, by facsimile, or electronically no later than the close of the next business day following knowledge of the patient's death. The date and time that the patient's death was reported is documented in the patient's medical record. CoPs: §482.13(g)(1), §482.13(g)(3)(i)	Moved and Revised	PC.13.02.19, EP 2	For hospitals that use Joint Commission accreditation for deemed status purposes: The deaths addressed in PC.13.02.19, EP 1, are reported to the Centers for Medicare & Medicaid Services by telephone, by facsimile, or electronically no later than the close of the next business day following knowledge of the patient's death. The date and time that the patient's death was reported is documented in the patient's medical record. CoPs: §482.13(g)(1), §482.13(g)(3)(i)
PC.03.05.19, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes: When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, non-rigid, cloth-like material, the hospital does the following: - Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. - Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. - Documents in the patient record the date and time that the death was recorded in the log or other system - Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the care of the patient, medical record number, and primary diagnosis(es)	Moved and Revised	PC.13.02.19, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes: When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, nonrigid, cloth-like material, the hospital does the following: - Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. - Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. - Documents in the patient record the date and time that the death was recorded in the log or other system - Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the patient's care, medical record number, and primary diagnosis(es)

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	- Makes the information in the log or other system available to CMS, either electronically or in writing, immediately upon request CoPs: §482.13(g)(2)(i), §482.13(g)(2)(ii), §482.13(g)(3)(ii), §482.13(g)(4)(i), §482.13(g)(4)(ii), §482.13(g)(4)(iii)			- Makes the information in the log or other system available to the Centers for Medicare and Medicaid Services, either electronically or in writing, immediately upon request CoPs: §482.13(g)(2)(i), §482.13(g)(2)(ii), §482.13(g)(3)(ii), §482.13(g)(4)(i), §482.13(g)(4)(ii), §482.13(g)(4)(iii)
PC.04.01.01, EP 1	The hospital describes the following: - The reason(s) for and conditions under which the patient is discharged or transferred - The method for shifting responsibility for a patient's care from one provider, hospital, program, or service to another CoPs: §482.62(c)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.04.01.01, EP 22	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital informs the patient or the patient's representative of the patient's freedom to choose among participating Medicare providers and suppliers of post-discharge services and, when possible, respects the patient's or patient representative's goals of care and treatment preferences, as well as other preferences when they are expressed. The hospital does not limit the qualified providers who are available to the patient. CoPs: §482.43(c)(2)	Moved and Revised	PC.14.01.01, EP 10	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital informs the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of postdischarge services and, when possible, respects the patient's or their representative's goals of care and treatment preferences, as well as other preferences when they are expressed. The hospital does not limit the qualified providers or suppliers that are available to the patient. CoPs: §482.43(c)(2)
PC.04.01.01, EP 25	For hospitals that use Joint Commission accreditation for deemed status purposes: The discharge plan identifies any home health agency or skilled nursing facility in which the hospital has a disclosable financial interest, and any home health agency or skilled nursing facility that has a disclosable financial interest in a hospital. Note: Disclosure of financial interest is determined in accordance with the provisions in 42 CFR 420, subpart C and section 1861 of the Social Security Act. CoPs: §482.43(c)(3)	Moved and Revised	PC.14.01.01, EP 11	For hospitals that use Joint Commission accreditation for deemed status purposes: The discharge plan identifies any home health agency or skilled nursing facility in which the hospital has a disclosable financial interest and any home health agency or skilled nursing facility that has a disclosable financial interest in a hospital. Note: Disclosure of financial interest is determined in accordance with the provisions in 42 CFR 420, subpart C, and section 1861 of the Social Security Act (42 U.S.C. 1395x). CoPs: §482.43(c)(3)
PC.04.01.01, EP 31	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital assists patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, home health agency, skilled nursing facility, inpatient rehabilitation facility, and long term care hospital data on quality measures and resource-use measures. The hospital makes certain that the post-acute care data on quality measures and resource-use measures is relevant and applicable to the patient's goals of care and treatment preferences. CoPs: §482.43(a)(8)	Moved and Revised	PC.14.01.01, EP 7	The hospital assists the patient, their family, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes but is not limited to home health agency, skilled nursing facility, inpatient rehabilitation facility, and long-term care hospital data on quality measures and resource-use measures. The hospital makes certain that the post–acute care data on quality measures and resource-use measures is relevant and applicable to the patient's goals of care and treatment preferences. CoPs: §482.43(a)(8)
PC.04.01.01, EP 32	For hospitals that use Joint Commission accreditation for deemed status purposes: The patient's discharge plan includes a list of home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, or long-term care hospitals that are available to the patient, participating in the Medicare program, and serving the geographic area in which the patient resides (as defined by the home health agency or in the case of a skilled nursing facility, inpatient rehabilitation facility, or long-term care hospital, in the geographic area requested by the patient). The hospital documents in the medical record that this list was presented to the patient or the	Moved and Revised	PC.14.01.01, EP 8	For hospitals that use Joint Commission accreditation for deemed status purposes: The patient's discharge plan includes a list of home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, or long-term care hospitals that are available to the patient, participating in the Medicare program, and serving the geographic area in which the patient resides (as defined by the home health agency or, in the case of a skilled nursing facility, inpatient rehabilitation facility, or long-term care hospital, in the geographic area requested by the patient). The hospital documents in the medical record that this list was presented to the patient or the

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	patient's representative. Note 1: Home health agencies must request to be listed by the hospital. Note 2: This list is only presented to patients for whom home health care, post-hospital extended care services, skilled nursing, inpatient rehabilitation, or long-term care hospital services are identified as needed. CoPs: §482.43(c)(1), §482.43(c)(1)(i), §482.43(c)(1)(iii)			patient's representative. Note 1: Home health agencies must request to be listed by the hospital. Note 2: This list is only presented to patients for whom home health care, posthospital extended care services, skilled nursing, inpatient rehabilitation, or long-term care hospital services are identified as needed. CoPs: §482.43(c)(1), §482.43(c)(1)(i), §482.43(c)(1)(iii)
PC.04.01.01, EP 33	For hospitals that use Joint Commission accreditation for deemed status purposes: For patients enrolled in managed care organizations, the hospital makes patients aware of the need to verify with their managed care organization which practitioners, providers, or certified suppliers are in the managed care organization's network. If the hospital has information on which practitioners, providers, or certified suppliers are in the network of the patient's managed care organization, it shares this information with the patient or the patient's representative. CoPs: §482.43(c)(1)(ii)	Moved	PC.14.01.01, EP 9	For hospitals that use Joint Commission accreditation for deemed status purposes: For patients enrolled in managed care organizations, the hospital makes patients aware of the need to verify with their managed care organization which practitioners, providers, or certified suppliers are in the network of the patient's managed care organization, it shares this information with the patient or the patient's representative. CoPs: §482.43(c)(1)(ii)
PC.04.01.03, EP 1	The hospital begins the discharge planning process early in the patient's episode of care, treatment, and services. CoPs: §482.43(a), §482.43(a)(1), §482.43(a)(4), §482.62, §482.62(a)(4)	Moved	PC.14.01.01, EP 2	The hospital begins the discharge planning process early in the patient's episode of care, treatment, and services. CoPs: §482.43(a)
PC.04.01.03, EP 2	The hospital identifies any needs the patient may have for psychosocial or physical care, treatment, and services after discharge or transfer. For hospitals that use Joint Commission accreditation for deemed status purposes: The identification of needs also includes hospice care, post-hospital extended care, home health, and non–health care services, as well as the need for community-based care providers. The hospital determines the availability of the post-hospital services as well as the patient's access to those services. CoPs: §482.43(a), §482.43(a)(1), §482.43(a)(2), §482.43(a)(4), §482.62, §482.62(a)(4)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.04.01.03, EP 3	The patient, the patient's family, physicians, other licensed practitioners, clinical psychologists, and staff involved in the patient's care, treatment, and services participate in planning the patient's discharge or transfer. Note 1: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). Note 2: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Social service staff responsibilities include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the hospital. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital notifies the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and reasons for the move in writing. The hospital also provides sufficient preparation and orientation to residents to make sure that transfer or discharge from the hospital is safe and orderly. The hospital sends a copy of the notice to a representative of the office of the state's long-term care ombudsman. Note 4: For hospitals that use Joint Commission accreditation for deemed status purposes: Discharge planning is performed by, or under the supervision of, a	Moved and Revised	PC.14.01.01, EP 4	The patient, the patient's caregiver(s) or support person(s), physicians, other licensed practitioners, clinical psychologists, and staff who are involved in the patient's care, treatment, and services participate in planning the patient's discharge or transfer. The patient and their caregiver(s) or support person(s) are included as active partners when planning for postdischarge care. Note 1: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (refer to the Glossary). Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital notifies the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and reasons for the move. The notice is in writing, in a language and manner they understand, and includes the items described in 42 CFR 483.15(c)(5). The hospital also provides sufficient preparation and orientation to residents to make sure that transfer or discharge from the hospital is safe and orderly. The hospital sends a copy of the notice to a representative of the office of the state's long-term care ombudsman. CoPs: §482.43, §482.58(b)(2), §482.62(f)(2), §483.15(c)(3)(i), §483.15(c)(3)(iii), §483.15(c)(7)

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	registered nurse, social worker, or other qualified person. CoPs: §482.43(a)(3), §482.43(a)(4), §482.43(a)(5), §482.58(b)(2), §482.62, §482.62(a)(4), §482.62(f)(2), §483.15(c)(3)(i), §483.15(c)(3)(iii), §483.15(c)(7)			
PC.04.01.03, EP 4	Prior to discharge, the hospital arranges or assists in arranging the services required by the patient after discharge in order to meet the patient's ongoing needs for care and services. CoPs: §482.43(a)(1), §482.43(a)(2), §482.43(a)(4)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.04.01.03, EP 5	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Except when specified in the CoP from 42 CFR 483.12(a)(5)(ii), the written notice of transfer or discharge required under paragraph 42 CFR 483.12(a)(4) must be made by the hospital at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered; the health of the individuals in the facility would be endangered; the resident's health improves sufficiently to allow a more immediate transfer or discharge, and immediate transfer or discharge is required by the resident's urgent medical needs; or a resident has not resided in the facility for 30 days. CoPs: §482.58(b)(2), §483.15(c)(4)(i), §483.15(c)(4)(ii)(A), §483.15(c)(4)(ii)(B), §483.15(c)(4)(ii)(C), §483.15(c)(4)(ii)(D), §483.15(c)(4)(ii)(E)	Moved and Revised	PC.14.01.01, EP 12	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides the written notice of transfer or discharge at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered, the health of the individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the facility for 30 days. CoPs: §482.58(b)(2), §483.15(c)(4)(i), §483.15(c)(4)(ii)(A), §483.15(c)(4)(ii)(B), §483.15(c)(4)(ii)(C), §483.15(c)(4)(ii)(D), §483.15(c)(4)(ii)(E)
PC.04.01.03, EP 6	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The written notice before transfer or discharge specified in the CoP from 42 CFR 483.12(a)(4) includes the following: - The reason for transfer or discharge - The effective date of transfer or discharge - The location to which the resident is transferred or discharged - A statement of the resident's appeal rights, including the name, address (mailing and e-mail), and telephone number of the entity which receives such requests; information on how to obtain an appeal form; where to find assistance in completing the form; and how to submit the appeal hearing request - The name, address (mailing and e-mail), and telephone number of the office of the state's long-term care ombudsman - For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 - For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act CoPs: §482.58(b)(2), §483.15(c)(5)(i), §483.15(c)(5)(ii), §483.15(c)(5)(iii), §483.15(c)(5)(iv), §483.15(c)(5)(v), §483.15(c)(5)(vi), §483.15(c)(5)(vii)	Moved and Revised	PC.14.01.01, EP 13	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The written notice before transfer or discharge specified in 42 CFR 483.15(c)(3) includes the following: - Reason for transfer or discharge - Effective date of transfer or discharge - Location to which the resident is transferred or discharged - Statement of the resident's appeal rights, including the name, address (mailing and e-mail), and telephone number of the entity which receives appeal requests; information on how to obtain an appeal form; where to find assistance in completing the form; and how to submit the appeal hearing request - Name, address (mailing and e-mail), and telephone number of the office of the state's long-term care ombudsman - For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 - For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act CoPs: §482.58(b)(2), §483.15(c)(5)(i), §483.15(c)(5)(ii), §483.15(c)(5)(iii), §483.15(c)(5)(iv), §483.15(c)(5)(v), §483.15(c)(5)(vi), §483.15(c)(5)(vii)
PC.04.01.03, EP 7	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has an effective discharge planning process that focuses on the patient's goals and treatment preferences and includes the patient and the patient's	Moved and Revised	PC.14.01.01, EP 1	The hospital has an effective discharge planning process that focuses on, and is consistent with, the patient's goals and treatment preferences; makes certain there is an effective transition of the patient from the hospital to postdischarge care; and

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	caregiver or support person(s) as active partners in the discharge planning for post-discharge care. The discharge planning process is consistent with the patient's goals for care and their treatment preferences, makes certain that there is an effective transition of the patient from the hospital to post-discharge care, and reduces the factors leading to preventable hospital readmissions. CoPs: §482.43			reduces the factors leading to preventable critical access hospital and hospital readmissions. Note: The hospital's discharge planning process requires regular reevaluation of the patient's condition to identify changes that require modification of the discharge plan. The discharge plan is updated as needed to reflect these changes. CoPs: §482.43, §482.43(a)(6)
PC.04.01.03, EP 10	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital assesses its discharge planning process within its established time frames. The assessment includes ongoing, periodic review of a representative sample of discharge plans, including those patients who were readmitted within 30 days of a previous admission, to make certain that the plans are responsive to patient post-discharge needs. CoPs: §482.43(a)(7)	Moved and Revised	PC.14.01.01, EP 14	The hospital assesses its discharge planning process on a regular basis, as defined by the hospital. The assessment includes an ongoing, periodic review of a representative sample of discharge plans, including plans for patients who were readmitted within 30 days of a previous admission, to make certain that the plans are responsive to patient postdischarge needs. CoPs: §482.43(a)(7)
PC.04.01.05, EP 1	When the hospital determines the patient's discharge or transfer needs, it promptly shares this information with the patient, and also with the patient's family when it is involved in decision making or ongoing care. CoPs: §482.58(b)(2), §482.62(a)(2), §482.62(a)(4), §483.15(c)(7)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.04.01.05, EP 2	Before the patient is discharged, the hospital informs the patient, and also the patient's family when it is involved in decision making or ongoing care, of the kinds of continuing care, treatment, and services the patient will need. CoPs: §482.58(b)(2), §483.15(c)(7)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.04.01.05, EP 7	The hospital educates the patient, and also the patient's family when it is involved in decision making or ongoing care, about how to obtain any continuing care, treatment, and services the patient will need.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.04.01.07, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital transfers or discharges residents only when at least one of the following conditions is met: - The resident's health has improved to the point where they no longer need the hospital's services. - The transfer or discharge is necessary for the resident's welfare and the hospital cannot meet the resident's needs. - The safety of the individuals in the hospital is endangered due to the clinical or behavioral status of the resident. - The health of individuals in the hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a hospital, the hospital may charge a resident only the allowable charges under Medicaid. - The hospital ceases operation.	Moved and Revised	PC.14.01.03, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital transfers or discharges residents only under at least one of the following conditions: - The resident's health has improved to the point where they no longer need the hospital's services. - The transfer or discharge is necessary for the resident's welfare, and the hospital cannot meet the resident's needs. - The safety of the individuals in the hospital is endangered due to the resident's clinical or behavioral status. - The health of individuals in the hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a hospital, the hospital may charge a resident only the allowable charges under Medicaid. - The hospital ceases operation.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	Note: The hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the hospital. The hospital documents the danger that failure to transfer or discharge would pose. CoPs: §482.58(b)(2), §483.15(c)(1)(i), §483.15(c)(1)(i)(A), §483.15(c)(1)(i)(B), §483.15(c)(1)(i)(C), §483.15(c)(1)(i)(D), §483.15(c)(1)(i)(E), §483.15(c)(1)(i)(F), §483.15(c)(1)(ii), §483.15(c)(4)(ii)(A), §483.15(c)(4)(ii)(B), §483.15(c)(4)(ii)(C), §483.15(c)(4)(ii)(D), §483.15(c)(4)(ii)(E)			Note: The hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the hospital. The hospital documents the danger that failure to transfer or discharge would pose. CoPs: §482.58(b)(2), §483.15(c)(1)(i)(A), §483.15(c)(1)(i)(B), §483.15(c)(1)(i)(C), §483.15(c)(1)(i)(D), §483.15(c)(1)(i)(E), §483.15(c)(1)(i)(F), §483.15(c)(1)(ii)
PC.04.02.01, EP 1	At the time of the patient's discharge or transfer, the hospital informs other service providers who will provide care, treatment, and services to the patient about the following: - The reason for the patient's discharge or transfer - The patient's physical and psychosocial status - A summary of care, treatment, and services it provided to the patient - The patient's progress toward goals - A list of community resources or referrals made or provided to the patient Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital also informs other service providers of the patient's treatment preferences. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The information sent to the receiving 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 CoPs: §482.43(b)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PC.05.01.09, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Hospitals" appendix. CoPs: §482.27(b)(1)(i), §482.27(b)(1)(ii), §482.27(b)(1)(iii), §482.27(b)(10), §482.27(b)(2), §482.27(b)(3), §482.27(b)(3)(i), §482.27(b)(3)(ii), §482.27(b)(3)(iii), §482.27(b)(4), §482.27(b)(4)(i), §482.27(b)(4)(ii)(A), §482.27(b)(4)(ii)(B), §482.27(b)(4)(iii), §482.27(b)(5)(i), §482.27(b)(5)(ii), §482.27(b)(6)(i), §482.27(b)(6)(ii), §482.27(b)(6)(iii), §482.27(b)(7), §482.27(b)(7)(i), §482.27(b)(7)(ii), §482.27(b)(8)(i), §482.27(b)(8)(ii), §482.27(b)(8)(iii), §482.27(b)(9), §482.27(c)(1), §482.27(c)(2)	Moved and Revised	PC.15.01.01, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital develops and implements written policies and procedures, including documentation and notification procedures, addressing potentially infectious blood and blood components, consistent with Centers for Medicare & Medicaid Services requirements at 42 CFR 482.27. Note 1: The procedures for notification and documentation conform to federal, state, and local laws, including requirements for the confidentiality of medical records and other patient information. Note 2: See Glossary for the definition of potentially infectious blood and blood components. CoPs: §482.27(b)(1)(i), §482.27(b)(1)(ii), §482.27(b)(1)(iii), §482.27(b)(2), §482.27(b)(9)
PC.05.01.09, EP 2	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27. Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the	Moved and Revised	LD.13.01.01, EP 7	The hospital maintains the following: - Records of the source and disposition of all units of blood and blood components for at least 10 years from the date of disposition in a manner that permits prompt retrieval

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	"Medicare Requirements for Hospitals" appendix. CoPs: §482.27(b)(1)(i), §482.27(b)(1)(ii), §482.27(b)(1)(iii), §482.27(b)(10), §482.27(b)(2), §482.27(b)(3), §482.27(b)(3)(i), §482.27(b)(3)(ii), §482.27(b)(3)(iii), §482.27(b)(4), §482.27(b)(4)(i), §482.27(b)(4)(ii)(A), §482.27(b)(4)(ii)(B), §482.27(b)(4)(iii), §482.27(b)(5)(i), §482.27(b)(5)(ii), §482.27(b)(6)(i), §482.27(b)(6)(ii), §482.27(b)(6)(iii), §482.27(b)(7), §482.27(b)(7)(i), §482.27(b)(7)(ii), §482.27(b)(8)(i), §482.27(b)(8)(ii), §482.27(b)(8)(iii), §482.27(c)(1), §482.27(c)(2)			- A fully funded plan to transfer these records to another hospital or other entity if the hospital ceases operation for any reason CoPs: §482.27(b)(5)(i), §482.27(b)(5)(ii)
PC.06.01.01, EP 1	Complete an assessment using an evidence-based tool for determining maternal hemorrhage risk on admission to labor and delivery and on admission to postpartum.	Deleted EP – Will replace with more direct EP(s) with CMS approval	N/A	N/A
PC.06.01.01, EP 2	Develop written evidence-based procedures for stage-based management of pregnant and postpartum patients who experience maternal hemorrhage that include the following: - The use of an evidence-based tool that includes an algorithm for identification and treatment of hemorrhage - The use of an evidence-based set of emergency response medications that are immediately available on the obstetric unit - Required response team members and their roles in the event of severe hemorrhage - How the response team and procedures are activated - Blood bank plan and response for emergency release of blood products and how to initiate the hospital's massive transfusion procedures - Guidance on when to consult additional experts and consider transfer to a higher level of care - Guidance on how to communicate with patients and families during and after the event - Criteria for when a team debrief is required immediately after a case of severe hemorrhage Note: The written procedures should be developed by a multidisciplinary team that includes representation from obstetrics, anesthesiology, nursing, laboratory, and blood bank.	Deleted EP – Will replace with more direct EP(s) with CMS approval	N/A	N/A
PC.06.01.01, EP 3	Each obstetric unit has a standardized, secured, and dedicated hemorrhage supply kit that must be stocked per the hospital's defined process and, at a minimum, contains the following: - Emergency hemorrhage supplies as determined by the hospital - The hospital's approved procedures for severe hemorrhage response	Deleted EP – Will replace with more direct EP(s) with CMS approval	N/A	N/A
PC.06.01.01, EP 4	Provide education to all staff who treat pregnant and postpartum patients about the hospital's hemorrhage procedure. At a minimum, education occurs at orientation, whenever changes to the procedure occur, or every two years. Note: Education provided should be role-specific.	Deleted EP – Will replace with more direct EP(s) with CMS approval	N/A	N/A
PC.06.01.01, EP 5	Conduct drills at least annually to determine system issues as part of ongoing quality improvement efforts. Drills include representation from each discipline identified in the hospital's hemorrhage response procedure and include a team debrief after the drill.	Deleted EP – Will replace with more direct EP(s) with CMS approval	N/A	N/A
PC.06.01.01, EP 6	Review hemorrhage cases that meet criteria established by the hospital to evaluate the effectiveness of the care, treatment, and services provided by the hemorrhage response team during the event.	Deleted EP – Will replace with more	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
		direct EP(s) with CMS approval		
PC.06.01.01, EP 7	Provide education to patients (and their families including the designated support person whenever possible). At a minimum, education includes the following: - Signs and symptoms of postpartum hemorrhage during hospitalization that alert the patient to seek immediate care - Signs and symptoms of postpartum hemorrhage after discharge that alert the patient to seek immediate care	Deleted EP – Will replace with more direct EP(s) with CMS approval	N/A	N/A
PC.06.03.01, EP 1	Develop written evidence-based procedures for measuring and remeasuring blood pressure. These procedures include criteria that identify patients with severely elevated blood pressure.	Deleted EP – Will replace with more direct EP(s) with CMS approval	N/A	N/A
PC.06.03.01, EP 2	Develop written evidence-based procedures for managing pregnant and postpartum patients with severe hypertension/preeclampsia that includes the following: - The use of an evidence-based set of emergency response medications that are stocked and immediately available on the obstetric unit - The use of seizure prophylaxis - Guidance on when to consult additional experts and consider transfer to a higher level of care - Guidance on when to use continuous fetal monitoring - Guidance on when to consider emergent delivery - Criteria for when a team debrief is required Note: The written procedures should be developed by a multidisciplinary team that includes representation from obstetrics, emergency department, anesthesiology, nursing, laboratory, and pharmacy.	Deleted EP – Will replace with more direct EP(s) with CMS approval	N/A	N/A
PC.06.03.01, EP 3	Provide role-specific education to all staff who treat pregnant/postpartum patients about the hospital's evidence-based severe hypertension/preeclampsia procedure. At a minimum, education occurs at orientation, whenever changes to the procedure occur, or every two years. Note: The emergency department is often where patients with symptoms or signs of severe hypertension present for care after delivery. For this reason, education should be provided to staff in emergency departments regardless of the hospital's ability to provide labor and delivery services.	Deleted EP – Will replace with more direct EP(s) with CMS approval	N/A	N/A
PC.06.03.01, EP 4	Conduct drills at least annually to determine system issues as part of ongoing quality improvement efforts. Severe hypertension/preeclampsia drills include a team debrief.	Deleted EP – Will replace with more direct EP(s) with CMS approval	N/A	N/A
PC.06.03.01, EP 5	Review severe hypertension/preeclampsia cases that meet criteria established by the hospital to evaluate the effectiveness of the care, treatment, and services provided to the patient during the event.	Deleted EP – Will replace with more direct EP(s) with CMS approval	N/A	N/A
PC.06.03.01, EP 6	Provide printed education to patients (and their families including the designated support person whenever possible). At a minimum, education includes: - Signs and symptoms of severe hypertension/preeclampsia during hospitalization that alert the patient to seek immediate care - Signs and symptoms of severe hypertension/preeclampsia after discharge that alert the patient to seek immediate care - When to schedule a postdischarge follow-up appointment	Deleted EP – Will replace with more direct EP(s) with CMS approval	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
N/A	N/A	New, more-direct EP for CoP requirement	PC.11.03.01, EP 2	The hospital involves the patient in the development and implementation of their plan of care. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to be informed, in advance, of changes to their plan of care. CoPs: §482.13(b)(1), §482.58(b)(1), §483.10(c)(2)(iii)
N/A	N/A	New, more-direct EP for CoP requirement	PC.11.03.01, EP 3	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Each patient has an individual comprehensive treatment plan that is based on an inventory of the patient's strengths and disabilities. The written plan includes the following: - Substantiated diagnosis - Short-term and long-term goals - Specific treatment modalities utilized - Responsibilities of each member of the treatment team - Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out CoPs: §482.61(c)(1), §482.61(c)(1)(i), §482.61(c)(1)(ii), §482.61(c)(1)(iii), §482.61(c)(1)(iv), §482.61(c)(1)(v)
N/A	N/A	New, more-direct EP for CoP requirement	PC.12.01.01, EP 2	Any physician or other licensed practitioner who orders outpatient services meets the following conditions: - Responsible for the care of the patient - Licensed in the state where they provide care to the patient - Acting within their scope of practice under state law - Authorized in accordance with state law and policies adopted by the medical staff and approved by the governing body to order the applicable outpatient services Note: This applies to physicians or other licensed practitioners who are appointed to the hospital's medical staff or have been granted privileges, as well as practitioners not appointed to the medical staff who satisfy the above criteria. CoPs: §482.54(c)(1), §482.54(c)(2), §482.54(c)(3), §482.54(c)(4), §482.54(c)(4)(i), §482.54(c)(4)(ii)
N/A	N/A	New, more-direct EP for CoP requirement	PC.12.01.01, EP 4	If the hospital provides rehabilitation, physical therapy, occupational therapy, speech-language pathology, or audiology services, the services are organized and provided in accordance with national accepted standards of practice. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The provision of rehabilitation services is in accordance with 42 CFR 409.17. CoPs: §482.56, §482.56(a), §482.56(b)(2)
N/A	N/A	New, more-direct EP for CoP requirement	PC.13.01.03, EP 5	The hospital has adequate provisions for immediate postoperative care. CoPs: §482.51(b)(4)
N/A	N/A	New, more-direct EP for CoP requirement	PC.13.02.01, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital does not use physical or chemical restraints that are imposed for purposes of discipline or convenience and are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the hospital uses the least restrictive alternative for the least amount of time and

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
				documents ongoing reevaluation of the need for restraints. CoPs: §483.12(a)(2)
N/A	N/A	New, more-direct EP for CoP requirement	PC.13.02.01, EP 4	The hospital restraint policies are followed when any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or when a drug or medication is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. Note: A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort). CoPs: §482.13(e)(1)(i)(A), §482.13(e)(1)(i)(B), §482.13(e)(1)(i)(C)
N/A	N/A	New, more-direct EP for CoP requirement	PC.13.02.01, EP 5	The hospital seclusion policies are followed when a patient is involuntarily confined alone in a room or area from which the patient is physically prevented from leaving. Note: Seclusion is only used for the management of violent or self-destructive behavior. CoPs: §482.13(e)(1)(ii)
N/A	N/A	New, more-direct EP for CoP requirement	PC.14.01.01, EP 3	As part of the discharge planning evaluation, the hospital evaluates the patient's need for appropriate posthospital services, including but not limited to hospice care services, extended care services, home health services, and non–health care services and community-based care providers. The hospital also evaluates the availability of the appropriate services and the patient's access to those services as part of the discharge planning evaluation. CoPs: §482.43(a)(2)
N/A	N/A	New, more-direct EP for CoP requirement	PC.14.01.01, EP 5	The hospital performs a discharge planning evaluation and creates a discharge plan for those patients it identifies at an early stage of hospitalization are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning or at the request of the patient, patient's representative, or the patient's physician. Note 1: The discharge planning evaluation is completed in a timely manner so that appropriate arrangements for post–hospital care are made before discharge and unnecessary delays in discharge are avoided. Note 2: The discharge planning evaluation is performed and subsequent discharge plan is created by, or under the supervision of, a registered nurse, social worker, or other qualified person. CoPs: §482.43(a), §482.43(a)(1), §482.43(a)(4), §482.43(a)(5)
N/A	N/A	New, more-direct EP for CoP requirement	PC.14.01.01, EP 6	The hospital discusses the results of the discharge planning evaluation with the patient or their representative, including any reevaluations performed and any arrangements made. CoPs: §482.43(a)(3)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
N/A	N/A	New, more-direct EP for CoP requirement	PC.14.02.01, EP 2	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides medically related social services to attain or maintain the optimal physical, mental, and psychosocial well-being of each resident. CoPs: §482.58(b)(4), §483.40(d)
N/A	N/A	New, more-direct EP for CoP requirement	PC.14.02.01, EP 5	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: If necessary or requested, the hospital assists residents in making dental appointments and arranging for transportation to and from the dental services location. CoPs: §482.58(b)(7), §483.55(a)(4)(i), §483.55(a)(4)(ii), §483.55(b)(2)(i), §483.55(b)(2)(ii)
N/A	N/A	New, more-direct EP for CoP requirement	PC.14.02.01, EP 7	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides or obtains from an outside resource routine (to the extent covered under the state plan) and emergency dental services. CoPs: §482.58(b)(7), §483.55(b)(1)(i)
N/A	N/A	New, more-direct EP for CoP requirement	PC.14.02.01, EP 8	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: If a resident's comprehensive plan of care requires specialized rehabilitative services, including but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for a mental disorder and intellectual disability or services of a lesser intensity, the hospital provides or obtains the required services from a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Social Security Act. CoPs: §482.58(b)(6), §483.65(a)(1), §483.65(a)(2)
N/A	N/A	New, more-direct EP for CoP requirement	PC.14.02.03, EP 1	The hospital provides or transmits necessary medical information when discharging, transferring, or referring the patient to post–acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners who are responsible for the patient's follow-up or ancillary care. Necessary medical information includes, at a minimum, the following: - Current course of illness and treatment - Postdischarge goals of care - Treatment preferences at the time of discharge CoPs: §482.43(b)
N/A	N/A	New, more-direct EP for CoP requirement	PC.15.01.01, EP 2	For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital receives notification of blood that is reactive to the human immunodeficiency virus (HIV) or hepatitis C virus (HCV) screening test, the hospital determines the disposition of the blood or blood components and quarantines all previously donated blood and blood components in inventory. CoPs: §482.27(b)(4)
N/A	N/A	New, more-direct EP for CoP requirement	PC.15.01.01, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital receives notification that the result of the supplemental (additional, more specific) test for potentially infectious blood or blood components or other

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
				follow-up testing required by the US Food and Drug Administration is negative and there are no other informative test results, the hospital may release the blood and blood components from quarantine. CoPs: §482.27(b)(4)(i)
N/A	N/A	New, more-direct EP for CoP requirement	PC.15.01.01, EP 4	For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital receives notification that the result of the supplemental (additional, more specific) test for potentially infectious blood or blood components or other follow-up testing required by the US Food and Drug Administration is positive, the hospital does the following: - Disposes of the blood and blood components - Notifies the transfusion recipients as set forth in 42 CFR 482.27(b)(6) CoPs: §482.27(b)(4)(ii)(A), §482.27(b)(4)(ii)(B)
N/A	N/A	New, more-direct EP for CoP requirement	PC.15.01.01, EP 5	For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital receives notification that the result of the supplemental (additional, more specific) test for potentially infectious blood or blood components or other follow-up testing required by the US Food and Drug Administration (FDA) is indeterminate, the hospital destroys or labels prior collections of blood or blood components held in quarantine, consistent with FDA requirements 21 CFR 610.46(b)(2) and 610.47(b)(2). CoPs: §482.27(b)(4)(iii)
N/A	N/A	New, more-direct EP for CoP requirement	PC.15.01.01, EP 6	For hospitals that use Joint Commission accreditation for deemed status purposes: When potentially human immunodeficiency virus (HIV) or hepatitis C virus (HCV) infectious blood or blood components are administered (either directly through the hospital's own blood collecting establishment or under an agreement) or released to another entity or individual, the hospital takes the following actions: - Makes reasonable attempts to notify the patient, the attending physician or other licensed practitioner, or the physician or other licensed practitioner who ordered the blood or blood component and ask the practitioner to notify the patient, or other individuals as permitted under 42 CFR 482.27, that potentially HIV or HCV infectious blood or blood components were transfused to the patient and that there may be a need for HIV or HCV testing and counseling - Attempts to notify to the patient, legal guardian, or relative if the practitioner is unavailable or declines to make the notification - Documents in the patient's medical record the notification or attempts to give the required notification CoPs: §482.27(b)(6)(i), §482.27(b)(6)(ii), §482.27(b)(6)(iii)
N/A	N/A	New, more-direct EP for CoP requirement	PC.15.01.01, EP 7	If the hospital receives notification that it received potentially human immunodeficiency virus (HIV) or hepatitis C virus (HCV) infectious blood and blood components, the hospital makes reasonable attempts to give notification over a period of 12 weeks unless one of the following occurs: - The patient is located and notified. - The hospital is unable to locate the patient and documents in the patient's medical record the extenuating circumstances beyond the hospital's control that caused the notification timeframe to exceed 12 weeks. Note: For notifications resulting from donors tested on or after February 20, 2008 as

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
				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. CoPs: §482.27(b)(7), §482.27(b)(7)(i), §482.27(b)(7)(ii)
N/A	N/A	New, more-direct EP for CoP requirement	PC.15.01.01, EP 8	When notifying patients who have received potentially human immune deficiency virus (HIV) or hepatitis C virus (HCV) infectious blood or blood components, the notification includes the following: - Oral or written information explaining the need for HIV or HCV testing and counseling, so that the patient can make an informed decision about whether to obtain HIV or HCV testing and counseling - A list of programs or places where the person can obtain HIV or HCV testing and counseling, including any requirements or restrictions the program may impose CoPs: §482.27(b)(8)(i), §482.27(b)(8)(ii), §482.27(b)(8)(iii)
N/A	N/A	New, more-direct EP for CoP requirement	PC.15.01.01, EP 9	If a patient has received an infectious blood or blood component, the hospital notifies the specified individual(s) under the following circumstances: - A legal representative designated in accordance with state law if the patient has been adjudged incompetent by a state court - The patient or his or her legal representative or relative if the patient is competent but state law permits a legal representative or relative to receive the information on the patient's behalf - The patient's legal representative or relative if the beneficiary of the potentially human immunodeficiency virus infectious transfusion is deceased - The parents or legal guardian if the patient is a minor CoPs: §482.27(b)(10)
N/A	N/A	New, more-direct EP for CoP requirement	PC.15.01.01, EP 10	The hospital complies with US Food and Drug Administration regulations pertaining to blood safety issues in the following areas: - Appropriate testing and quarantining of infectious blood and blood components - Notification and counseling of potential recipients of infectious blood and blood components Note: This applies to lookback activities only related to new blood safety issues that are identified after August 24, 2007. CoPs: §482.27(c)(1), §482.27(c)(2)
N/A	N/A	New, more-direct EP for CoP requirement	PE.04.01.01, EP 2	The hospital maintains essential equipment in safe operating condition. CoPs: §482.41(d)(2)
N/A	N/A	New, more-direct EP for CoP requirement	PE.04.01.01, EP 5	The hospital maintains supplies to ensure an acceptable level of safety and quality. Note: Supplies are stored in a manner to ensure the safety of the stored supplies and to not violate fire codes or otherwise endanger patients. CoPs: §482.41(d)(2)
N/A	N/A	New, more-direct EP for CoP requirement	PE.04.01.03, EP 2	The hospital has a system to provide emergency gas and water supply. Note 1: The system includes making arrangements with local utility companies and others for the provision of emergency sources of water and gas. Note 2: Emergency gas includes fuels such as propane, natural gas, fuel oil, or liquefied natural gas, as well as any gases the hospital uses in the care of patients,

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
				such as oxygen, nitrogen, or nitrous oxide. CoPs: §482.41(a)(2)
PI.01.01.01, EP 2	The hospital collects data on the following: Performance improvement priorities identified by leaders. CoPs: §482.21(a)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PI.01.01.01, EP 3	The hospital collects data on the following: Operative or other procedures that place patients at risk of disability or death. CoPs: §482.21(a)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PI.01.01.01, EP 4	The hospital collects data on the following: Surgeries in which the postoperative diagnosis (clinical or pathological) was unexpected and could indicate that a clinically significant diagnostic error occurred. Note: The hospital's medical staff determine which unexpected postoperative diagnoses are clinically significant. Examples may include but are not limited to the following: - A preoperative pathology or cytology report was interpreted as a malignancy, but no malignancy was found in the surgical specimen. - A patient underwent surgery for acute appendicitis, but the appendix was normal on the postsurgical pathology exam. - An operation was performed because of a presumed malignancy based on a radiology report, but no malignancy was found. CoPs: §482.21(a)(2), §482.21(e)(1)	Consolidation of PI.01.01.01, EP 4; PI.01.01.01, EP 14; PI.01.01.01, EP 34; PI.01.01.01, EP 35; PI.01.01.01, EP 40	NPG.13.04.01, EP 1	The hospital collects data on the following: - Patient thermal injuries that occur during magnetic resonance imaging (MRI) exams - Incidents where ferromagnetic object unintentionally entered the MRI scanner room - Injuries resulting from the presence of ferromagnetic objects in the MRI scanner room
PI.01.01.01, EP 5	The hospital collects data on the following: Adverse events related to using moderate or deep sedation or anesthesia. CoPs: §482.21(a)(2), §482.21(e)(1)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PI.01.01.01, EP 6	The hospital collects data on the following: The use of blood and blood components. CoPs: §482.21(a)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PI.01.01.01, EP 7	The hospital collects data on the following: All reported and confirmed transfusion reactions. CoPs: §482.21(a)(2), §482.21(e)(1), §482.23(c)(5)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PI.01.01.01, EP 10	The hospital collects data on the following: - The number and location of cardiac arrests (for example, ambulatory area, telemetry unit, critical care unit) - The outcomes of resuscitation (for example, return of spontaneous circulation [ROSC], survival to discharge) Note: ROSC is defined as return of spontaneous and sustained circulation for at least 20 consecutive minutes following resuscitation efforts.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	- Transfer to a higher level of care CoPs: §482.21(a)(2)			
PI.01.01.01, EP 12	The hospital collects data on the following: Significant medication errors. CoPs: §482.21(a)(2), §482.21(e)(1), §482.23(c)(5), §482.25(b)(6)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PI.01.01.01, EP 13	The hospital collects data on the following: Significant adverse drug reactions. CoPs: §482.21(a)(2), §482.21(e)(1), §482.23(c)(5), §482.25(b)(6)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PI.01.01.01, EP 14	The hospital collects data on the following: Patient perception of the safety and quality of care, treatment, or services. CoPs: §482.21(a)(2)	Consolidation of PI.01.01.01, EP 4; PI.01.01.01, EP 14; PI.01.01.01, EP 34; PI.01.01.01, EP 35; PI.01.01.01, EP 40	NPG.13.04.01, EP 1	The hospital collects data on the following: - Patient thermal injuries that occur during magnetic resonance imaging (MRI) exams - Incidents where ferromagnetic object unintentionally entered the MRI scanner room - Injuries resulting from the presence of ferromagnetic objects in the MRI scanner room
PI.01.01.01, EP 28	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home collects data on the following: Disease management outcomes.	Consolidation of PI.01.01.01, EP 28; PI.01.01.01, EP 29; PI.01.01.01, EP 30	PI.12.01.01, EP 5	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home collects data on the following: - Disease management outcomes - Patient access to care within time frames established by the hospital - Patient experience and satisfaction related to access to care, treatment, or services and communication - Patient perception of the comprehensiveness of care, treatment, or services - Patient perception of the coordination of care, treatment, or services - Patient perception of the continuity of care, treatment, or services
PI.01.01.01, EP 29	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home collects data on the following: Patient access to care within time frames established by the hospital.	Consolidation of PI.01.01.01, EP 28; PI.01.01.01, EP 29; PI.01.01.01, EP 30	PI.12.01.01, EP 5	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home collects data on the following: - Disease management outcomes - Patient access to care within time frames established by the hospital - Patient experience and satisfaction related to access to care, treatment, or services and communication - Patient perception of the comprehensiveness of care, treatment, or services - Patient perception of the coordination of care, treatment, or services - Patient perception of the continuity of care, treatment, or services
PI.01.01.01, EP 30	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home collects data on the following: - Patient experience and satisfaction related to access to care, treatment, or services, and communication - Patient perception of the comprehensiveness of care, treatment, or services - Patient perception of the coordination of care, treatment, or services - Patient perception of the continuity of care, treatment, or services	Consolidation of PI.01.01.01, EP 28; PI.01.01.01, EP 29; PI.01.01.01, EP 30	PI.12.01.01, EP 5	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home collects data on the following: - Disease management outcomes - Patient access to care within time frames established by the hospital - Patient experience and satisfaction related to access to care, treatment, or services and communication - Patient perception of the comprehensiveness of care, treatment, or services - Patient perception of the coordination of care, treatment, or services - Patient perception of the continuity of care, treatment, or services
PI.01.01.01, EP 34	The hospital collects data on patient thermal injuries that occur during magnetic resonance imaging exams.	Consolidation of PI.01.01.01, EP 4; PI.01.01.01, EP 14;	NPG.13.04.01, EP 1	The hospital collects data on the following: - Patient thermal injuries that occur during magnetic resonance imaging (MRI) exams - Incidents where ferromagnetic object unintentionally entered the MRI scanner

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
		PI.01.01.01, EP 34; PI.01.01.01, EP 35; PI.01.01.01, EP 40		room - Injuries resulting from the presence of ferromagnetic objects in the MRI scanner room
PI.01.01.01, EP 35	The hospital collects data on the following: - Incidents where ferromagnetic objects unintentionally entered the magnetic resonance imaging (MRI) scanner room - Injuries resulting from the presence of ferromagnetic objects in the MRI scanner room	Consolidation of PI.01.01.01, EP 4; PI.01.01.01, EP 14; PI.01.01.01, EP 34; PI.01.01.01, EP 35; PI.01.01.01, EP 40	NPG.13.04.01, EP 1	The hospital collects data on the following: - Patient thermal injuries that occur during magnetic resonance imaging (MRI) exams - Incidents where ferromagnetic object unintentionally entered the MRI scanner room - Injuries resulting from the presence of ferromagnetic objects in the MRI scanner room
PI.01.01.01, EP 40	The hospital collects data on pain assessment and pain management including types of interventions and effectiveness.	Consolidation of PI.01.01.01, EP 4; PI.01.01.01, EP 14; PI.01.01.01, EP 34; PI.01.01.01, EP 35; PI.01.01.01, EP 40	NPG.13.04.01, EP 1	The hospital collects data on the following: - Patient thermal injuries that occur during magnetic resonance imaging (MRI) exams - Incidents where ferromagnetic object unintentionally entered the MRI scanner room - Injuries resulting from the presence of ferromagnetic objects in the MRI scanner room
PI.02.01.01, EP 1	Performance improvement priorities established by hospital leaders are described in a written plan that includes the following: - The defined process(es) needing improvement, along with any stakeholder (for example, patient, staff, regulatory) requirements, project goals, and improvement activities - Method(s) for measuring performance of the process(es) identified for improvement - Analysis method(s) for identifying causes of variation and poor performance in the process(es) - Methods implemented to address process deficiencies and improve performance - Methods for monitoring and sustaining the improved process(es)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PI.02.01.01, EP 2	Leaders review the plan for addressing performance improvement priorities at least annually and updates it to reflect any changes in strategic priorities and in response to changes in the internal or external environment.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PI.03.01.01, EP 3	The hospital uses statistical tools and techniques to analyze and display data. CoPs: §482.21, §482.21(a)(2), §482.21(e)(1)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
PI.03.01.01, EP 4	The hospital analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations. CoPs: §482.21, §482.21(a)(2), §482.21(b)(2)(i), §482.21(c)(2), §482.21(e)(1)	Consolidation of PI.03.01.01, EP 4; PI.03.01.01, EP 8	PI.13.01.01, EP 1	The hospital analyzes and compares internal data over time and uses the results of data analysis to do the following: - Monitor the effectiveness and safety of services - Monitor the quality of care - Identify opportunities for improvement and changes that will lead to improvement CoPs: §482.21(b)(2)(i), §482.21(b)(2)(ii)
PI.03.01.01, EP 6	The hospital reviews and analyzes incidents where the radiation dose index (computed tomography dose index [CTDIvol], dose length product [DLP], or size-specific dose estimate [SSDE]) from diagnostic CT examinations exceeded expected dose index ranges identified in imaging protocols. These incidents are then compared to external benchmarks. Note 1: While the CTDIvol, DLP, and SSDE are useful indicators for monitoring	Moved and Revised	NPG.13.04.01, EP 2	The hospital reviews and analyzes incidents where the radiation dose index (computed tomography dose index [CTDIvol], dose length product [DLP], or size-specific dose estimate [SSDE]) from diagnostic CT examinations exceeded expected dose index ranges identified in imaging protocols. These incidents are then compared to external benchmarks. Note 1: While the CTDIvol, DLP, and SSDE are useful indicators for monitoring

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	radiation dose indices from the CT machine, they do not represent the patient's radiation dose. Note 2: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.			radiation dose indices from the CT machine, they do not represent the patient's radiation dose. Note 2: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.
PI.03.01.01, EP 8	The hospital uses the results of data analysis to identify improvement opportunities. CoPs: §482.21, §482.21(a)(2), §482.21(b)(2)(ii), §482.21(e)(1)	Consolidation of PI.03.01.01, EP 4; PI.03.01.01, EP 8	PI.13.01.01, EP 1	The hospital analyzes and compares internal data over time and uses the results of data analysis to do the following: - Monitor the effectiveness and safety of services - Monitor the quality of care - Identify opportunities for improvement and changes that will lead to improvement CoPs: §482.21(b)(2)(i), §482.21(b)(2)(ii)
PI.03.01.01, EP 12	When the hospital identifies undesirable patterns, trends, or variations in its performance related to the safety or quality of care (for example, as identified in the analysis of data or a single undesirable event), it includes the adequacy of staffing, including nurse staffing, in its analysis of possible causes. Note 1: Adequacy of staffing includes the number, skill mix, and competency of all staff. In their analysis, hospitals may also wish to examine issues such as processes related to work flow; competency assessment; credentialing; supervision of staff; and orientation, training, and education. Note 2: Hospitals may find value in using the staffing effectiveness indicators (which include National Quality Forum Nursing Sensitive Measures) to help identify potential staffing issues.	Moved and Revised	NPG.12.06.01, EP 1	When the hospital identifies undesirable patterns, trends, or variations in its performance related to the safety or quality of care (for example, as identified in the analysis of data or a single undesirable event), it includes the adequacy of staffing, including nurse staffing, in its analysis of possible causes. Note 1: Adequacy of staffing includes the number, skill mix, and competency of all staff. In their analysis, hospitals may also wish to examine issues such as processes related to workflow; competency assessment; credentialing; supervision of staff; and orientation, training, and education. Note 2: Hospitals may find value in using the staffing effectiveness indicators (which include National Quality Forum Nursing Sensitive Measures) to help identify potential staffing issues.
PI.03.01.01, EP 13	When analysis reveals a problem with the adequacy of staffing, the leaders responsible for the hospitalwide patient safety program (as addressed at LD.03.09.01, EP 1) are informed, in a manner determined by the safety program, of the results of this analysis and actions taken to resolve the identified problem(s).	Moved and Revised	NPG.12.06.01, EP 2	When analysis reveals a problem with the adequacy of staffing, the leaders responsible for the hospitalwide patient safety program (as addressed at NPG.02.03.01, EP 1) are informed, in a manner determined by the safety program, of the results of this analysis and actions taken to resolve the identified problem(s).
PI.03.01.01, EP 14	At least once a year, the leaders responsible for the hospitalwide patient safety program review a written report on the results of any analyses related to the adequacy of staffing and any actions taken to resolve identified problems.	Moved	NPG.12.06.01, EP 3	At least once a year, the leaders responsible for the hospitalwide patient safety program review a written report on the results of any analyses related to the adequacy of staffing and any actions taken to resolve identified problems.
PI.03.01.01, EP 18	The hospital analyzes data collected on pain assessment and pain management to identify areas that need change to increase safety and quality for patients.	Moved	NPG.06.03.01, EP 1	The hospital analyzes data collected on pain assessment and pain management to identify areas that need change to increase safety and quality for patients.
PI.03.01.01, EP 22	An interdisciplinary committee reviews cases and data to identify and suggest practice and system improvements in resuscitation performance. Note 1: Examples of the review could include the following: - How often early warning signs of clinical deterioration were present prior to in-hospital cardiac arrest in patients in non-monitored or non–critical care units - Timeliness of staff's response to a cardiac arrest - The quality of cardiopulmonary resuscitation (CPR) - Post–cardiac arrest care processes - Outcomes following cardiac arrest Note 2: The review functions may be designated to an existing interdisciplinary committee.	Moved and Revised	NPG.01.05.05, EP 1	An interdisciplinary committee reviews cases and data to identify and suggest practice and system improvements in resuscitation performance. Note 1: Review examples could include the following: - How often early warning signs of clinical deterioration were present prior to in-hospital cardiac arrest in patients in nonmonitored or non–critical care units - Timeliness of staff's response to a cardiac arrest - Quality of cardiopulmonary resuscitation (CPR) - Post–cardiac arrest care processes - Outcomes following cardiac arrest Note 2: The review functions may be designated to an existing interdisciplinary committee.
PI.04.01.01, EP 2	The hospital acts on improvement priorities. CoPs: §482.21, §482.21(c)(3), §482.21(d)(4), §482.21(e)(1)	Moved	PI.14.01.01, EP 1	The hospital acts on improvement priorities. CoPs: §482.21, §482.21(c)(3), §482.21(d)(4), §482.21(e)(1)
PI.04.01.01, EP 3	The hospital uses improvement tools or methodologies to improve its performance.	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
		moved to guidance within SPG		
PI.04.01.01, EP 5	The hospital acts when it does not achieve or sustain planned improvements. CoPs: §482.21, §482.21(c)(3), §482.21(d)(3), §482.21(d)(4), §482.21(e)(1)	Moved and Revised	PI.12.01.01, EP 4	The hospital takes action to improve its performance. After implementing changes, the hospital measures its success and tracks performance to ensure that improvements are sustained. CoPs: §482.21(c)(3)
PI.04.01.01, EP 11	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home uses the data it collects on the patient's perception of the safety and quality of care, treatment, or services to improve its performance. This data includes the following: - Patient experience and satisfaction related to access to care, treatment, or services and communication - Patient perception of the comprehensiveness of care, treatment, or services - Patient perception of the coordination of care, treatment, or services - Patient perception of the continuity of care, treatment, or services	Moved	PI.14.01.01, EP 2	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home uses the data it collects on the patient's perception of the safety and quality of care, treatment, or services to improve its performance. This data includes the following: - Patient experience and satisfaction related to access to care, treatment, or services and communication - Patient perception of the comprehensiveness of care, treatment, or services - Patient perception of the coordination of care, treatment, or services - Patient perception of the continuity of care, treatment, or services
N/A	N/A	New, more-direct EP for CoP requirement	PI.11.01.01, EP 2	The hospital has an ongoing quality assessment and performance improvement program that shows measurable improvement for indicators that are selected based on evidence that they will improve health outcomes and aid in the identification and reduction of medical errors. The program incorporates quality indicator data, including patient care data and other relevant data to achieve the goals of the program. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Relevant data includes data submitted to or received from Medicare quality reporting and quality performance programs including but not limited to data related to hospital readmissions and hospital-acquired conditions. CoPs: §482.21(a)(1), §482.21(b)(1)
N/A	N/A	New, more-direct EP for CoP requirement	PI.11.01.01, EP 3	The hospital conducts performance improvement projects as part of its quality assessment and performance improvement program. The number and scope of distinct improvement projects conducted annually is proportional to the scope and complexity of the hospital's services and operations. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital may, as one of its projects, develop and implement an information technology system explicitly designed to improve patient safety and quality of care. In the initial stage of development, this project does not need to demonstrate measurable improvement in indicators related to health outcomes. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital is not required to participate in a quality improvement organization cooperative project, but its own projects are required to be of comparable effort. CoPs: §482.21(d), §482.21(d)(1), §482.21(d)(2), §482.21(d)(4)
N/A	N/A	New, more-direct EP for CoP requirement	PI.12.01.01, EP 1	The hospital tracks medical errors and adverse patient events, analyzes their causes, and implements preventive actions and mechanisms that include feedback and learning throughout the hospital. Medical errors and adverse patient events include but are not limited to the following: - Medication administration errors - Surgical errors

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
				- Equipment failure - Infection control errors - Blood transfusion–related errors - Diagnostic errors CoPs: §482.21(c)(2)
N/A	N/A	New, more-direct EP for CoP requirement	PI.12.01.01, EP 2	The hospital documents what quality improvement projects it is conducting, the reasons for conducting these projects, and the measurable progress achieved on these projects. CoPs: §482.21(d)(3)
N/A	N/A	New, more-direct EP for CoP requirement	PI.12.01.01, EP 3	The hospital measures, analyzes, and tracks quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital service, and operations. CoPs: §482.21(a)(2)
RC.01.01.01, EP 1	The hospital defines the components of a complete medical record. CoPs: §482.24, §482.24(b)	Moved and Revised	RC.11.01.01, EP 1	The hospital maintains a medical record for every inpatient and outpatient in the hospital. CoPs: §482.24, §482.24(b)
RC.01.01.01, EP 5	The medical record includes the following: - Information needed to support the patient's diagnosis and condition - Information needed to justify the patient's care, treatment, and services - Information that documents the course and result of the patient's care, treatment, and services - Information about the patient's care, treatment, and services that promotes continuity of care among staff and providers Note: For hospitals that elect The Joint Commission Primary Care Medical Home option: This requirement refers to care provided by both internal and external providers. CoPs: §482.24, §482.24(b), §482.24(c), §482.24(c)(1), §482.58(b)(2), §482.61(a)(2), §482.61(c)(1)(i), §482.61(c)(1)(iv), §482.61(c)(1)(v), §482.61(c)(2), §483.15(c)(3)(ii), §483.15(c)(3)(iii)	Moved and Revised	RC.11.01.01, EP 2	The medical record includes the following: - Information needed to justify the patient's admission and continued care, treatment, and services - Information needed to support the patient's diagnosis and condition - Information about the patient's care, treatment, and services that promotes continuity of care among staff and providers Note: For hospitals that elect The Joint Commission Primary Care Medical Home option: This requirement refers to care provided by both internal and external providers. CoPs: §482.24(c)
RC.01.01.01, EP 7	All entries in the medical record are dated. CoPs: §482.24(c)(1), §482.24(c)(2), §482.53(d), §482.53(d)(2)	Consolidation of RC.01.01.01, EP 7; RC.01.01.01, EP 13; RC.01.02.01, EP 2; RC.01.02.01, EP 3	RC.11.01.01, EP 4	The hospital develops and implements policies and procedures for accurate, legible, complete, signed, dated, and timed medical record entries that are authenticated by the person responsible for providing or evaluating the service provided. The medical records are promptly completed, properly filed and retained, and readily accessible. CoPs: §482.24(b), §482.24(c)(1), §482.53(d), §482.53(d)(2)
RC.01.01.01, EP 13	For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed. CoPs: §482.24(c)(1), §482.24(c)(2)	Consolidation of RC.01.01.01, EP 7; RC.01.01.01, EP 13; RC.01.02.01, EP 2; RC.01.02.01, EP 3	RC.11.01.01, EP 4	The hospital develops and implements policies and procedures for accurate, legible, complete, signed, dated, and timed medical record entries that are authenticated by the person responsible for providing or evaluating the service provided. The medical records are promptly completed, properly filed and retained, and readily accessible. CoPs: §482.24(b), §482.24(c)(1), §482.53(d), §482.53(d)(2)
RC.01.02.01, EP 1	Only authorized individuals make entries in the medical record. CoPs: §482.23(c)(3)(iii)	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
		moved to guidance within SPG		
RC.01.02.01, EP 2	The hospital defines the types of entries in the medical record made by licensed practitioners that require countersigning, in accordance with law and regulation. CoPs: §482.23(c)(3)(iii), §482.24(c)(1), §482.24(c)(2)	Consolidation of RC.01.01.01, EP 7; RC.01.01.01, EP 13; RC.01.02.01, EP 2; RC.01.02.01, EP 3	RC.11.01.01, EP 4	The hospital develops and implements policies and procedures for accurate, legible, complete, signed, dated, and timed medical record entries that are authenticated by the person responsible for providing or evaluating the service provided. The medical records are promptly completed, properly filed and retained, and readily accessible. CoPs: §482.24(b), §482.24(c)(1), §482.53(d), §482.53(d)(2)
RC.01.02.01, EP 3	The author of each medical record entry is identified in the medical record. CoPs: §482.23(c)(3)(iii), §482.24(b), §482.24(c)(1), §482.24(c)(2), §482.26(d)(1), §482.53(d), §482.53(d)(2)	Consolidation of RC.01.01.01, EP 7; RC.01.01.01, EP 13; RC.01.02.01, EP 2; RC.01.02.01, EP 3	RC.11.01.01, EP 4	The hospital develops and implements policies and procedures for accurate, legible, complete, signed, dated, and timed medical record entries that are authenticated by the person responsible for providing or evaluating the service provided. The medical records are promptly completed, properly filed and retained, and readily accessible. CoPs: §482.24(b), §482.24(c)(1), §482.53(d), §482.53(d)(2)
RC.01.02.01, EP 4	Entries in the medical record are authenticated by the author. Information introduced into the medical record through transcription or dictation is authenticated by the author. Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key. Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or hospital policy. For electronic records, electronic signatures will be date-stamped. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: All orders, including verbal orders, are dated and authenticated by the ordering physician or other licensed practitioner who is responsible for the care of the patient, and who, in accordance with hospital policy; law and regulation; and medical staff bylaws, rules, and regulations, is authorized to write orders. CoPs: §482.23(c)(3), §482.23(c)(3)(iii), §482.24(b), §482.24(c)(1), §482.24(c)(2), §482.26(d)(1), §482.51(b)(6), §482.53(d), §482.53(d)(2)	Moved and Revised	RC.11.02.01, EP 1	All orders, including verbal orders, are dated, timed, and authenticated by the ordering physician or other licensed practitioner who is responsible for the patient's care and who is authorized to write orders, in accordance with hospital policy, law and regulation, and medical staff bylaws, rules, and regulations. CoPs: §482.24(c)(2)
RC.01.02.01, EP 5	The individual identified by the signature stamp or method of electronic authentication is the only individual who uses it. CoPs: §482.23(c)(3), §482.24(b), §482.24(c)(1), §482.24(c)(2), §482.26(d)(1), §482.53(d), §482.53(d)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
RC.01.03.01, EP 1	The hospital defines the time frame for completion of the medical record, which does not exceed 30 days after the patient's discharge. CoPs: §482.24(b), §482.24(c)(4)(viii)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
RC.01.03.01, EP 2	The hospital follows its written policy requiring timely entry of information into the patient's medical record. CoPs: §482.24(b)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
RC.01.03.01, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital records the patient's medical history and physical examination, including updates, in the medical record within 24 hours after registration or inpatient admission but prior to surgery or a procedure requiring anesthesia services.	Consolidation of RC.01.03.01, EP 3; RC.02.01.03, EP 3;	RC.12.01.01, EP 6	The medical history and physical examination or updates to the medical history and physical examination are placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.24(c)(4)(i)(A), §482.24(c)(4)(i)(B), §482.51(b)(1)(i), §482.51(b)(1)(ii)	RC.02.01.03, EP 5; RC.02.01.03, EP 7		CoPs: §482.24(c)(4)(i)(A), §482.24(c)(4)(i)(B)
RC.01.04.01, EP 1	The hospital conducts an ongoing review of medical records at the point of care, based on the following indicators: presence, timeliness, legibility (whether handwritten or printed), accuracy, authentication, and completeness of data and information. CoPs: §482.24(b), §482.24(c)(1)	Moved and Revised	RC.11.02.01, EP 2	The hospital uses a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. CoPs: §482.24(b)
RC.01.05.01, EP 1	The retention time of the original or legally reproduced medical record is determined by its use and hospital policy, in accordance with law and regulation. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Medical records are retained in their original or legally reproduced form for at least five years. This includes nuclear medicine reports; radiological reports, printouts, films, scans; and other applicable image records. CoPs: §482.24(b), §482.24(b)(1), §482.26(d)(2), §482.26(d)(2)(i), §482.26(d)(2)(ii), §482.53(d)(1)	Moved and Revised	RC.11.03.01, EP 1	The retention time of the original or legally reproduced medical record is determined by its use and hospital policy, in accordance with law and regulation. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Medical records are retained in their original or legally reproduced form for at least five years. This includes nuclear medicine reports; radiological reports, printouts, films, and scans; and other applicable image records. CoPs: §482.24(b)(1), §482.26(d)(2), §482.26(d)(2)(i), §482.26(d)(2)(ii), §482.53(d)(1)
RC.01.05.01, EP 8	Original medical records are not released unless the hospital is responding to law and regulation. CoPs: §482.24(b), §482.24(b)(3)	Moved and Revised	IM.12.01.01, EP 3	The hospital develops and implements policies and procedures for the release of medical records. The policies and procedures are in accordance with law and regulation, court orders, or subpoenas. Note: Information from or copies of records may be released only to authorized individuals, and the hospital makes certain that unauthorized individuals cannot gain access to or alter patient records. CoPs: §482.24(b)(3)
RC.02.01.01, EP 1	The medical record contains the following demographic information: - The patient's name, address, and date of birth and the name of any legally authorized representative - The patient's sex - The legal status of any patient receiving behavioral health care services - The patient's communication needs, including preferred language for discussing health care Note: If the patient is a minor, is incapacitated, or has a designated advocate, the communication needs of the parent or legal guardian, surrogate decision-maker, or legally authorized representative is documented in the medical record. CoPs: §482.61(a)(1)	Consolidation of RC.02.01.01, EP 1; RC.02.01.01, EP 25	RC.12.01.01, EP 1	The medical record contains the following demographic information for the patient: - Name, address, and date of birth and the name of any legally authorized representative - Sex - Legal status of any patient receiving behavioral health care services - Communication needs, including preferred language for discussing health care - Race and ethnicity Note: If the patient is a minor, is incapacitated, or has a designated advocate, the communication needs of the parent or legal guardian, surrogate decision-maker, or legally authorized representative are documented in the medical record.
RC.02.01.01, EP 2	The medical record contains the following clinical information: - The reason(s) for admission for care, treatment, and services - The patient's initial diagnosis, diagnostic impression(s), or condition(s) - Any findings of assessments and reassessments - Any allergies to food - Any allergies to medications - Any conclusions or impressions drawn from the patient's medical history and physical examination - Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric hospitals using Joint Commission accreditation for deemed status purposes: The diagnosis includes intercurrent diseases (diseases that occur during	Moved and Revised	RC.12.01.01, EP 2	The medical record contains the following clinical information: - Admitting diagnosis - Any emergency care, treatment, and services provided to the patient before their arrival - Any allergies to food and medications - Any findings of assessments and reassessments - Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient - Treatment goals, plan of care, and revisions to the plan of care - Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia - All practitioners' orders

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	the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival - Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration Note 1: When rapid titration of a medication is necessary, the hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. Note 2: For the definition and a further explanation of block charting, refer to the Glossary. - Any access site for medication, administration devices used, and rate of administration - Any adverse drug reactions - Treatment goals, plan of care, and revisions to the plan of care - Results of diagnostic and therapeutic tests and procedures - Any medications dispensed or prescribed on discharge - Discharge diagnosis - Discharge plan and discharge planning evaluation CoPs: §482.23(c)(3), §482.23(c)(6)(i)(E), §482.23(c)(6)(ii)(E), §482.24(c), §482.24(c)(4)(ii), §482.24(c)(4)(iii), §482.24(c)(4)(iv), §482.24(c)(4)(vi), §482.24(c)(4)(viii), §482.26(d), §482.43(a)(3), §482.53(d), §482.56(b)(1), §482.57(b)(4), §482.61(d), §482.61(a), §482.61(a)(2), §482.61(a)(3), §482.61(a)(4), §482.61(a)(5), §482.61(c)(1)(i), §482.61(c)(1)(ii), §482.61(c)(1)(iv), §482.61(c)(1)(v), §482.61(c)(2)			- Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition - Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. - Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) - Records of radiology and nuclear medicine services, including signed interpretation reports - All care, treatment, and services provided to the patient - Patient's response to care, treatment, and services - Medical history and physical examination, including any conclusions or impressions drawn from the information - Discharge plan and discharge planning evaluation - Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge - Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis. CoPs: §482.23(c)(6)(i)(E), §482.23(c)(6)(ii)(E), §482.24(c), §482.24(c)(4)(ii), §482.24(c)(4)(iii), §482.24(c)(4)(iv), §482.24(c)(4)(vi), §482.24(c)(4)(vii), §482.24(c)(4)(viii), §482.26(d), §482.26(d)(1), §482.43(a)(3), §482.53(d), §482.56(b)(1), §482.57(b)(4)
RC.02.01.01, EP 4	As needed to provide care, treatment, and services, the medical record contains the following additional information: - Any advance directives - Any informed consent, when required by hospital policy Note: The properly executed informed consent is placed in the patient's medical record prior to surgery, except in emergencies. A properly executed informed consent contains documentation of a patient's mutual understanding of and agreement for care, treatment, and services through written signature; electronic signature; or, when a patient is unable to provide a signature, documentation of the verbal agreement by the patient or surrogate decision-maker. - Any records of communication with the patient, such as telephone calls or e-mail - Any patient-generated information CoPs: §482.24(c)(4)(v), §482.51(b)(2)	Moved and Revised	RC.12.01.01, EP 3	The medical record contains any informed consent, when required by hospital policy or federal or state law or regulation. Note: The properly executed informed consent is placed in the patient's medical record prior to surgery, except in emergencies. A properly executed informed consent contains documentation of a patient's mutual understanding of and agreement for care, treatment, and services through written signature; electronic signature; or, when a patient is unable to provide a signature, documentation of the verbal agreement by the patient or surrogate decision-maker. CoPs: §482.24(c)(4)(v), §482.51(b)(2)
RC.02.01.01, EP 7	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Progress notes must be documented in accordance with applicable state scope-of-practice laws and hospital policies by the following qualified practitioners:	Moved and Revised	RC.12.01.01, EP 4	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Progress notes are documented in accordance with applicable state scope-of-practice laws and hospital policies by the following qualified practitioners:

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	- Doctor(s) of medicine or osteopathy or other licensed practitioner(s) who is responsible for the care of the patient - Nurse(s) - Social worker(s) or social service staff involved in the care of the patient - When appropriate, others significantly involved in the patient's active treatment modalities The frequency of progress notes is determined by the condition of the patient but must be recorded at least weekly for the first 2 months and at least once a month thereafter, and must contain recommendations for revisions in the treatment plan as indicated as well as a precise assessment of the patient's progress in accordance with the original or revised treatment plan. CoPs: §482.61(d), §482.61(d)			- Doctor(s) of medicine or osteopathy or other licensed practitioner(s) who is responsible for the care of the patient - Nurse(s) - Social worker(s) or social service staff involved in the care of the patient - When appropriate, others significantly involved in the patient's active treatment modalities The patient's condition determines the frequency of progress notes, but they must be recorded at least weekly for the first 2 months and at least once a month thereafter. The progress notes must contain recommendations for revisions in the treatment plan as indicated, as well as a precise assessment of the patient's progress in accordance with the original or revised treatment plan. CoPs: §482.61(d)
RC.02.01.01, EP 18	The medical record of a patient who receives urgent or immediate care, treatment, and services contains all of the following: - The time and means of arrival - Indication that the patient left against medical advice, when applicable - Conclusions reached at the termination of care, treatment, and services, including the patient's final disposition, condition, and instructions given for follow-up care, treatment, and services - A copy of any information made available to the provider providing follow-up care, treatment, or services	Moved and Revised	RC.11.01.01, EP 3	The medical record of a patient who receives urgent or immediate care, treatment, and services contains all of the following: - Time and means of arrival - Indication that the patient left against medical advice, when applicable - Conclusions reached at the termination of care, treatment, and services, including the patient's final disposition, condition, and instructions given for follow-up care, treatment, and services - A copy of any information made available to the provider furnishing follow-up care, treatment, or services
RC.02.01.01, EP 25	The medical record contains the patient's race and ethnicity.	Consolidation of RC.02.01.01, EP 1; RC.02.01.01, EP 25	RC.12.01.01, EP 1	The medical record contains the following demographic information for the patient: - Name, address, and date of birth and the name of any legally authorized representative - Sex - Legal status of any patient receiving behavioral health care services - Communication needs, including preferred language for discussing health care - Race and ethnicity Note: If the patient is a minor, is incapacitated, or has a designated advocate, the communication needs of the parent or legal guardian, surrogate decision-maker, or legally authorized representative are documented in the medical record.
RC.02.01.01, EP 26	For hospitals that elect The Joint Commission Primary Care Medical Home option: The medical record includes the patient's self-management goals and the patient's progress toward achieving those goals. (Refer to PC.01.03.01, EP 44)	Moved and Revised	RC.11.01.01, EP 9	For hospitals that elect The Joint Commission Primary Care Medical Home option: The medical record includes the patient's self-management goals and their progress toward achieving those goals. (Refer to PC.11.03.01, EP 7)
RC.02.01.03, EP 1	The hospital documents in the patient's medical record any operative or other high-risk procedure and/or the administration of moderate or deep sedation or anesthesia. CoPs: §482.52(b)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
RC.02.01.03, EP 2	A physician or other licensed practitioner involved in the patient's care documents the provisional diagnosis in the medical record before an operative or other high-risk procedure is performed. CoPs: §482.51(b)(6)	Consolidation of RC.02.01.03, EP 2; RC.02.01.03, EP 5; RC.02.01.03, EP 6; RC.02.01.03, EP 7; RC.02.01.03, EP 8; RC.02.01.03, EP 11	RC.12.01.03, EP 2	An operative report is written or dictated immediately following surgery and signed by the surgeon. The report includes the following: - Name and hospital identification number of the patient - Date and times of the surgery - Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include opening and closing, harvesting grafts, dissecting tissue,

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				removing tissue, implanting devices, altering tissues) - Preoperative and postoperative diagnosis - Name of the specific surgical procedure(s) performed - Type of anesthesia administered - Complications, if any - Description of techniques, findings, and tissues removed or altered - Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any - Any estimated blood loss Note 1: The exception to this requirement occurs when an operative or other high-risk procedure progress note is written immediately after the procedure, in which case the full report can be written or dictated within a time frame defined by the hospital. Note 2: If the physician or other licensed practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be written or dictated in the new unit or area of care. CoPs: §482.51(b)(6)
RC.02.01.03, EP 3	The patient's medical history and physical examination are recorded in the medical record before an operative or other high-risk procedure is performed. CoPs: §482.24(c)(4)(i)(A)	Consolidation of RC.01.03.01, EP 3; RC.02.01.03, EP 3; RC.02.01.03, EP 5; RC.02.01.03, EP 7	RC.12.01.01, EP 6	The medical history and physical examination or updates to the medical history and physical examination are placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. CoPs: §482.24(c)(4)(i)(A), §482.24(c)(4)(i)(B)
RC.02.01.03, EP 5	An operative or other high-risk procedure report is written or dictated upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care. Note 1: The exception to this requirement occurs when an operative or other high-risk procedure progress note is written immediately after the procedure, in which case the full report can be written or dictated within a time frame defined by the hospital. Note 2: If the physician or other licensed practitioner 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. CoPs: §482.51(b)(6)	Split to RC.12.01.01, EP 6; RC.12.01.03, EP 2	RC.12.01.01, EP 6	The medical history and physical examination or updates to the medical history and physical examination are placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. CoPs: §482.24(c)(4)(i)(A), §482.24(c)(4)(i)(B)
RC.02.01.03, EP 5	An operative or other high-risk procedure report is written or dictated upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care. Note 1: The exception to this requirement occurs when an operative or other high-risk procedure progress note is written immediately after the procedure, in which case the full report can be written or dictated within a time frame defined by the hospital. Note 2: If the physician or other licensed practitioner 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.	Split to RC.12.01.01, EP 6; RC.12.01.03, EP 2	RC.12.01.03, EP 2	An operative report is written or dictated immediately following surgery and signed by the surgeon. The report includes the following: - Name and hospital identification number of the patient - Date and times of the surgery - Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues) - Preoperative and postoperative diagnosis - Name of the specific surgical procedure(s) performed

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	CoPs: §482.51(b)(6)			- Type of anesthesia administered - Complications, if any - Description of techniques, findings, and tissues removed or altered - Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any - Any estimated blood loss Note 1: The exception to this requirement occurs when an operative or other high-risk procedure progress note is written immediately after the procedure, in which case the full report can be written or dictated within a time frame defined by the hospital. Note 2: If the physician or other licensed practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be written or dictated in the new unit or area of care. CoPs: §482.51(b)(6)
RC.02.01.03, EP 6	The operative or other high-risk procedure report includes the following information: - The name(s) of the physician or other licensed practitioner(s) who performed the procedure and their assistant(s) - The name of the procedure performed - A description of the procedure - Findings of the procedure - Any estimated blood loss - Any specimen(s) removed - The postoperative diagnosis CoPs: §482.51(b)(6)	Consolidation of RC.02.01.03, EP 2; RC.02.01.03, EP 5; RC.02.01.03, EP 6; RC.02.01.03, EP 7; RC.02.01.03, EP 8; RC.02.01.03, EP 11	RC.12.01.03, EP 2	An operative report is written or dictated immediately following surgery and signed by the surgeon. The report includes the following: - Name and hospital identification number of the patient - Date and times of the surgery - Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues) - Preoperative and postoperative diagnosis - Name of the specific surgical procedure(s) performed - Type of anesthesia administered - Complications, if any - Description of techniques, findings, and tissues removed or altered - Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any - Any estimated blood loss Note 1: The exception to this requirement occurs when an operative or other high-risk procedure progress note is written immediately after the procedure, in which case the full report can be written or dictated within a time frame defined by the hospital. 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. CoPs: §482.51(b)(6)
RC.02.01.03, EP 7	When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon(s) and their assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis.	Split to RC.12.01.01, EP 6; RC.12.01.03, EP 2	RC.12.01.01, EP 6	The medical history and physical examination or updates to the medical history and physical examination are placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. CoPs: §482.24(c)(4)(i)(A), §482.24(c)(4)(i)(B)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.51(b)(6)			
RC.02.01.03, EP 7	When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon(s) and their assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis. CoPs: §482.51(b)(6)	Split to RC.12.01.01, EP 6; RC.12.01.03, EP 2	RC.12.01.03, EP 2	An operative report is written or dictated immediately following surgery and signed by the surgeon. The report includes the following: - Name and hospital identification number of the patient - Date and times of the surgery - Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues) - Preoperative and postoperative diagnosis - Name of the specific surgical procedure(s) performed - Type of anesthesia administered - Complications, if any - Description of techniques, findings, and tissues removed or altered - Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any - Any estimated blood loss Note 1: The exception to this requirement occurs when an operative or other high-risk procedure progress note is written immediately after the procedure, in which case the full report can be written or dictated within a time frame defined by the hospital. 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. CoPs: §482.51(b)(6)
RC.02.01.03, EP 8	The medical record contains the following postoperative information: - The patient's vital signs and level of consciousness - Any medications, including intravenous fluids and any administered blood, blood products, and blood components - Any unanticipated events or complications (including blood transfusion reactions) and the management of those events CoPs: §482.24(c)(4)(iv), §482.51(b)(6)	Consolidation of RC.02.01.03, EP 2; RC.02.01.03, EP 5; RC.02.01.03, EP 6; RC.02.01.03, EP 7; RC.02.01.03, EP 8; RC.02.01.03, EP 11	RC.12.01.03, EP 2	An operative report is written or dictated immediately following surgery and signed by the surgeon. The report includes the following: - Name and hospital identification number of the patient - Date and times of the surgery - Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues) - Preoperative and postoperative diagnosis - Name of the specific surgical procedure(s) performed - Type of anesthesia administered - Complications, if any - Description of techniques, findings, and tissues removed or altered - Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any - Any estimated blood loss Note 1: The exception to this requirement occurs when an operative or other high-risk procedure progress note is written immediately after the procedure, in which case the full report can be written or dictated within a time frame defined by the

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
				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. CoPs: §482.51(b)(6)
RC.02.01.03, EP 9	The medical record contains documentation that the patient was discharged from the post-sedation or postanesthesia care area either by the physician or other licensed practitioner responsible for the patient's care or according to discharge criteria.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
RC.02.01.03, EP 10	The medical record contains documentation of the use of approved discharge criteria that determine the patient’s readiness for discharge.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
RC.02.01.03, EP 11	The postoperative documentation contains the name of the physician or other licensed practitioner responsible for discharge. CoPs: §482.51(b)(6)	Consolidation of RC.02.01.03, EP 2; RC.02.01.03, EP 5; RC.02.01.03, EP 6; RC.02.01.03, EP 7; RC.02.01.03, EP 8; RC.02.01.03, EP 11	RC.12.01.03, EP 2	An operative report is written or dictated immediately following surgery and signed by the surgeon. The report includes the following: - Name and hospital identification number of the patient - Date and times of the surgery - Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues) - Preoperative and postoperative diagnosis - Name of the specific surgical procedure(s) performed - Type of anesthesia administered - Complications, if any - Description of techniques, findings, and tissues removed or altered - Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any - Any estimated blood loss Note 1: The exception to this requirement occurs when an operative or other high-risk procedure progress note is written immediately after the procedure, in which case the full report can be written or dictated within a time frame defined by the hospital. 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. CoPs: §482.51(b)(6)
RC.02.01.03, EP 15	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a complete and up-to-date operating room register that includes the following: - Patient's name - Patient's hospital identification number	Moved and Revised	RC.12.01.03, EP 1	The hospital has a complete and up-to-date operating room register or equivalent record that includes the following: - Patient's name - Patient's hospital identification number - Date of operation

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	- Date of operation - Inclusive or total time of operation - Name of surgeon and any assistants - Name of nursing personnel - Type of anesthesia used and name of person administering it - Operation performed - Pre- and postoperative diagnosis - Age of patient Note: A postoperative summary may be considered equivalent if all items listed in this element of performance are included. CoPs: §482.51(b)(5)			- 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 CoPs: §482.51(b)(5)
RC.02.03.07, EP 1	The hospital identifies, in writing, the staff who are authorized to receive and record verbal orders, in accordance with law and regulation. CoPs: §482.23(c)(3)(ii)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
RC.02.03.07, EP 2	Only authorized staff receive and record verbal orders. CoPs: §482.23(c)(3)(ii)	Moved and Revised	RC.12.02.01, EP 1	Only staff authorized by hospital policies and procedures consistent with federal and state law accept and record verbal orders. CoPs: §482.23(c)(3)(ii)
RC.02.03.07, EP 3	Documentation of verbal orders includes the date and the names of individuals who gave, received, recorded, and implemented the orders. CoPs: §482.23(c)(3)(ii), §482.24(c)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
RC.02.03.07, EP 4	Verbal orders are authenticated within the time frame specified by law and regulation. CoPs: §482.23(c)(3), §482.23(c)(3)(ii), §482.24(c)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
RC.02.03.07, EP 6	For hospitals that use Joint Commission accreditation for deemed status purposes: Documentation of verbal orders includes the time the verbal order was received. CoPs: §482.23(c)(3)(ii), §482.24(c)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
RC.02.04.01, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. There is documentation in the resident's medical record by the resident's physician when the resident is transferred or discharged, either when the transfer is due to the resident improving and no longer needing long term care services or when the resident's needs cannot be met in the hospital's swing bed. There is documentation in the resident's medical record by a physician when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered. CoPs: §482.58(b)(2), §483.15(c)(2), §483.15(c)(2)(ii)(A), §483.15(c)(2)(ii)(B), §483.21(c)(2)(i), §483.21(c)(2)(ii), §483.21(c)(2)(iii), §483.21(c)(2)(iv)	Moved and Revised	RC.12.03.01, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. A physician documents in the resident's medical record when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered. The resident's physician documents in the medical record when the transfer is due to the resident improving and no longer needing long term care services or when the transfer is due to the resident's welfare and resident's needs cannot be met in the hospital's swing bed. CoPs: §482.58(b)(2), §483.15(c)(2), §483.15(c)(2)(ii)(A), §483.15(c)(2)(ii)(B)

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RC.02.04.01, EP 2	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident's discharge information includes the following: - The reason for transfer, discharge, or referral - Treatment provided, diet, medication orders, and orders for the resident's immediate care - Referrals provided to the resident, the referring physician's or other licensed practitioner's name, and the name of the physician or other licensed practitioner who has agreed to be responsible for the resident's medical care and treatment, if this person is someone other than the referring physician or other licensed practitioner - Medical findings and diagnoses; a summary of the care, treatment, and services provided; and progress reached toward goals - Information about the resident's behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation - Nursing information that is useful in the resident's care - Any advance directives - Instructions given to the resident before discharge CoPs: §482.58(b)(2), §483.15(c)(2), §483.15(c)(2)(i)(A), §483.15(c)(2)(i)(B), §483.21(c)(2)(i), §483.21(c)(2)(ii), §483.21(c)(2)(iii), §483.21(c)(2)(iv)	Moved and Revised	RC.12.03.01, EP 2	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident's discharge information includes the following: - Reason for transfer, discharge, or referral - Treatment provided, diet, medication orders, and orders for the resident's immediate care - Referrals provided to the resident, the referring physician's or other licensed practitioner's name, and the name of the physician or other licensed practitioner who has agreed to be responsible for the resident's medical care and treatment, if this person is someone other than the referring physician or other licensed practitioner - Medical findings and diagnoses; a summary of the care, treatment, and services provided; and progress reached toward goals - Information about the resident's behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation - Nursing information that is useful in the resident's care - Any advance directives - Instructions given to the resident before discharge CoPs: §482.58(b)(2), §483.15(c)(2)(i)(A)
RC.02.04.01, EP 3	In order to provide information to other caregivers and facilitate the patient's continuity of care, the medical record contains a concise discharge summary that includes the following: - The reason for hospitalization - The procedures performed - The care, treatment, and services provided - The patient's condition and disposition at discharge - Information provided to the patient and family - Provisions for follow-up care Note 1: A discharge summary is not required when a patient is seen for minor problems or interventions, as defined by the medical staff. In this instance, a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care. Note 2: When a patient is transferred to a different level of care within the hospital, and caregivers change, a transfer summary may be substituted for the discharge summary. If the caregivers do not change, a progress note may be used. Note 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The record of each patient discharged needs to include a discharge summary with the above information. The exceptions in Notes 1 and 2 are not applicable. All patients discharged need to have a discharge summary. CoPs: §482.24(c)(4)(vii), §482.61(e), §482.61(e), §482.61(e), §483.21(c)(2)(i), §483.21(c)(2)(ii), §483.21(c)(2)(iii), §483.21(c)(2)(iv)	Split to RC.11.01.01, EP 6; RC.12.03.01, EP 5	RC.11.01.01, EP 6	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The medical record contains the following information: - History of findings and treatment provided for the psychiatric condition for which the patient is hospitalized - Identification data, including the patient's legal status - Provisional or admitting diagnosis for the patient at the time of admission that includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses - Reasons for admission, as stated by the patient and/or others significantly involved - Social service records, including reports of interviews with patients, family members, and others; an assessment of home plans, family attitudes, and community resource contacts; and a social history - When indicated, record of a complete neurological examination, recorded at the time of the admission physical examination - Documentation of treatment received, including all active therapeutic efforts - Discharge summary of the patient's hospitalization that includes recommendations from appropriate services concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge CoPs: §482.61(a), §482.61(a)(1), §482.61(a)(2), §482.61(a)(3), §482.61(a)(4), §482.61(a)(5), §482.61(c)(2), §482.61(e)
RC.02.04.01, EP 3	In order to provide information to other caregivers and facilitate the patient's continuity of care, the medical record contains a concise discharge summary that includes the following: - The reason for hospitalization - The procedures performed	Split to RC.11.01.01, EP 6; RC.12.03.01, EP 5	RC.12.03.01, EP 5	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: When the hospital anticipates the discharge of a resident, the discharge summary includes but is not limited to the following: - A summary of the resident's stay that includes at a minimum the resident's diagnosis, course of illness/treatment or therapy, and pertinent laboratory, radiology,

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	- The care, treatment, and services provided - The patient's condition and disposition at discharge - Information provided to the patient and family - Provisions for follow-up care Note 1: A discharge summary is not required when a patient is seen for minor problems or interventions, as defined by the medical staff. In this instance, a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care. Note 2: When a patient is transferred to a different level of care within the hospital, and caregivers change, a transfer summary may be substituted for the discharge summary. If the caregivers do not change, a progress note may be used. Note 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The record of each patient discharged needs to include a discharge summary with the above information. The exceptions in Notes 1 and 2 are not applicable. All patients discharged need to have a discharge summary. CoPs: §482.24(c)(4)(vii), §482.61(e), §482.61(e), §482.61(e), §483.21(c)(2)(i), §483.21(c)(2)(ii), §483.21(c)(2)(iii), §483.21(c)(2)(iv)			and consultation results - A final summary of the resident's status to include items in 42 CFR 483.20 (b)(1) at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. - Reconciliation of all predischarge medications with the resident's postdischarge medications (both prescribed and over-the-counter). - A postdischarge plan of care, which will assist the resident to adjust to his or her new living environment, that is developed with the participation of the resident and, with the resident's consent, the resident representative(s). The postdischarge plan of care indicates where the individual plans to reside, any arrangements that have been made for the resident's follow up care, and any postdischarge medical and nonmedical services CoPs: §482.58(b)(5), §483.21(c)(2)(i), §483.21(c)(2)(ii), §483.21(c)(2)(iii), §483.21(c)(2)(iv)
N/A	N/A	New, more-direct EP for CoP requirement	RC.11.01.01, EP 5	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The psychiatric hospital maintains clinical records on all patients to determine the degree and intensity of treatments, as specified in 42 CFR 482.61. CoPs: §482.60(c), §482.61
N/A	N/A	New, more-direct EP for CoP requirement	RC.12.01.01, EP 7	An assessment of the patient (in lieu of a medical history and physical examination as described in 42 CFR 482.24(c)(4)(i)(A) and (B)) is completed and documented after registration, but prior to surgery or a procedure requiring anesthesia services, when the following conditions are met: - The patient is receiving specific outpatient surgical or procedural services. - The medical staff has chosen to develop and maintain a policy that identifies, in accordance with the requirements at §482.22(c)(5)(v), specific patients as not requiring a comprehensive medical history and physical examination, or any update to it, prior to specific outpatient surgical or procedural services. CoPs: §482.24(c)(4)(i)(C)
N/A	N/A	New, more-direct EP for CoP requirement	RC.12.03.01, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: When the resident is transferred or discharged because the hospital cannot meet their needs, the hospital documents which needs could not be met, the hospital's attempts to meet the resident's needs, and the services available at the receiving organization that will meet the resident's needs. CoPs: §482.58(b)(2), §483.15(c)(2)(i)(B)
N/A	N/A	New, more-direct EP for CoP requirement	RC.12.03.01, EP 4	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital records the reasons for the transfer or discharge in the resident's medical record in accordance with 42 CFR 483.15(c)(2). CoPs: §482.58(b)(2), §483.15(c)(3)(ii)
RI.01.01.01, EP 1	The hospital has written policies on patient rights. Note: For hospitals that use Joint Commission accreditation for deemed status	Moved and Revised	RI.11.01.01, EP 1	The hospital develops and implements written policies to protect and promote patient rights.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	purposes: The hospital's written policies address procedures regarding patient visitation rights, including any clinically necessary or reasonable restrictions or limitations. CoPs: §482.13, §482.13(a)(1), §482.13(h), §482.58(b)(1), §483.10(b)(7), §483.10(b)(7)(i), §483.10(b)(7)(ii), §483.10(h)(3), §483.10(h)(3)(i)			CoPs: §482.13, §482.58(b)(1)
RI.01.01.01, EP 2	The hospital informs the patient of the patient's rights. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital informs the patient (or support person, where appropriate) of the patient's visitation rights. Visitation rights include the right to receive the visitors designated by the patient, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. Also included is the right to withdraw or deny such consent at any time. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital informs each patient (or support person, where appropriate) of the patient's rights in advance of furnishing or discontinuing patient care whenever possible. CoPs: §482.13, §482.13(a)(1), §482.13(h)(1), §482.13(h)(2), §482.58(b)(1), §483.10(c)(1)	Moved and Revised	RI.11.01.01, EP 2	The hospital informs each patient, or when appropriate, the patient's representative (as allowed, under state law) of the patient's rights in advance of providing or discontinuing patient care whenever possible. CoPs: §482.13(a)(1)
RI.01.01.01, EP 4	The hospital treats the patient in a dignified and respectful manner that supports the patient's dignity. CoPs: §482.13, §482.13(c)(2)	Moved and Revised	RI.11.01.01, EP 3	The patient has the right to receive care in a safe setting. CoPs: §482.13(c)(2)
RI.01.01.01, EP 5	The hospital respects the patient's right to and need for effective communication. CoPs: §482.13(b)(4), §482.58(b)(1), §482.58(b)(2), §483.10(c)(1), §483.15(c)(3)(i), §483.15(c)(3)(iii)	Moved and Revised	NPG.07.01.01, EP 1	The hospital respects the patient's right to and need for effective communication.
RI.01.01.01, EP 6	The hospital respects the patient's cultural and personal values, beliefs, and preferences. CoPs: §482.58(b)(1), §483.10(b)(7)(ii)	Moved	NPG.07.04.01, EP 1	The hospital respects the patient's cultural and personal values, beliefs, and preferences.
RI.01.01.01, EP 7	The hospital respects the patient's right to privacy. Note 1: This element of performance (EP) addresses a patient's personal privacy. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident's right to privacy includes privacy and confidentiality of their personal records and written communications, including the right to send and receive mail promptly. CoPs: §482.13(c)(1), §482.58(b)(1), §483.10(g)(8)(i), §483.10(h), §483.10(h)(1), §483.10(h)(2)	Moved and Revised	RI.11.01.01, EP 5	The hospital respects the patient's right to personal privacy. Note 1: This element of performance (EP) addresses a patient's personal privacy. For EPs addressing the privacy of a patient's health information, refer to Standard IM.12.01.01. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. CoPs: §482.13(c)(1), §482.58(b)(1), §483.10(h)(1), §483.10(h)(2)
RI.01.01.01, EP 9	The hospital accommodates the patient's right to religious and other spiritual services.	Moved	NPG.07.04.01, EP 2	The hospital accommodates the patient's right to religious and other spiritual services.
RI.01.01.01, EP 10	The hospital allows the patient, through oral or written request, to access, request amendment to, and obtain information on disclosures of the patient's health information, in accordance with law and regulation. Note: For hospitals that use Joint Commission accreditation for deemed status	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	purposes: Access to medical records, including past and current records, is in the form and format requested by the patient (including in electronic form or format when available). If electronic is unavailable, the medical record is in hard copy form or another form agreed to by the organization and patient. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these electronic or hard-copy requests within a reasonable time frame (that is, as quickly as its recordkeeping system permits). CoPs: §482.13(d)(2)	moved to guidance within SPG		
RI.01.01.01, EP 28	The hospital allows a family member, friend, or other individual to be present with the patient for emotional support during the course of stay. Note: The hospital allows for the presence of a support individual of the patient's choice, unless the individual's presence infringes on others' rights, safety, or is medically or therapeutically contraindicated. The individual may or may not be the patient's surrogate decision-maker or legally authorized representative. (For more information on surrogate or family involvement in patient care, treatment, and services, refer to RI.01.02.01, EP 8.) CoPs: §482.13(h)(2), §482.13(h)(4)	Moved and Revised	RI.11.01.01, EP 7	The hospital develops and implements policies and procedures for patient visitation rights. Visitation rights include the right to receive visitors designated by the patient, including but not limited to a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. The patient also has the right to withdraw or deny consent for visitors at any time. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital's written policies and procedures include any restrictions or limitations that are clinically necessary or reasonable that need to be placed on visitation rights and the reasons for the restriction or limitation. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital informs the patient (or support person, where appropriate) of the patient's visitation rights, including any clinical restriction or limitation on such rights. CoPs: §482.13(h), §482.13(h)(1), §482.13(h)(2)
RI.01.01.01, EP 29	The hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression. Note: This includes prohibiting discrimination through restricting, limiting, or otherwise denying visitation privileges. CoPs: §482.13(h)(3)	Moved and Revised	RI.11.01.01, EP 4	The hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression. Note: This includes prohibiting discrimination through restricting, limiting, or otherwise denying visitation privileges. The hospital allows all visitors to have full and equal visitation privileges consistent with patient preferences. CoPs: §482.13(h)(3), §482.13(h)(4)
RI.01.01.01, EP 37	The hospital considers patients' privacy and complies with law and regulation when making and using recordings, films, or other images of patients. Note: The term "recordings, films, or other images" refers to photographic, video, digital, electronic, or audio media.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
RI.01.01.03, EP 1	The hospital provides information in a manner tailored to the patient's age, language, and ability to understand. CoPs: §482.13(a)(2)(i), §482.58(b)(1), §482.58(b)(2), §483.10(c)(1), §483.15(c)(3)(i), §483.15(c)(3)(iii)	Moved and Revised	RI.11.02.01, EP 1	The hospital provides information, including but not limited to the patient's total health status, in a manner tailored to the patient's age, language, and ability to understand. Note: The hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs. CoPs: §482.58(b)(1), §483.10(c)(1)
RI.01.01.03, EP 2	The hospital provides language interpreting and translation services. Note: Language interpreting options may include hospital-employed language interpreters, contract interpreting services, or trained bilingual staff. These options	Moved and Revised	NPG.07.01.01, EP 2	The hospital provides interpreting and translation services, as necessary. Note: For hospitals that elect The Joint Commission Primary Care Medical Home option: Language interpreting options may include trained bilingual staff, contract

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	may be provided in person or via telephone or video. The hospital determines which translated documents and languages are needed based on its patient population.			interpreting services, or employed language interpreters. These options may be provided in person or via telephone or video. The documents translated, and the languages into which they are translated, are dependent on the primary care medical home's patient population.
RI.01.01.03, EP 3	The hospital provides information to the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient's needs. CoPs: §482.13(b)(2), §482.58(b)(1), §483.10(c)(1)	Moved and Revised	NPG.07.01.01, EP 3	The hospital communicates with the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient's needs.
RI.01.02.01, EP 1	The hospital involves the patient in making decisions about their care, treatment, and services, including the right to have the patient's family and physician or other licensed practitioner promptly notified of their admission to or discharge or transfer from the hospital. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient is informed, prior to the notification occurring, of any process to automatically notify the patient's established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well as all applicable post–acute care services providers and suppliers. The hospital has a process for documenting a patient's refusal to permit notification of registration to the emergency department, admission to an inpatient unit, or discharge or transfer from the emergency department or inpatient unit. Notifications with primary care practitioners and entities are in accordance with all applicable federal and state laws and regulations. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to be informed in advance of changes to their plan of care. CoPs: §482.13(b)(1), §482.13(b)(2), §482.13(b)(4), §482.58(b)(1), §483.10(b)(7), §483.10(b)(7)(i), §483.10(b)(7)(ii), §483.10(b)(7)(iii), §483.10(c)(1), §483.10(c)(2)(iii), §483.10(c)(6)	Split to RI.12.01.01, EP 1; RI.12.01.01, EP 2; RI.12.01.01, EP 3; RI.12.01.01, EP 4	RI.12.01.01, EP 1	The patient or their representative (as allowed, in accordance with state law) has the right to make informed decisions regarding their care. The patient's rights include being informed of their health status, being involved in care planning and treatment, and being able to request or refuse treatment. This does not mean the patient has the right to demand the provision of treatment or services deemed medically unnecessary or inappropriate. CoPs: §482.13(b)(2), §482.58(b)(1), §483.10(c)
RI.01.02.01, EP 1	The hospital involves the patient in making decisions about their care, treatment, and services, including the right to have the patient's family and physician or other licensed practitioner promptly notified of their admission to or discharge or transfer from the hospital. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient is informed, prior to the notification occurring, of any process to automatically notify the patient's established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well as all applicable post–acute care services providers and suppliers. The hospital has a process for documenting a patient's refusal to permit notification of registration to the emergency department, admission to an inpatient unit, or discharge or transfer from the emergency department or inpatient unit. Notifications with primary care practitioners and entities are in accordance with all applicable federal and state laws and regulations. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to be informed in advance of changes to their plan of care. CoPs: §482.13(b)(1), §482.13(b)(2), §482.13(b)(4), §482.58(b)(1), §483.10(b)(7),	Split to RI.12.01.01, EP 1; RI.12.01.01, EP 2; RI.12.01.01, EP 3; RI.12.01.01, EP 4	RI.12.01.01, EP 2	The hospital asks the patient whether they want a family member, representative, or physician or other licensed practitioner notified of their admission to the hospital. The hospital promptly notifies the identified individual(s). Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient is informed, prior to the notification occurring, of any process to automatically notify the patient's established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well as all applicable post–acute care service providers and suppliers. The hospital has a process for documenting a patient's refusal to permit notification of registration to the emergency department, admission to an inpatient unit, or discharge or transfer from the emergency department or inpatient unit. Notifications with primary care practitioners and entities are in accordance with all applicable federal and state laws and regulations. CoPs: §482.13(b)(4)

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	§483.10(b)(7)(i), §483.10(b)(7)(ii), §483.10(b)(7)(iii), §483.10(c)(1), §483.10(c)(2)(iii), §483.10(c)(6)			
RI.01.02.01, EP 1	The hospital involves the patient in making decisions about their care, treatment, and services, including the right to have the patient's family and physician or other licensed practitioner promptly notified of their admission to or discharge or transfer from the hospital. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient is informed, prior to the notification occurring, of any process to automatically notify the patient's established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well as all applicable post–acute care services providers and suppliers. The hospital has a process for documenting a patient's refusal to permit notification of registration to the emergency department, admission to an inpatient unit, or discharge or transfer from the emergency department or inpatient unit. Notifications with primary care practitioners and entities are in accordance with all applicable federal and state laws and regulations. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to be informed in advance of changes to their plan of care. CoPs: §482.13(b)(1), §482.13(b)(2), §482.13(b)(4), §482.58(b)(1), §483.10(b)(7), §483.10(b)(7)(i), §483.10(b)(7)(ii), §483.10(b)(7)(iii), §483.10(c)(1), §483.10(c)(2)(iii), §483.10(c)(6)	Split to RI.12.01.01, EP 1; RI.12.01.01, EP 2; RI.12.01.01, EP 3; RI.12.01.01, EP 4	RI.12.01.01, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: If a resident is adjudged incompetent under state law by a court of proper jurisdiction, the rights of the resident automatically transfer to and are exercised by a resident representative appointed by the court under state law to act on the resident's behalf. The resident representative exercises the resident's rights to the extent allowed by the court in accordance with state law. Note 1: If a resident representative's decision-making authority is limited by state law or court appointment, the resident retains the right to make those decisions outside the representative's authority. Note 2: The resident's wishes and preferences are considered by the representative when exercising the patient's rights. Note 3: To the extent practicable, the resident is provided with opportunities to participate in the care planning process. CoPs: §482.58(b)(1), §483.10(b)(7), §483.10(b)(7)(i), §483.10(b)(7)(ii), §483.10(b)(7)(iii)
RI.01.02.01, EP 1	The hospital involves the patient in making decisions about their care, treatment, and services, including the right to have the patient's family and physician or other licensed practitioner promptly notified of their admission to or discharge or transfer from the hospital. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient is informed, prior to the notification occurring, of any process to automatically notify the patient's established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well as all applicable post–acute care services providers and suppliers. The hospital has a process for documenting a patient's refusal to permit notification of registration to the emergency department, admission to an inpatient unit, or discharge or transfer from the emergency department or inpatient unit. Notifications with primary care practitioners and entities are in accordance with all applicable federal and state laws and regulations. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to be informed in advance of changes to their plan of care. CoPs: §482.13(b)(1), §482.13(b)(2), §482.13(b)(4), §482.58(b)(1), §483.10(b)(7), §483.10(b)(7)(i), §483.10(b)(7)(ii), §483.10(b)(7)(iii), §483.10(c)(1), §483.10(c)(2)(iii), §483.10(c)(6)	Split to RI.12.01.01, EP 1; RI.12.01.01, EP 2; RI.12.01.01, EP 3; RI.12.01.01, EP 4	RI.12.01.01, EP 4	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to request, refuse, and/or discontinue treatment; to participate in or refuse to participate in experimental research; and to formulate an advance directive. CoPs: §482.58(b)(1), §483.10(c)(6)
RI.01.02.01, EP 2	When a patient is unable to make decisions about their care, treatment, and services, the hospital involves a surrogate decision-maker in making these decisions. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The selection of the surrogate decision-maker is in	Split to RI.12.01.01, EP 1; RI.12.01.01, EP 3	RI.12.01.01, EP 1	The patient or their representative (as allowed, in accordance with state law) has the right to make informed decisions regarding their care. The patient's rights include being informed of their health status, being involved in care planning and treatment, and being able to request or refuse treatment. This does not mean the patient has the right to demand the provision of treatment or services deemed medically

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	accordance with state law. CoPs: §482.13(a)(1), §482.13(b)(1), §482.13(b)(2), §482.58(b)(1), §483.10(b)(7), §483.10(b)(7)(i), §483.10(b)(7)(ii)			unnecessary or inappropriate. CoPs: §482.13(b)(2), §482.58(b)(1), §483.10(c)
RI.01.02.01, EP 2	When a patient is unable to make decisions about their care, treatment, and services, the hospital involves a surrogate decision-maker in making these decisions. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The selection of the surrogate decision-maker is in accordance with state law. CoPs: §482.13(a)(1), §482.13(b)(1), §482.13(b)(2), §482.58(b)(1), §483.10(b)(7), §483.10(b)(7)(i), §483.10(b)(7)(ii)	Split to RI.12.01.01, EP 1; RI.12.01.01, EP 3	RI.12.01.01, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: If a resident is adjudged incompetent under state law by a court of proper jurisdiction, the rights of the resident automatically transfer to and are exercised by a resident representative appointed by the court under state law to act on the resident's behalf. The resident representative exercises the resident's rights to the extent allowed by the court in accordance with state law. Note 1: If a resident representative's decision-making authority is limited by state law or court appointment, the resident retains the right to make those decisions outside the representative's authority. Note 2: The resident's wishes and preferences are considered by the representative when exercising the patient's rights. Note 3: To the extent practicable, the resident is provided with opportunities to participate in the care planning process. CoPs: §482.58(b)(1), §483.10(b)(7), §483.10(b)(7)(i), §483.10(b)(7)(ii), §483.10(b)(7)(iii)
RI.01.02.01, EP 3	The hospital provides the patient or surrogate decision-maker with written information about the right to refuse care, treatment, and services. CoPs: §482.13(a)(1), §482.13(b)(2), §482.58(b)(1), §483.10(c)(6)	Consolidation of RI.01.02.01, EP 1; RI.01.02.01, EP 2; RI.01.02.01, EP 3; RI.01.02.01, EP 4; RI.01.02.01, EP 8; RI.01.02.01, EP 20	RI.12.01.01, EP 1	The patient or their representative (as allowed, in accordance with state law) has the right to make informed decisions regarding their care. The patient's rights include being informed of their health status, being involved in care planning and treatment, and being able to request or refuse treatment. This does not mean the patient has the right to demand the provision of treatment or services deemed medically unnecessary or inappropriate. CoPs: §482.13(b)(2), §482.58(b)(1), §483.10(c)
RI.01.02.01, EP 4	The hospital respects the right of the patient or surrogate decision-maker to refuse care, treatment, and services in accordance with law and regulation. CoPs: §482.13(b)(2), §482.58(b)(1), §483.10(c)(6)	Split to RI.12.01.01, EP 1; RI.12.01.01, EP 3; RI.12.01.01, EP 4	RI.12.01.01, EP 1	The patient or their representative (as allowed, in accordance with state law) has the right to make informed decisions regarding their care. The patient's rights include being informed of their health status, being involved in care planning and treatment, and being able to request or refuse treatment. This does not mean the patient has the right to demand the provision of treatment or services deemed medically unnecessary or inappropriate. CoPs: §482.13(b)(2), §482.58(b)(1), §483.10(c)
RI.01.02.01, EP 4	The hospital respects the right of the patient or surrogate decision-maker to refuse care, treatment, and services in accordance with law and regulation. CoPs: §482.13(b)(2), §482.58(b)(1), §483.10(c)(6)	Split to RI.12.01.01, EP 1; RI.12.01.01, EP 3; RI.12.01.01, EP 4	RI.12.01.01, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: If a resident is adjudged incompetent under state law by a court of proper jurisdiction, the rights of the resident automatically transfer to and are exercised by a resident representative appointed by the court under state law to act on the resident's behalf. The resident representative exercises the resident's rights to the extent allowed by the court in accordance with state law. Note 1: If a resident representative's decision-making authority is limited by state law or court appointment, the resident retains the right to make those decisions outside the representative's authority. Note 2: The resident's wishes and preferences are considered by the representative when exercising the patient's rights. Note 3: To the extent practicable, the resident is provided with opportunities to participate in the care planning process.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
				CoPs: §482.58(b)(1), §483.10(b)(7), §483.10(b)(7)(i), §483.10(b)(7)(ii), §483.10(b)(7)(iii)
RI.01.02.01, EP 4	The hospital respects the right of the patient or surrogate decision-maker to refuse care, treatment, and services in accordance with law and regulation. CoPs: §482.13(b)(2), §482.58(b)(1), §483.10(c)(6)	Split to RI.12.01.01, EP 1; RI.12.01.01, EP 3; RI.12.01.01, EP 4	RI.12.01.01, EP 4	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to request, refuse, and/or discontinue treatment; to participate in or refuse to participate in experimental research; and to formulate an advance directive. CoPs: §482.58(b)(1), §483.10(c)(6)
RI.01.02.01, EP 8	The hospital involves the patient's family in care, treatment, and services decisions to the extent permitted by the patient or surrogate decision-maker, in accordance with law and regulation. CoPs: §482.13(a)(1), §482.13(b)(1), §482.13(b)(2), §482.13(b)(4)	Split to RI.12.01.01, EP 1; RI.12.01.01, EP 2	RI.12.01.01, EP 1	The patient or their representative (as allowed, in accordance with state law) has the right to make informed decisions regarding their care. The patient's rights include being informed of their health status, being involved in care planning and treatment, and being able to request or refuse treatment. This does not mean the patient has the right to demand the provision of treatment or services deemed medically unnecessary or inappropriate. CoPs: §482.13(b)(2), §482.58(b)(1), §483.10(c)
RI.01.02.01, EP 8	The hospital involves the patient's family in care, treatment, and services decisions to the extent permitted by the patient or surrogate decision-maker, in accordance with law and regulation. CoPs: §482.13(a)(1), §482.13(b)(1), §482.13(b)(2), §482.13(b)(4)	Split to RI.12.01.01, EP 1; RI.12.01.01, EP 2	RI.12.01.01, EP 2	The hospital asks the patient whether they want a family member, representative, or physician or other licensed practitioner notified of their admission to the hospital. The hospital promptly notifies the identified individual(s). Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient is informed, prior to the notification occurring, of any process to automatically notify the patient's established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well as all applicable post–acute care service providers and suppliers. The hospital has a process for documenting a patient's refusal to permit notification of registration to the emergency department, admission to an inpatient unit, or discharge or transfer from the emergency department or inpatient unit. Notifications with primary care practitioners and entities are in accordance with all applicable federal and state laws and regulations. CoPs: §482.13(b)(4)
RI.01.02.01, EP 20	The hospital provides the patient or surrogate decision-maker with the information about the following: - Outcomes of care, treatment, and services that the patient needs in order to participate in current and future health care decisions. - Unanticipated outcomes of the patient's care, treatment, and services that are sentinel events as defined by The Joint Commission. This information is provided by the physician or other licensed practitioner responsible for managing the patient's care, treatment, and services. (Refer to the Glossary for a definition of sentinel event.) CoPs: §482.13(b)(2)	Consolidation of RI.01.02.01, EP 1; RI.01.02.01, EP 2; RI.01.02.01, EP 3; RI.01.02.01, EP 4; RI.01.02.01, EP 8; RI.01.02.01, EP 20	RI.12.01.01, EP 1	The patient or their representative (as allowed, in accordance with state law) has the right to make informed decisions regarding their care. The patient's rights include being informed of their health status, being involved in care planning and treatment, and being able to request or refuse treatment. This does not mean the patient has the right to demand the provision of treatment or services deemed medically unnecessary or inappropriate. CoPs: §482.13(b)(2), §482.58(b)(1), §483.10(c)
RI.01.02.01, EP 31	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home respects the patient's right to make decisions about the management of the patient's care.	Moved	RI.12.01.01, EP 8	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home respects the patient's right to make decisions about the management of the patient's care.
RI.01.02.01, EP 32	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home respects the patient's right and provides the patient the opportunity to do the following:	Moved and Revised	RI.12.01.01, EP 9	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home respects the patient's rights and provides the patient the opportunity to do the following:

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	- Obtain care from other clinicians of the patient's choosing within the primary care medical home - Seek a second opinion from a clinician of the patient's choosing - Seek specialty care Note: This element of performance does not imply financial responsibility for any activities associated with these rights.			- Obtain care from other clinicians of the patient's choosing within the primary care medical home - Seek a second opinion from a clinician of the patient's choosing - Seek specialty care Note: This element of performance does not imply financial responsibility for any activities associated with these rights.
RI.01.03.01, EP 1	The hospital follows a written policy on informed consent that describes the following: - The specific care, treatment, and services that require informed consent - Circumstances that would allow for exceptions to obtaining informed consent - The process used to obtain informed consent - The physician or other licensed practitioner permitted to conduct the informed consent discussion in accordance with law and regulation - How informed consent is documented in the patient record Note: Documentation may be recorded in a form, in progress notes, or elsewhere in the record. - When a surrogate decision-maker may give informed consent CoPs: §482.13(b)(2), §482.24(c)(4)(v), §482.51(b)(2)	Moved and Revised	NPG.07.02.01, EP 1	The hospital develops and implements a written policy on informed consent that describes the following: - Specific care, treatment, and services that require informed consent - Circumstances that would allow for exceptions to obtaining informed consent - Process used to obtain informed consent - Physicians or other licensed practitioners permitted to conduct the informed consent discussion in accordance with law and regulation - How informed consent is documented in the patient record Note: Documentation may be recorded in a form, in progress notes, or elsewhere in the record. - When a surrogate decision-maker may give informed consent
RI.01.03.01, EP 2	The informed consent process includes a discussion about the following: - The patient's proposed care, treatment, and services. - Potential benefits, risks, and side effects of the patient's proposed care, treatment, and services; the likelihood of the patient achieving their goals; and any potential problems that might occur during recuperation. - Reasonable alternatives to the patient's proposed care, treatment, and services. The discussion encompasses risks, benefits, and side effects related to the alternatives and the risks related to not receiving the proposed care, treatment, and services. CoPs: §482.13(b)(2), §482.24(c)(4)(v)	Moved and Revised	NPG.07.02.01, EP 2	The informed consent process includes a discussion about the following: - Patient's proposed care, treatment, and services. - Potential benefits, risks, and side effects of the patient's proposed care, treatment, and services; the likelihood of the patient achieving their goals; and any potential problems that might occur during recuperation. - Reasonable alternatives to the patient's proposed care, treatment, and services. The discussion encompasses risks, benefits, and side effects related to the alternatives and the risks related to not receiving the proposed care, treatment, and services.
RI.01.03.05, EP 2	To help the patient determine whether or not to participate in research, investigation, or clinical trials, the hospital provides the patient with all of the following information: - An explanation of the purpose of the research - The expected duration of the patient's participation - A clear description of the procedures to be followed - A statement of the potential benefits, risks, discomforts, and side effects - Alternative care, treatment, and services available to the patient that might prove advantageous to the patient	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
RI.01.03.05, EP 3	The hospital informs the patient that refusing to participate in research, investigation, or clinical trials or discontinuing participation at any time will not jeopardize the patient's access to care, treatment, and services unrelated to the research. CoPs: §482.58(b)(1), §483.10(c)(6)	Consolidation of RI.01.02.01, EP 1; RI.01.02.01, EP 4; RI.01.03.05, EP 3; RI.01.05.01, EP 1	RI.12.01.01, EP 4	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to request, refuse, and/or discontinue treatment; to participate in or refuse to participate in experimental research; and to formulate an advance directive. CoPs: §482.58(b)(1), §483.10(c)(6)
RI.01.03.05, EP 4	The hospital documents the following in the research consent form: - That the patient received information to help determine whether or not to participate in the research, investigation, or clinical trials - That the patient was informed that refusing to participate in research, investigation,	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	or clinical trials or discontinuing participation at any time will not jeopardize their access to care, treatment, and services unrelated to the research - The name of the person who provided the information and the date the form was signed - The patient's right to privacy, confidentiality, and safety	moved to guidance within SPG		
RI.01.04.01, EP 1	The hospital informs the patient of the following: - The name of the physician, clinical psychologist, or other licensed practitioner who has primary responsibility for the patient's care, treatment, and services - The name of the physician(s), clinical psychologist(s), or other licensed practitioner(s) who will provide the patient's care, treatment, and services Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). CoPs: §482.61(c)(1)(iv)	Moved and Revised	RI.12.02.01, EP 1	The hospital informs the patient of the following: - Name of the physician, clinical psychologist, or other licensed practitioner who has primary responsibility for the patient's care, treatment, and services - Name of the physician(s), clinical psychologist(s), or other licensed practitioner(s) who will provide the patient's care, treatment, and services Note 1: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital also provides the resident and the resident's family with the specialty of the physician or other licensed practitioner primarily responsible for the resident’s care and a method to contact them. CoPs: §483.10(d)(3)
RI.01.04.01, EP 7	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home allows the patient to select their primary care clinician.	Moved	RI.12.01.01, EP 7	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home allows the patient to select their primary care clinician.
RI.01.04.03, EP 1	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides information to the patient about its mission, vision, and goals. Note: This may include how it provides for patient-centered and team-based comprehensive care, a systems-based approach to quality and safety, and enhanced patient access.	Moved	RI.12.02.03, EP 1	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides information to the patient about its mission, vision, and goals. Note: This may include how it provides for patient-centered and team-based comprehensive care, a systems-based approach to quality and safety, and enhanced patient access.
RI.01.04.03, EP 2	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides information to the patient about the scope of care and types of services it provides. (Refer to LD.01.03.01, EP 3)	Moved and Revised	RI.12.02.03, EP 2	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides information to the patient about the scope of care and types of services it provides.
RI.01.04.03, EP 3	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides information to the patient about how it functions, including the following: - Processes supporting patient selection of a primary care clinician - Involving the patient in their treatment plan - Obtaining and tracking referrals - Coordinating care - Collaborating with patient-selected clinicians who provide specialty care or second opinions Note: Supporting patients in selecting a primary care clinician may include providing patients with information regarding the clinician’s credentials, area(s) of specialty, interests, languages spoken, and gender.	Moved	RI.12.02.03, EP 3	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides information to the patient about how it functions, including the following: - Processes supporting patient selection of a primary care clinician - Involving the patient in their treatment plan - Obtaining and tracking referrals - Coordinating care - Collaborating with patient-selected clinicians who provide specialty care or second opinions Note: Supporting patients in selecting a primary care clinician may include providing patients with information regarding the clinician’s credentials, area(s) of specialty, interests, languages spoken, and gender.
RI.01.04.03, EP 4	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides information to the patient about how to access the organization for care or information.	Moved	RI.12.02.03, EP 4	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides information to the patient about how to access the organization for care or information.
RI.01.04.03, EP 5	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides information to the patient about patient responsibilities, including providing health history and current medications, and participating in self-management activities. (Refer to RI.02.01.01, EP 2)	Moved and Revised	RI.12.02.03, EP 5	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides information to the patient about patient responsibilities, including providing health history and current medications, and participating in self-management activities. (Refer to RI.15.01.01, EP 2)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
RI.01.04.03, EP 6	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides information to the patient about the patient's right to obtain care from other clinicians within the primary care medical home, to seek a second opinion, and to seek specialty care. (Refer to RI.01.01.03, EPs 1 and 3)	Moved and Revised	RI.12.02.03, EP 6	For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides information to the patient about the patient's right to obtain care from other clinicians within the primary care medical home, to seek a second opinion, and to seek specialty care. (Refer to RI.11.02.01, EPs 1 and 3)
RI.01.05.01, EP 1	The hospital follows written policies on advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services that address the following: - Providing patients with written information about advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services. - Providing the patient upon admission with information on the extent to which the hospital is able, unable, or unwilling to honor advance directives. - For outpatient hospital settings: Communicating its policy on advance directives upon request or when warranted by the care, treatment, and services provided. - Whether the hospital will honor advance directives in its outpatient settings. - That the hospital will honor the patient's right to formulate or review and revise the patient's advance directives. - Informing staff who are involved in the patient's care, treatment, and services whether or not the patient has an advance directive. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The patient's right to formulate advance directives and have staff and licensed practitioners comply with these directives is in accordance with 42 CFR 489.100, 489.102, and 489.104. CoPs: §482.13(b)(2), §482.13(b)(3), §482.58(b)(1), §483.10(c)(6)	Consolidation of RI.01.02.01, EP 1; RI.01.02.01, EP 4; RI.01.03.05, EP 3; RI.01.05.01, EP 1	RI.12.01.01, EP 4	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to request, refuse, and/or discontinue treatment; to participate in or refuse to participate in experimental research; and to formulate an advance directive. CoPs: §482.58(b)(1), §483.10(c)(6)
RI.01.05.01, EP 9	The hospital documents whether or not the patient has an advance directive. CoPs: §482.13(b)(3)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
RI.01.05.01, EP 10	Upon request, the hospital refers the patient to resources for assistance in formulating advance directives. CoPs: §482.13(b)(3)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
RI.01.05.01, EP 17	The existence or lack of an advance directive does not determine the patient's right to access care, treatment, and services. CoPs: §482.13(b)(3)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
RI.01.06.01, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital has policies and procedures that support the resident's right to be free from chemical and physical restraint. Note: The hospital's use of restraint is consistent with the requirements in the "Provision of Care, Treatment, and Services" (PC) chapter. CoPs: §482.58(b)(3), §483.12(a)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
RI.01.06.03, EP 1	The hospital protects the patient from harassment, neglect, exploitation, and abuse that could occur while the patient is receiving care, treatment, and services.	Moved and Revised	RI.13.01.01, EP 1	The hospital protects the patient from harassment, neglect, exploitation, corporal punishment, involuntary seclusion, and verbal, mental, sexual, or physical abuse

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital also determines how it will protect residents from corporal punishment and involuntary seclusion. CoPs: §482.13(c)(2), §482.13(c)(3), §482.13(e), §482.58(b)(3), §483.12(a)(1), §483.12(b)(1), §483.12(c)(1), §483.12(c)(2), §483.12(c)(3), §483.12(c)(4)			that could occur while the patient is receiving care, treatment, and services. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital also protects the resident from misappropriation of property. CoPs: §482.13(c)(3), §482.13(e), §482.58(b)(3), §483.12, §483.12(a)(1)
RI.01.06.03, EP 2	The hospital evaluates all allegations, observations, and suspected cases of neglect, exploitation, and abuse that occur within the hospital. CoPs: §482.13(c)(3), §482.13(e)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
RI.01.06.03, EP 3	The hospital reports allegations, observations, and suspected cases of neglect, exploitation, and abuse to appropriate authorities based on its evaluation of the suspected events, or as required by law. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to the administrator of the facility and to other officials (including the state survey agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law and established procedures. The alleged violations are reported in the following time frames: - No later than 2 hours after the allegation is made if the allegation involves abuse or serious bodily injury - No later than 24 hours after the allegation is made if the allegation does not involve abuse or serious bodily injury CoPs: §482.13(c)(3), §482.13(e), §482.58(b)(3), §483.12(c)(1)	Moved and Revised	RI.13.01.01, EP 4	The hospital reports allegations, observations, and suspected cases of neglect, exploitation, and abuse to appropriate authorities based on its evaluation of the suspected events or as required by law. Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to the administrator of the facility and to other officials (including the state survey agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law and established procedures. The alleged violations are reported in the following time frames: - No later than 2 hours after the allegation is made if the allegation involves abuse or serious bodily injury - No later than 24 hours after the allegation is made if the allegation does not involve abuse or serious bodily injury CoPs: §482.58(b)(3), §483.12(c)(1)
RI.01.06.03, EP 4	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital develops and implements written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. CoPs: §482.58(b)(3), §483.12(b)(1)	Moved and Revised	RI.13.01.01, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital develops and implements written policies and procedures that prohibit and prevent mistreatment, neglect, and abuse of residents and misappropriation of resident property. The policies and procedures also address investigation of allegations related to these issues. CoPs: §482.58(b)(3), §483.12(b)(1), §483.12(b)(2)
RI.01.06.03, EP 5	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital has evidence that all alleged violations are thoroughly investigated and that it prevents further abuse while the investigation is in progress. The results of all investigations are reported to the administrator or their designated representative and to other officials in accordance with state law, within five working days of the incident. If the alleged violation is verified, appropriate corrective action is taken. CoPs: §482.58(b)(3), §483.12(b)(2), §483.12(c)(2), §483.12(c)(3), §483.12(c)(4)	Moved and Revised	RI.13.01.01, EP 5	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital has evidence that all alleged violations of abuse, neglect, exploitation, or mistreatment are thoroughly investigated and that it prevents further abuse, neglect, exploitation, or mistreatment while the investigation is in progress. The results of all investigations are reported to the administrator or their designated representative and to other officials in accordance with state law, including the state survey agency, within five working days of the incident. If the alleged violation is verified, appropriate corrective action is taken. CoPs: §482.58(b)(3), §483.12(c)(2), §483.12(c)(3), §483.12(c)(4)
RI.01.06.05, EP 4	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital allows the patient to keep and use personal clothing and possessions, unless this infringes on others' rights or is medically or therapeutically contraindicated, based on the setting or service.	Moved	RI.13.01.03, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital allows the patient to keep and use personal clothing and possessions, unless this infringes on others' rights or is medically or therapeutically contraindicated, based on the setting or service.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.58(b)(1), §483.10(e)(2)			CoPs: §482.58(b)(1), §483.10(e)(2)
RI.01.06.05, EP 8	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides accommodations for residents with significant others living in the same facility when both individuals consent to the arrangement. CoPs: §482.58(b)(1), §483.10(e)(4)	Moved and Revised	RI.13.01.03, EP 2	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital allows the resident to share a room with their spouse when married residents are living in the same hospital and when both individuals consent to the arrangement. CoPs: §482.58(b)(1), §483.10(e)(4)
RI.01.06.05, EP 14	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to have access to stationery, postage, and writing implements at the resident's own expense. CoPs: §482.58(b)(1), §483.10(g)(8)(ii)	Consolidation of RI.01.06.05, EP 14; RI.01.06.05, EP 15	RI.13.01.03, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident's right to send and promptly receive unopened mail through the postal service and to receive letters, packages, and other materials delivered to the hospital for the resident through a means other than a postal service. The hospital respects the resident's right to privacy of such communications and allows access to stationery, postage, and writing implements at the resident's expense. CoPs: §482.58(b)(1), §483.10(g)(8), §483.10(g)(8)(i), §483.10(g)(8)(ii), §483.10(h)(2)
RI.01.06.05, EP 15	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital offers patients telephone and mail service, based on the setting and population. CoPs: §482.58(b)(1), §483.10(g)(8), §483.10(h)(2)	Consolidation of RI.01.06.05, EP 14; RI.01.06.05, EP 15	RI.13.01.03, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident's right to send and promptly receive unopened mail through the postal service and to receive letters, packages, and other materials delivered to the hospital for the resident through a means other than a postal service. The hospital respects the resident's right to privacy of such communications and allows access to stationery, postage, and writing implements at the resident's expense. CoPs: §482.58(b)(1), §483.10(g)(8), §483.10(g)(8)(i), §483.10(g)(8)(ii), §483.10(h)(2)
RI.01.06.09, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident's right to choose an attending physician, dentist, and other care providers. Note: The hospital informs the resident if it determines that the physician chosen by the resident is unlicensed or unable to serve as the attending physician. The hospital also discusses alternative physician participation with the resident and honors the resident's preferences, if any, among the options. CoPs: §482.58(b)(1), §483.10(d), §483.10(d)(2), §483.10(d)(4), §483.10(d)(5)	Moved and Revised	RI.12.01.01, EP 6	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident's right to choose a licensed attending physician. Note: If the physician chosen by the resident refuses to or does not meet the requirements for attending physicians at 42 CFR 483, the hospital may seek alternative physician participation to assure provision of appropriate and adequate care and treatment. The hospital informs the resident if it determines that the physician chosen by the resident is unlicensed or unable to serve as the attending physician. The hospital also discusses alternative physician participation with the resident and honors the resident's preferences, if any, among the options. CoPs: §482.58(b)(1), §483.10(d), §483.10(d)(1), §483.10(d)(2), §483.10(d)(4), §483.10(d)(5)
RI.01.06.11, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides the resident and the resident's family with the name, specialty, and telephone number of the physician or other licensed practitioner primarily responsible for the resident's care. CoPs: §482.58(b)(1), §483.10(d)(3)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
RI.01.06.11, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital helps the resident make and keep appointments with medical, dental, and other care providers.	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	CoPs: §482.58(b)(7), §483.55(a)(4)(i), §483.55(a)(4)(ii), §483.55(b)(2)(i), §483.55(b)(2)(ii)	moved to guidance within SPG		
RI.01.07.01, EP 1	The hospital establishes a complaint resolution process for the prompt resolution of patient complaints that includes a clearly explained procedure for the submission of a patient's written or verbal complaint and informs the patient and the patient's family about it. Note: The governing body is responsible for the effective operation of the complaint resolution process unless it delegates this responsibility in writing to a complaint resolution committee. CoPs: §482.13(a)(2), §482.13(a)(2) continued, §482.13(a)(2)(i)	Moved and Revised	RI.14.01.01, EP 2	The hospital develops and implements policies and procedures for the prompt resolution of patient grievances. The policies clearly explain the procedure for patients to submit written or verbal grievances and specify timeframes for the review of and response to the grievance. CoPs: §482.13(a)(2), §482.13(a)(2)(i), §482.13(a)(2)(ii)
RI.01.07.01, EP 4	The hospital reviews and, when possible, resolves complaints from the patient and the patient's family.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
RI.01.07.01, EP 6	The hospital acknowledges receipt of a complaint that the hospital cannot resolve immediately and notifies the patient of follow-up to the complaint.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
RI.01.07.01, EP 7	The hospital provides the patient with the phone number and address needed to file a complaint with the relevant state authority.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
RI.01.07.01, EP 18	For hospitals that use Joint Commission accreditation for deemed status purposes: In its resolution of complaints, the hospital provides the individual with a written notice of its decision, which contains the following: - The name of the hospital contact person - The steps taken on behalf of the individual to investigate the complaint - The results of the process - The date of completion of the complaint process CoPs: §482.13(a)(2)(iii)	Moved and Revised	RI.14.01.01, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes: In its resolution of grievances, the hospital provides the patient with a written notice of its decision, which contains the following: - Name of the hospital contact person - Steps taken on behalf of the individual to investigate the grievances - Results of the process - Date of completion of the grievance process CoPs: §482.13(a)(2)(iii)
RI.01.07.01, EP 19	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital determines time frames for complaint review and response. CoPs: §482.13(a)(2)(ii)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
RI.01.07.01, EP 20	For hospitals that use Joint Commission accreditation for deemed status purposes: The process for resolving complaints includes a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. CoPs: §482.13(a)(2) continued	Moved and Revised	RI.14.01.01, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes: The process for resolving grievances includes a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. CoPs: §482.13(a)(2)
RI.01.07.03, EP 1	When the hospital serves a population of patients that need protective services (for example, guardianship or advocacy services, conservatorship, or child or adult	Moved	NPG.07.03.01, EP 5	When the hospital serves a population of patients that need protective services (for example, guardianship or advocacy services, conservatorship, or child or adult

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	protective services), it provides resources to help the family and the courts determine the patient's needs for such services.			protective services), it provides resources to help the family and the courts determine the patient's needs for such services.
RI.01.07.05, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital establishes liberal visiting hours that are limited only by the resident's personal preferences. CoPs: §482.58(b)(1), §483.10(f)(4)(ii), §483.10(f)(4)(iii)	Consolidation of RI.01.07.05, EP 1; RI.01.07.05, EP 5; RI.01.07.05, EP 6	RI.11.01.01, EP 8	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides immediate family and other relatives immediate access to the resident, except when the resident denies or withdraws consent. The hospital provides others who are visiting immediate access to the resident, except when reasonable clinical or safety restrictions apply or when the resident denies or withdraws consent. CoPs: §482.58(b)(1), §483.10(f)(4)(ii), §483.10(f)(4)(iii)
RI.01.07.05, EP 3	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides space for the resident to receive visitors in comfort and privacy. CoPs: §482.58(b)(1), §483.10(h)(1)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
RI.01.07.05, EP 5	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident's right to choose with whom the resident communicates. CoPs: §482.58(b)(1), §483.10(f)(4)(ii), §483.10(f)(4)(iii)	Consolidation of RI.01.07.05, EP 1; RI.01.07.05, EP 5; RI.01.07.05, EP 6	RI.11.01.01, EP 8	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides immediate family and other relatives immediate access to the resident, except when the resident denies or withdraws consent. The hospital provides others who are visiting immediate access to the resident, except when reasonable clinical or safety restrictions apply or when the resident denies or withdraws consent. CoPs: §482.58(b)(1), §483.10(f)(4)(ii), §483.10(f)(4)(iii)
RI.01.07.05, EP 6	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital complies with law and regulation regarding individuals who are exempted from visiting hour restrictions in order to gain immediate access to the resident. CoPs: §482.58(b)(1), §483.10(f)(4)(ii), §483.10(f)(4)(iii)	Consolidation of RI.01.07.05, EP 1; RI.01.07.05, EP 5; RI.01.07.05, EP 6	RI.11.01.01, EP 8	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides immediate family and other relatives immediate access to the resident, except when the resident denies or withdraws consent. The hospital provides others who are visiting immediate access to the resident, except when reasonable clinical or safety restrictions apply or when the resident denies or withdraws consent. CoPs: §482.58(b)(1), §483.10(f)(4)(ii), §483.10(f)(4)(iii)
RI.01.07.07, EP 1	For psychiatric hospital settings that provide longer term care (more than 30 days): The hospital follows a written policy that addresses situations in which patients and residents work for or on behalf of the hospital.	Deleted	N/A	N/A
RI.01.07.07, EP 3	For psychiatric hospital settings that provide longer term care (more than 30 days): Wages paid to patients and residents who work for or on behalf of the hospital are in accordance with law and regulation.	Deleted	N/A	N/A
RI.01.07.07, EP 4	For psychiatric hospital settings that provide longer term care (more than 30 days): The hospital incorporates work performed by the patient or resident for or on behalf of the hospital into the plan of care.	Deleted	N/A	N/A
RI.01.07.07, EP 5	For psychiatric hospital settings that provide longer term care (more than 30 days): Patients and residents have the right to refuse to work for or on behalf of the hospital.	Deleted	N/A	N/A
RI.01.07.13, EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital arranges transportation for the resident to and from medical or dental appointments and other activities identified in the resident's care or service plan. CoPs: §482.58(b)(7), §483.55(a)(4)(i), §483.55(a)(4)(ii), §483.55(b)(2)(i), §483.55(b)(2)(ii)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
RI.02.01.01, EP 1	The hospital has a written policy that defines patient responsibilities, including but not limited to the following: - Providing information that facilitates their care, treatment, and services - Asking questions or acknowledging when they do not understand the treatment course or care decision - Following instructions, policies, rules, and regulations in place to support quality care for patients and a safe environment for all individuals in the hospital - Supporting mutual consideration and respect by maintaining civil language and conduct in interactions with staff - Meeting financial commitments	Moved and Revised	RI.15.01.01, EP 1	The hospital develops and implements a written policy that defines patient responsibilities, including but not limited to the following: - Providing information that facilitates their care, treatment, and services - Asking questions or acknowledging when they do not understand the treatment course or care decision - Following instructions, policies, rules, and regulations in place to support quality care for patients and a safe environment for all individuals in the hospital - Supporting mutual consideration and respect by maintaining civil language and conduct in interactions with staff - Meeting financial commitments
RI.02.01.01, EP 2	The hospital informs the patient about the patient's responsibilities in accordance with its policy. Note: Information about patient responsibilities can be shared verbally, in writing, or both.	Moved	RI.15.01.01, EP 2	The hospital informs the patient about the patient's responsibilities in accordance with its policy. Note: Information about patient responsibilities can be shared verbally, in writing, or both.
N/A	N/A	New, more-direct EP for CoP requirement	RI.11.01.01, EP 6	The hospital provides the patient, upon an oral or written request, with access to medical records, including past and current records, in the form and format requested (including in electronic form or format when available). If electronic is unavailable, the medical record is provided in hard copy or another form agreed to by the hospital and patient. The hospital does not impede the legitimate efforts of individuals to gain access to their own medical records and fulfills these electronic or hard-copy requests within a reasonable time frame (that is, as quickly as its recordkeeping system permits). CoPs: §482.13(d)(2)
N/A	N/A	New, more-direct EP for CoP requirement	RI.12.01.01, EP 5	Staff and licensed practitioners who provide care, treatment, or services in the hospital honor the patient's right to formulate advance directives and comply with these directives, in accordance with law and regulation. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Law and regulation includes, at a minimum, 42 CFR 489.100, 489.102, and 489.104. CoPs: §482.13(b)(3)
TS.01.01.01, EP 1	The hospital has a written agreement with an organ procurement organization (OPO) and follows its rules and regulations. CoPs: §482.45(a)(1)	Moved and Revised	TS.11.01.01, EP 1	The hospital develops and implements written policies and procedures that include the following: - A written agreement with an organ procurement organization (OPO) that requires the hospital to notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the hospital, and that includes the OPO's responsibility to determine medical suitability for organ donation - A written agreement with at least one tissue bank and at least one eye bank to cooperate in retrieving, processing, preserving, storing, and distributing tissues and eyes to make certain that all usable tissues and eyes are obtained from potential donors, to the extent that the agreement does not interfere with organ procurement - Designation of an individual, who is an organ procurement representative, an organizational representative of a tissue or eye bank, or a designated requestor, to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes. - Procedures for informing the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes, in collaboration with the

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
				designated OPO - Education and training of staff in the use of discretion and sensitivity to the circumstances, views, and beliefs of the family when discussing potential organ, tissue, or eye donations Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has an agreement with an OPO designated under 42 CFR part 486. Note 2: The requirements for a written agreement with at least one tissue bank and at least one eye bank may be satisfied through a single agreement with an OPO that provides services for organ, tissue, and eye, or by a separate agreement with another tissue and/or eye bank outside the OPO, chosen by the hospital. Note 3: A designated requestor is an individual who has completed a course offered or approved by the organ procurement organization. This course is designed in conjunction with the tissue and eye bank community to provide a methodology for approaching potential donor families and requesting organ and tissue donation. Note 4: The term “organ” means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs). Note 5: 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. CoPs: §482.45(a)(1), §482.45(a)(2), §482.45(a)(3), §482.45(a)(4), §482.45(b)(2)
TS.01.01.01, EP 3	The hospital has a written agreement with at least one tissue bank and at least one eye bank to cooperate in retrieving, processing, preserving, storing, and distributing tissues and eyes. Note 1: This process should not interfere with organ procurement. Note 2: It is not necessary for a hospital to have a separate agreement with a tissue bank if it has an agreement with its organ procurement organization (OPO) to provide tissue procurement services, nor is it necessary for a hospital to have a separate agreement with an eye bank if its OPO provides eye procurement services. The hospital is not required to use the OPO for tissue or eye procurement, and is free to have an agreement with the tissue bank or eye bank of its choice. CoPs: §482.45(a)(2)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
TS.01.01.01, EP 4	The hospital works with the organ procurement organization (OPO) and tissue and eye banks to do the following: - Review death records in order to improve identification of potential donors. - Maintain potential donors while the necessary testing and placement of potential donated organs, tissues, and eyes takes place in order to maximize the viability of donor organs for transplant. - Educate staff about issues surrounding donation. - Develop a written donation policy that addresses opportunities for asystolic recovery that is mutually agreed upon by the hospital, its medical staff, and the designated OPO. When the hospital and its medical staff agree not to provide for asystolic recovery and cannot achieve agreement with the designated OPO, the	Moved and Revised	TS.11.01.01, EP 2	The hospital develops and implements policies and procedures for working with the organ procurement organization (OPO) and tissue and eye banks to do the following: - Review death records in order to improve identification of potential donors - Maintain potential donors while the necessary testing and placement of potential donated organs, tissues, and eyes takes place in order to maximize the viability of donor organs for transplant - Educate staff about issues surrounding donation CoPs: §482.45(a)(5)

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
	hospital documents its efforts to reach an agreement with its OPO, and the donation policy addresses the hospital's justification for not providing for asystolic recovery. CoPs: §482.45(a)(5), §482.45(a)(5) continued, §482.45(a)(5) continued			
TS.01.01.01, EP 5	Staff who have been designated to discuss potential organ, tissue, or eye donations with families are educated and trained in the use of discretion and sensitivity to the circumstances, beliefs, and desires of the families. CoPs: §482.45(a)(4), §482.45(a)(5)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
TS.01.01.01, EP 6	The hospital develops, in collaboration with the designated organ procurement organization, written procedures for notifying the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes. CoPs: §482.45(a)(3)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
TS.01.01.01, EP 7	The individual designated by the hospital to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes is an organ procurement representative, an organizational representative of a tissue or eye bank, or a designated requestor. Note: A designated requestor is an individual who has completed a course offered or approved by the organ procurement organization. This course is designed in conjunction with the tissue and eye bank community to provide a methodology for approaching potential donor families and requesting organ and tissue donation. CoPs: §482.45(a)(3) continued	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
TS.01.01.01, EP 8	The individual designated by the hospital documents that the patient or family accepts or declines the opportunity for the patient to become an organ, tissue, or eye donor.	Moved	TS.11.01.01, EP 3	The individual designated by the hospital documents that the patient or family accepts or declines the opportunity for the patient to become an organ, tissue, or eye donor.
TS.01.01.01, EP 9	The hospital notifies the organ procurement organization (OPO) of patients who have died and of mechanically ventilated patients whose death is imminent, according to the following: - Clinical triggers defined jointly with its medical staff and the designated OPO - Within the time frames (ideally, within one hour of death for patients who have expired) jointly agreed on by the hospital and the designated OPO - For mechanically ventilated patients, prior to the withdrawal of life-sustaining therapies including medical or pharmacological support Note: For additional information about criteria for the determination of brain death, please see the American Academy of Neurology guidelines available at https://n.neurology.org/content/early/2023/09/13/WNL.0000000000207740 and the American Academy of Pediatrics guidelines available at https://www.aan.com/Guidelines/Home/GuidelineDetail/1085 and the interactive tool that can be used alongside the new guidance to help walk clinicians through the BD/DNC evaluation process at https://www.aan.com/Guidelines/BDDNC. CoPs: §482.45(a)(1)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
TS.01.01.01, EP 10	In Department of Defense hospitals, Veterans Affairs medical centers, and other federally administered health care agencies, notification to the organ procurement organization of patients who have died or whose death is imminent is done according to procedures approved by the respective agency.	Moved	NPG.09.01.01, EP 7	In Department of Defense hospitals, Veterans Affairs medical centers, and other federally administered health care agencies, notification to the organ procurement organization of patients who have died or whose death is imminent is done according to procedures approved by the respective agency.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
TS.01.01.01, EP 11	The organ procurement organization determines medical suitability of organs for organ donation and, in the absence of alternative arrangements by the hospital, it determines the medical suitability of tissue and eyes for donation. CoPs: §482.45(a)(1)	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
TS.01.01.01, EP 12	The hospital maintains records of potential organ, tissue, or eye donors whose names have been sent to the organ procurement organization and tissue and eye banks.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
TS.02.01.01, EP 1	The hospital performing organ transplants belongs to and abides by the rules of the Organ Procurement and Transplantation Network (OPTN) * established under section 372 of the Public Health Service (PHS) Act. Footnote *: The term "rules of the OPTN" means those rules provided for in regulations issued by the Secretary in accordance with section 372 of the PHS Act which are enforceable under 42 CFR 121.10. No hospital is considered to be out of compliance with section 1138(a)(1)(B) of the Act, or with the requirements of this paragraph, unless the Secretary has given the OPTN formal notice that the Secretary approves the decision to exclude the hospital from the OPTN and has notified the hospital in writing. CoPs: §482.45(b)(1)	Moved and Revised	TS.12.01.01, EP 1	The hospital performing organ transplants belongs to and abides by the rules of the Organ Procurement and Transplantation Network (OPTN) established under section 372 of the Public Health Service (PHS) Act. Note: The term "rules of the OPTN" means those rules provided for in regulations issued by the Secretary of the US Department of Health & Human Services in accordance with section 372 of the PHS Act which are enforceable under 42 CFR 121.10. No hospital is considered to be out of compliance with section 1138(a)(1)(B) of the Act, or with the requirements of this element of performance, unless the Secretary has given the OPTN formal notice that the Secretary approves the decision to exclude the hospital from the OPTN and has notified the hospital in writing. CoPs: §482.45(b)(1)
TS.02.01.01, EP 2	If requested, the hospital provides all data related to organ transplant to the Organ Procurement and Transplantation Network (OPTN), the Scientific Registry, or the hospital's designated organ procurement organization (OPO), and when requested by the Office of the Secretary, directly to the US Department of Health & Human Services. CoPs: §482.45(b)(3)	Moved and Revised	TS.12.01.01, EP 2	If requested, the hospital provides all data related to organ transplant to the Organ Procurement and Transplantation Network (OPTN), the Scientific Registry of Transplant Recipients (SRTR), the hospital's designated organ procurement organization (OPO), and, when requested by the Office of the Secretary, directly to the US Department of Health & Human Services. CoPs: §482.45(b)(3)
TS.03.01.01, EP 1	The hospital assigns responsibility to one or more individuals for overseeing the acquisition, receipt, storage, and issuance of tissues throughout the hospital. Note: Responsibility for this oversight involves coordinating efforts to provide standardized practices throughout the hospital. A hospital may have a centralized process (one department responsible for the ordering, receipt, storage, and issuance of tissue throughout the hospital) or a decentralized process (multiple departments responsible for the ordering, receipt, storage, and issuance of tissue throughout the hospital).	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
TS.03.01.01, EP 2	The hospital develops and maintains standardized written procedures for the acquisition, receipt, storage, and issuance of tissues.	Moved and Revised	NPG.09.01.01, EP 1	The hospital develops and implements standardized written procedures for the acquisition, receipt, storage, and issuance of tissues.
TS.03.01.01, EP 3	The hospital confirms that tissue suppliers are registered with the US Food and Drug Administration (FDA) as a tissue establishment and maintain a state license when required. * Note: This element of performance does not apply to autologous tissue- or cellular-based products considered tissue for the purposes of these standards but classified as medical devices by the FDA. Footnote *: For US Food and Drug Administration (FDA) registration, the supplier registration status may also be checked annually by using the FDA's online database: https://www.fda.gov/vaccines-blood-biologics/biologics-establishment-registration/find-tissue-establishment.	Moved and Revised	NPG.09.01.01, EP 2	The hospital confirms that tissue suppliers are registered with the US Food and Drug Administration (FDA) as a tissue establishment and maintain a state license when required. Note 1: This element of performance does not apply to autologous tissue- or cellular-based products considered tissue for the purposes of these standards but classified as medical devices by the FDA. Note 2: The supplier's FDA registration status may also be checked annually by using the FDA's online database: https://www.fda.gov/vaccines-blood-biologics/biologics-establishment-registration/find-tissue-establishment.

Standard/EP	EP Text	Disposition	New Standard/EP	New EP Text
TS.03.01.01, EP 5	The hospital follows the tissue suppliers' or manufacturers' written directions for transporting, handling, storing, and using tissue.	Moved	NPG.09.01.01, EP 3	The hospital follows the tissue suppliers' or manufacturers' written directions for transporting, handling, storing, and using tissue.
TS.03.01.01, EP 6	The hospital documents the receipt of all tissues.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
TS.03.01.01, EP 7	The hospital verifies at the time of receipt that package integrity is met and transport temperature range was controlled and acceptable for tissues requiring a controlled environment. This verification is documented. Note 1: If the distributor uses validated shipping containers, then the receiver may document that the shipping container was received undamaged and within the stated time frame. Note 2: Tissues requiring no greater control than "ambient temperature" (generally defined as the temperature of the immediate environment) for transport and storage would not need to have the temperature verified on receipt.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
TS.03.01.01, EP 8	The hospital maintains daily records to demonstrate that tissues requiring a controlled environment are stored at the required temperatures. Note 1: Types of tissue storage include room temperature, refrigerated, frozen (for example, deep freezing colder than -40°C), and liquid nitrogen storage. Note 2: Tissues requiring no greater control than "ambient temperature" (defined as the temperature of the immediate environment) for storage would not require temperature monitoring.	Moved and Revised	NPG.09.01.01, EP 4	The hospital maintains daily records to demonstrate that tissues requiring a controlled environment are stored at the required temperatures. Note 1: Types of tissue storage include room temperature, refrigerated, frozen (for example, deep freezing colder than -40°C), and liquid nitrogen storage. Note 2: Tissues requiring no greater control than "ambient temperature" (defined as the temperature of the immediate environment) for storage would not require temperature monitoring.
TS.03.01.01, EP 9	The hospital continuously monitors the temperature of refrigerators, freezers, nitrogen tanks, and other storage equipment used to store tissues. Note 1: Continuous temperature recording is not required but may be available with some continuous temperature monitoring systems. Note 2: For tissue stored at room temperature, continuous temperature monitoring is not required.	Moved and Revised	NPG.09.01.01, EP 5	The hospital continuously monitors the temperature of refrigerators, freezers, nitrogen tanks, and other storage equipment used to store tissues. Note 1: Continuous temperature recording is not required but may be available with some continuous temperature monitoring systems. Note 2: For tissue stored at room temperature, continuous temperature monitoring is not required.
TS.03.01.01, EP 10	Refrigerators, freezers, nitrogen tanks, and other storage equipment used to store tissues at a controlled temperature have functional alarms and an emergency backup plan. Note: For tissue stored at room temperature, alarm systems are not required.	Moved and Revised	NPG.09.01.01, EP 6	Refrigerators, freezers, nitrogen tanks, and other storage equipment used to store tissues at a controlled temperature have functional alarms and an emergency backup plan. Note: For tissue stored at room temperature, alarm systems are not required.
TS.03.02.01, EP 1	The hospital's records allow any tissue to be traced from the donor or tissue supplier to the recipient(s) or other final disposition, including discard, and from the recipient(s) or other final disposition back to the donor or tissue supplier.	Moved	NPG.09.02.01, EP 1	The hospital's records allow any tissue to be traced from the donor or tissue supplier to the recipient(s) or other final disposition, including discard, and from the recipient(s) or other final disposition back to the donor or tissue supplier.
TS.03.02.01, EP 2	The hospital identifies, in writing, the materials and related instructions used to prepare or process tissues.	Moved	NPG.09.02.01, EP 2	The hospital identifies, in writing, the materials and related instructions used to prepare or process tissues.
TS.03.02.01, EP 3	The hospital documents the dates, times, and staff involved when tissue is accepted, prepared, and issued.	Deleted	N/A	N/A
TS.03.02.01, EP 4	The hospital documents in the recipient's medical record the tissue type and its unique identifier.	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
TS.03.02.01, EP 5	The hospital retains tissue records on storage temperatures, outdated procedures, manuals, and publications for a minimum of 10 years. If required by state and/or federal laws, hospitals may have to retain tissue records longer than 10 years.	Deleted EP - Replaced with more direct EP(s) or	N/A	N/A

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		moved to guidance within SPG		
TS.03.02.01, EP 6	The hospital retains tissue records for a minimum of 10 years beyond the date of distribution, transplantation, disposition, or expiration of tissue (whichever is latest). If required by state and/or federal laws, hospitals may have to retain tissue records longer than 10 years. Records are kept on all of the following: - The tissue supplier Note: For medical devices, the manufacturer may be the tissue supplier. - The original numeric or alphanumeric donor and lot identification - The name(s) of the recipient(s) or the final disposition of each tissue - The expiration dates of all tissues	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
TS.03.02.01, EP 7	The hospital completes and returns tissue usage information cards requested by the tissue supplier. * Footnote *: According to the Health Insurance Portability and Accountability Act (HIPAA) regulations regarding protected health information, "A covered entity may disclose protected health information for public health activities or other purposes to a person subject to the jurisdiction of the Food and Drug Administration (FDA) for the following purposes: - To track products if the disclosure is made to a person required or directed by the FDA to track the product - To enable product recalls, repairs or replacement (including locating and notifying individuals who have received products of product recalls, withdrawals, or other problems" (Refer to 45 CFR 164.512(b)(1)(iii)(B) and (C))	Deleted EP - Replaced with more direct EP(s) or moved to guidance within SPG	N/A	N/A
TS.03.03.01, EP 1	The hospital has a written procedure to investigate tissue adverse events, including disease transmission or other complications that are suspected of being directly related to the use of tissue.	Consolidation of TS.03.03.01, EP 1; TS.03.03.01, EP 2; TS.03.03.01, EP 3; TS.03.03.01, EP 4; TS.03.03.01, EP 5	NPG.09.03.01, EP 1	The hospital has a written procedure to investigate tissue adverse events, including disease transmission or other complications that are suspected of being directly related to the use of tissue. The procedure includes the following at a minimum: - Investigating disease transmission or other complications that are suspected of being directly related to the use of tissue - Reporting of a post-transplant infection or adverse event related to the use of tissue to the tissue supplier as soon as the hospital becomes aware - Sequestering of tissue whose integrity may have been compromised or that is reported by the tissue supplier as a suspected cause of infection - Identifying and informing tissue recipients of infection risk when donors are subsequently found to have human immunodeficiency virus (HIV), human T-lymphotropic virus-I/II (HTLV-I/II), viral hepatitis, or other infectious agents known to be transmitted through tissue
TS.03.03.01, EP 2	The hospital investigates tissue adverse events, including disease transmission or other complications that are suspected of being directly related to the use of tissue.	Consolidation of TS.03.03.01, EP 1; TS.03.03.01, EP 2; TS.03.03.01, EP 3; TS.03.03.01, EP 4; TS.03.03.01, EP 5	NPG.09.03.01, EP 1	The hospital has a written procedure to investigate tissue adverse events, including disease transmission or other complications that are suspected of being directly related to the use of tissue. The procedure includes the following at a minimum: - Investigating disease transmission or other complications that are suspected of being directly related to the use of tissue - Reporting of a post-transplant infection or adverse event related to the use of tissue to the tissue supplier as soon as the hospital becomes aware - Sequestering of tissue whose integrity may have been compromised or that is reported by the tissue supplier as a suspected cause of infection - Identifying and informing tissue recipients of infection risk when donors are subsequently found to have human immunodeficiency virus (HIV), human T-lymphotropic virus-I/II (HTLV-I/II), viral hepatitis, or other infectious agents known to be transmitted through tissue

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TS.03.03.01, EP 3	As soon as the hospital becomes aware of a post-transplant infection or other adverse event related to the use of tissue, it reports the infection or adverse event to the tissue supplier.	Consolidation of TS.03.03.01, EP 1; TS.03.03.01, EP 2; TS.03.03.01, EP 3; TS.03.03.01, EP 4; TS.03.03.01, EP 5	NPG.09.03.01, EP 1	The hospital has a written procedure to investigate tissue adverse events, including disease transmission or other complications that are suspected of being directly related to the use of tissue. The procedure includes the following at a minimum: - Investigating disease transmission or other complications that are suspected of being directly related to the use of tissue - Reporting of a post-transplant infection or adverse event related to the use of tissue to the tissue supplier as soon as the hospital becomes aware - Sequestering of tissue whose integrity may have been compromised or that is reported by the tissue supplier as a suspected cause of infection - Identifying and informing tissue recipients of infection risk when donors are subsequently found to have human immunodeficiency virus (HIV), human T-lymphotropic virus-I/II (HTLV-I/II), viral hepatitis, or other infectious agents known to be transmitted through tissue
TS.03.03.01, EP 4	The hospital sequesters tissue whose integrity may have been compromised or that is reported by the tissue supplier as a suspected cause of infection.	Consolidation of TS.03.03.01, EP 1; TS.03.03.01, EP 2; TS.03.03.01, EP 3; TS.03.03.01, EP 4; TS.03.03.01, EP 5	NPG.09.03.01, EP 1	The hospital has a written procedure to investigate tissue adverse events, including disease transmission or other complications that are suspected of being directly related to the use of tissue. The procedure includes the following at a minimum: - Investigating disease transmission or other complications that are suspected of being directly related to the use of tissue - Reporting of a post-transplant infection or adverse event related to the use of tissue to the tissue supplier as soon as the hospital becomes aware - Sequestering of tissue whose integrity may have been compromised or that is reported by the tissue supplier as a suspected cause of infection - Identifying and informing tissue recipients of infection risk when donors are subsequently found to have human immunodeficiency virus (HIV), human T-lymphotropic virus-I/II (HTLV-I/II), viral hepatitis, or other infectious agents known to be transmitted through tissue
TS.03.03.01, EP 5	The hospital identifies and informs tissue recipients of infection risk when donors are subsequently found to have human immunodeficiency virus (HIV), human T-lymphotropic virus-I/II (HTLV-I/II), viral hepatitis, or other infectious agents known to be transmitted through tissue.	Consolidation of TS.03.03.01, EP 1; TS.03.03.01, EP 2; TS.03.03.01, EP 3; TS.03.03.01, EP 4; TS.03.03.01, EP 5	NPG.09.03.01, EP 1	The hospital has a written procedure to investigate tissue adverse events, including disease transmission or other complications that are suspected of being directly related to the use of tissue. The procedure includes the following at a minimum: - Investigating disease transmission or other complications that are suspected of being directly related to the use of tissue - Reporting of a post-transplant infection or adverse event related to the use of tissue to the tissue supplier as soon as the hospital becomes aware - Sequestering of tissue whose integrity may have been compromised or that is reported by the tissue supplier as a suspected cause of infection - Identifying and informing tissue recipients of infection risk when donors are subsequently found to have human immunodeficiency virus (HIV), human T-lymphotropic virus-I/II (HTLV-I/II), viral hepatitis, or other infectious agents known to be transmitted through tissue
UP.01.01.01, EP 1	Implement a preprocedure process to verify the correct procedure, for the correct patient, at the correct site. Note: The patient is involved in the verification process when possible.	Moved and Revised	NPG.01.06.01, EP 1	The hospital implements a preprocedure process to verify the correct procedure, for the correct patient, at the correct site. Note: The patient is involved in the verification process when possible.
UP.01.01.01, EP 2	Identify the items that must be available for the procedure and use a standardized list to verify their availability. At a minimum, these items include the following: - Relevant documentation (for example, history and physical, signed procedure consent form, nursing assessment, and preanesthesia assessment) - Labeled diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly displayed - Any required blood products, implants, devices, and/or special equipment for the	Moved and Revised	NPG.01.06.01, EP 2	The hospital identifies the items that must be available for the procedure and uses a standardized list to verify their availability. At a minimum, these items include the following: - Relevant documentation (for example, history and physical, signed procedure consent form, nursing assessment, and preanesthesia assessment) - Labeled diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly displayed

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	procedure Note: The expectation of this element of performance is that the standardized list is available and is used consistently during the preprocedure verification. It is not necessary to document that the standardized list was used for each patient.			- Any required blood products, implants, devices, and/or special equipment for the procedure Note: The expectation of this element of performance is that the standardized list is available and is used consistently during the preprocedure verification. It is not necessary to document that the standardized list was used for each patient.
UP.01.02.01, EP 1	Identify those procedures that require marking of the incision or insertion site. At a minimum, sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety. Note: For spinal procedures, in addition to preoperative skin marking of the general spinal region, special intraoperative imaging techniques may be used for locating and marking the exact vertebral level.	Moved and Revised	NPG.01.06.02, EP 1	The hospital identifies those procedures that require marking of the incision or insertion site. At a minimum, sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety. Note: For spinal procedures, in addition to preoperative skin marking of the general spinal region, special intraoperative imaging techniques may be used for locating and marking the exact vertebral level.
UP.01.02.01, EP 2	Mark the procedure site before the procedure is performed and, if possible, with the patient involved.	Moved and Revised	NPG.01.06.02, EP 2	The procedure site is marked before the procedure is performed and, if possible, with the patient involved.
UP.01.02.01, EP 3	The procedure site is marked by a licensed practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed. In limited circumstances, the licensed practitioner may delegate site marking to an individual who is permitted by the organization to participate in the procedure and has the following qualifications: - An individual in a medical postgraduate education program who is being supervised by the licensed practitioner performing the procedure; who is familiar with the patient; and who will be present when the procedure is performed - A licensed individual who performs duties requiring a collaborative agreement or supervisory agreement with the licensed practitioner performing the procedure (that is, an advanced practice registered nurse [APRN] or physician assistant [PA]); who is familiar with the patient; and who will be present when the procedure is performed. Note: The hospital's leaders define the limited circumstances (if any) in which site marking may be delegated to an individual meeting these qualifications.	Moved	NPG.01.06.02, EP 3	The procedure site is marked by a licensed practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed. In limited circumstances, the licensed practitioner may delegate site marking to an individual who is permitted by the organization to participate in the procedure and has the following qualifications: - An individual in a medical postgraduate education program who is being supervised by the licensed practitioner performing the procedure; who is familiar with the patient; and who will be present when the procedure is performed - A licensed individual who performs duties requiring a collaborative agreement or supervisory agreement with the licensed practitioner performing the procedure (that is, an advanced practice registered nurse [APRN] or physician assistant [PA]); who is familiar with the patient; and who will be present when the procedure is performed. Note: The hospital's leaders define the limited circumstances (if any) in which site marking may be delegated to an individual meeting these qualifications.
UP.01.02.01, EP 4	The method of marking the site and the type of mark is unambiguous and is used consistently throughout the hospital. Note: The mark is made at or near the procedure site and is sufficiently permanent to be visible after skin preparation and draping. Adhesive markers are not the sole means of marking the site.	Moved	NPG.01.06.02, EP 4	The method of marking the site and the type of mark is unambiguous and is used consistently throughout the hospital. Note: The mark is made at or near the procedure site and is sufficiently permanent to be visible after skin preparation and draping. Adhesive markers are not the sole means of marking the site.
UP.01.02.01, EP 5	A written, alternative process is in place for patients who refuse site marking or when it is technically or anatomically impossible or impractical to mark the site (for example, mucosal surfaces or perineum). Note: Examples of other situations that involve alternative processes include: - Minimal access procedures treating a lateralized internal organ, whether percutaneous or through a natural orifice - Teeth - Premature infants, for whom the mark may cause a permanent tattoo	Moved and Revised	NPG.01.06.02, EP 5	A written, alternative process is in place for patients who refuse site marking or when it is technically or anatomically impossible or impractical to mark the site (for example, mucosal surfaces or perineum). Note: Examples of other situations that involve alternative processes include the following: - Minimal access procedures treating a lateralized internal organ, whether percutaneous or through a natural orifice - Teeth - Premature infants, for whom the mark may cause a permanent tattoo
UP.01.03.01, EP 1	Conduct a time-out immediately before starting the invasive procedure or making the incision.	Moved and Revised	NPG.01.06.03, EP 1	The hospital conducts a time-out immediately before starting the invasive procedure or making the incision.
UP.01.03.01, EP 2	The time-out has the following characteristics: - It is standardized, as defined by the hospital. - It is initiated by a designated member of the team. - It involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the	Moved	NPG.01.06.03, EP 2	The time-out has the following characteristics: - It is standardized, as defined by the hospital. - It is initiated by a designated member of the team. - It involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the

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	operating room technician, and other active participants who will be participating in the procedure from the beginning.			operating room technician, and other active participants who will be participating in the procedure from the beginning.
UP.01.03.01, EP 3	When two or more procedures are being performed on the same patient, and the person performing the procedure changes, perform a time-out before each procedure is initiated.	Moved and Revised	NPG.01.06.03, EP 3	When two or more procedures are being performed on the same patient, and the person performing the procedure changes, the hospital performs a time-out before each procedure is initiated.
UP.01.03.01, EP 4	During the time-out, the team members agree, at a minimum, on the following: - Correct patient identity - The correct site - The procedure to be done	Moved	NPG.01.06.03, EP 4	During the time-out, the team members agree, at a minimum, on the following: - Correct patient identity - The correct site - The procedure to be done
UP.01.03.01, EP 5	Document the completion of the time-out. Note: The hospital determines the amount and type of documentation.	Moved and Revised	NPG.01.06.03, EP 5	The hospital documents the completion of the time-out. Note: The hospital determines the amount and type of documentation.
WT.01.01.01, EP 1	The director named on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate approves a consistent approach for when waived test results can be used for diagnosis and treatment and when follow-up testing is required.	Consolidation of WT.01.01.01, EP 1; WT.01.01.01, EP 2	NPG.10.01.01, EP 1	The person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate, or a qualified designee, establishes written policies and procedures for waived testing that address the following: - Clinical usage and limitations of the test methodology - Need for confirmatory testing (for example, recommendations made by the manufacturer for rapid tests) and result follow-up recommendations (for example, a recommendation to repeat the test when results are higher or lower than the reportable range of the test) - Specimen type, collection, and identification, and required labeling - Specimen preservation, if applicable - Instrument maintenance and function checks, such as calibration - Storage conditions for test components - Reagent use, including not using a reagent after its expiration date - Quality control (including frequency and type) and corrective action when quality control is unacceptable - Test performance - Result reporting, including not reporting individual patient results unless quality control is acceptable - Equipment performance evaluation Note 1: Policies and procedures for waived testing are made available to testing personnel. Note 2: The designee should be knowledgeable by virtue of training, experience, and competence about the waived testing performed.
WT.01.01.01, EP 2	The person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate, or a qualified designee, establishes written policies and procedures for waived testing that address the following: - Clinical usage and limitations of the test methodology - Need for confirmatory testing (for example, recommendations made by the manufacturer for rapid tests) and result follow-up recommendations (for example, a recommendation to repeat the test when results are higher or lower than the reportable range of the test) - Specimen type, collection, and identification, and required labeling - Specimen preservation, if applicable - Instrument maintenance and function checks, such as calibration - Storage conditions for test components - Reagent use, including not using a reagent after its expiration date	Consolidation of WT.01.01.01, EP 1; WT.01.01.01, EP 2	NPG.10.01.01, EP 1	The person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate, or a qualified designee, establishes written policies and procedures for waived testing that address the following: - Clinical usage and limitations of the test methodology - Need for confirmatory testing (for example, recommendations made by the manufacturer for rapid tests) and result follow-up recommendations (for example, a recommendation to repeat the test when results are higher or lower than the reportable range of the test) - Specimen type, collection, and identification, and required labeling - Specimen preservation, if applicable - Instrument maintenance and function checks, such as calibration - Storage conditions for test components - Reagent use, including not using a reagent after its expiration date

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	- Quality control (including frequency and type) and corrective action when quality control is unacceptable - Test performance - Result reporting, including not reporting individual patient results unless quality control is acceptable - Equipment performance evaluation Note 1: Policies and procedures for waived testing are made available to testing personnel. Note 2: The designee should be knowledgeable by virtue of training, experience, and competence about the waived testing performed.			- Quality control (including frequency and type) and corrective action when quality control is unacceptable - Test performance - Result reporting, including not reporting individual patient results unless quality control is acceptable - Equipment performance evaluation Note 1: Policies and procedures for waived testing are made available to testing personnel. Note 2: The designee should be knowledgeable by virtue of training, experience, and competence about the waived testing performed.
WT.01.01.01, EP 3	If manufacturers' manuals or package inserts are used as the policies or procedures for each waived test, they are enhanced to include specific operational policies (that is, detailed quality control protocols and any other institution-specific procedures regarding the test or instrument).	Moved and Revised	NPG.10.01.01, EP 2	Policies or procedures for each waived test are consistent with manufacturers' instructions for use and include specific operational policies (that is, detailed quality control protocols and any other institution-specific procedures regarding the test or instrument).
WT.02.01.01, EP 1	The person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate, or a qualified designee, identifies in writing the staff responsible for performing and supervising waived testing.	Deleted	N/A	N/A
WT.03.01.01, EP 1	The person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate, or a qualified designee, provides orientation and training to, and assesses the competency of, staff who perform waived testing.	Deleted	N/A	N/A
WT.03.01.01, EP 2	Staff who perform waived testing have received orientation in accordance with the hospital's specific services. The orientation for waived testing is documented.	Deleted	N/A	N/A
WT.03.01.01, EP 3	Staff who perform waived testing have been trained for each test that they are authorized to perform. The training for each waived test is documented.	Consolidation of WT.03.01.01, EP 3; WT.03.01.01, EP 4	NPG.10.02.01, EP 1	Staff who perform waived testing have been trained for each test that they are authorized to perform. The training for each waived test is documented. Note: This includes training on the use and maintenance of instruments.
WT.03.01.01, EP 4	Staff who perform waived testing that requires the use of an instrument have been trained on its use and maintenance. The training on the use and maintenance of an instrument for waived testing is documented.	Consolidation of WT.03.01.01, EP 3; WT.03.01.01, EP 4	NPG.10.02.01, EP 1	Staff who perform waived testing have been trained for each test that they are authorized to perform. The training for each waived test is documented. Note: This includes training on the use and maintenance of instruments.
WT.03.01.01, EP 5	Competency for waived testing is assessed using at least two of the following methods per person per test: - Performance of a test on a blind specimen - Periodic observation of routine work by the supervisor or qualified designee - Monitoring of each user's quality control performance - Use of a written test specific to the test assessed	Consolidation of WT.03.01.01, EP 5; WT.03.01.01, EP 6	NPG.10.02.01, EP 2	Competence for waived testing is assessed according to hospital policy at defined intervals, but at least at the time of orientation and annually thereafter. Competency is assessed using at least two of the following methods per person per test: - Performance of a test on a blind specimen - Periodic observation of routine work by the supervisor or qualified designee - Monitoring of each user's quality control performance - Use of a written test specific to the test assessed This competency is documented. Note 1: When a licensed practitioner performs waived testing that does not involve an instrument and the test falls within their specialty, the hospital may use the medical staff credentialing and privileging process to document evidence of training and competency in lieu of annual competency assessment. In this circumstance, individual privileges include the specific waived tests appropriate to the scope of practice that they are authorized to perform. At the discretion of the person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate or according to hospital policy, more stringent competency requirements may be implemented. Note 2: Provider-performed microscopy (PPM) procedures are not waived tests.

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WT.03.01.01, EP 6	Competence for waived testing is assessed according to hospital policy at defined intervals, but at least at the time of orientation and annually thereafter. This competency is documented. Note 1: When a physician or other licensed practitioner performs waived testing that does not involve an instrument and the test falls within their specialty, the hospital may use the medical staff credentialing and privileging process to document evidence of training and competency in lieu of annual competency assessment. In this circumstance, individual privileges include the specific waived tests appropriate to the scope of practice that they are authorized to perform. At the discretion of the person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate or according to hospital policy, more stringent competency requirements may be implemented. Note 2: Provider-performed microscopy (PPM) procedures are not waived tests.	Consolidation of WT.03.01.01, EP 5; WT.03.01.01, EP 6	NPG.10.02.01, EP 2	Competence for waived testing is assessed according to hospital policy at defined intervals, but at least at the time of orientation and annually thereafter. Competency is assessed using at least two of the following methods per person per test: - Performance of a test on a blind specimen - Periodic observation of routine work by the supervisor or qualified designee - Monitoring of each user's quality control performance - Use of a written test specific to the test assessed This competency is documented. Note 1: When a licensed practitioner performs waived testing that does not involve an instrument and the test falls within their specialty, the hospital may use the medical staff credentialing and privileging process to document evidence of training and competency in lieu of annual competency assessment. In this circumstance, individual privileges include the specific waived tests appropriate to the scope of practice that they are authorized to perform. At the discretion of the person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate or according to hospital policy, more stringent competency requirements may be implemented. Note 2: Provider-performed microscopy (PPM) procedures are not waived tests.
WT.04.01.01, EP 2	The documented quality control rationale for waived testing is based on the following: - How the test is used - Reagent stability - Manufacturers' recommendations - The hospital's experience with the test - Currently accepted guidelines	Deleted	N/A	N/A
WT.04.01.01, EP 3	For non-instrument-based waived testing, quality control checks are performed at the frequency and number of levels recommended by the manufacturer and as defined by the hospital's policies. Note: If these elements are not defined by the manufacturer, the hospital defines the frequency and number of levels for quality control.	Deleted	N/A	N/A
WT.04.01.01, EP 4	For instrument-based waived testing, quality control checks are performed on each instrument used for patient testing per manufacturers' instructions.	Deleted	N/A	N/A
WT.04.01.01, EP 5	For instrument-based waived testing, quality control checks require two levels of control, if commercially available.	Deleted	N/A	N/A
WT.05.01.01, EP 1	Quality control results, including internal and external controls for waived testing, are documented. Note 1: Internal quality controls may include electronic, liquid, or control zone. External quality controls may include electronic or liquid. Note 2: Quality control results may be located in the medical record.	Deleted	N/A	N/A
WT.05.01.01, EP 3	Quantitative test result reports in the medical record for waived testing are accompanied by reference intervals (normal values) specific to the test method used and the population served. Note 1: Semiquantitative results, such as urine macroscopic and urine dipsticks, are not required to comply with this element of performance. Note 2: If the reference intervals (normal values) are not documented on the same page as and adjacent to the waived test result, they must be located elsewhere within the permanent medical record. The result must have a notation directing the reader to the location of the reference intervals (normal values) in the medical record.	Deleted	N/A	N/A

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WT.05.01.01, EP 4	Individual test results for waived testing are associated with quality control results and instrument records. Note: A formal log is not required, but a functional audit trail is maintained that allows retrieval of individual test results and their association with quality control and instrument records.	Deleted	N/A	N/A
WT.05.01.01, EP 5	Quality control result records, test result records, and instrument records for waived testing are retained for at least two years.	Deleted	N/A	N/A